



Primary Prevention Plan

2011-2016

March 2011



Government
of South Australia

SA Health

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We offer sincere thanks to the many contributors to the development of the SA Health Primary Prevention Plan 2011–2016.

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Minister's Foreword

This document marks the next step in the development of primary health care reforms outlined in the *SA Health Care Plan 2007-2016*.

When the Plan was launched, I said I wanted South Australians living healthier and more satisfying lives – as well as living longer lives. I wanted to see a focus on early detection and management of chronic disease, and on more promotion and prevention programs.

History shows that primary prevention makes a positive difference to people's health. Preventative programs have played a critical role in reducing rates of smoking - the single biggest threat to health - cardiovascular disease; road trauma; sudden infant death

syndrome; HIV/AIDS and other communicable diseases.

Many of the conditions which have a negative impact on people's lives can be prevented or delayed. Poor diet, physical inactivity and obesity all seriously compromise health. Risky alcohol use and binge drinking, sexually transmitted diseases and oral health problems impact on individuals, families, the community and the health system.

The Primary Prevention Plan sets out the Government's commitment to support good health and to reduce the conditions that contribute to poor health.

Many of the determinants of health are outside the direct control of the health sector. By forming strong partnerships with different organisations, we can collectively create healthy policies and environments. Our internationally recognised Health in All Policies approach provides us with a mechanism for effective collaboration.

Primary prevention is not easy. It takes "joined up" thinking and time to deliver results. But there is evidence it works and with the combined efforts of individuals, communities, the health care system, and all levels of government and non-government agencies we can make a difference to the lives of South Australians.

We already have a world class health care system in our state; the Primary Prevention Plan aims to ensure our primary prevention strategies are also first class.

A handwritten signature in black ink, which appears to read "John Hill". The signature is written in a cursive, flowing style.

Hon John Hill MP
Minister for Health
Minister for Mental Health and Substance Abuse

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1. Overview

Protecting and promoting good health and preventing illness are vital for individuals and the community. It makes good sense to do all we can to support people to be as healthy as possible.

Overall, South Australians have very good health status; nonetheless, many of the health problems affecting the everyday lives of individuals and their families are preventable or can be delayed. It is also clear that health is not evenly distributed across the population and there are some groups who experience avoidable differences in health, wellbeing and length of life. We need to use evidence-informed strategies to support the health of all South Australians and put in place particular strategies for those most in need.

South Australia's Health Care Plan 2007–2016, the state government's response to the Generational Health Review, includes a commitment to preventing ill-health and promoting a healthy population.¹ Indeed, the architecture of health system reform rests on building individual and community capacity for health and wellbeing, as illustrated in Figure 1.

The Primary Prevention Plan 2011–2016 (PPP) provides details on this commitment to good health. It sets out a framework for primary prevention effort across SA Health, through both the Department of Health (DH) and the regional health services. It recognises the importance of working with a broad range of government and non-government partners, as well as individuals and communities, to support South Australians to lead and maintain healthy lives.

There are already many important and successful prevention initiatives in place. The PPP provides an overarching framework for action to improve health and wellbeing outcomes for all South Australians and especially those most in need.

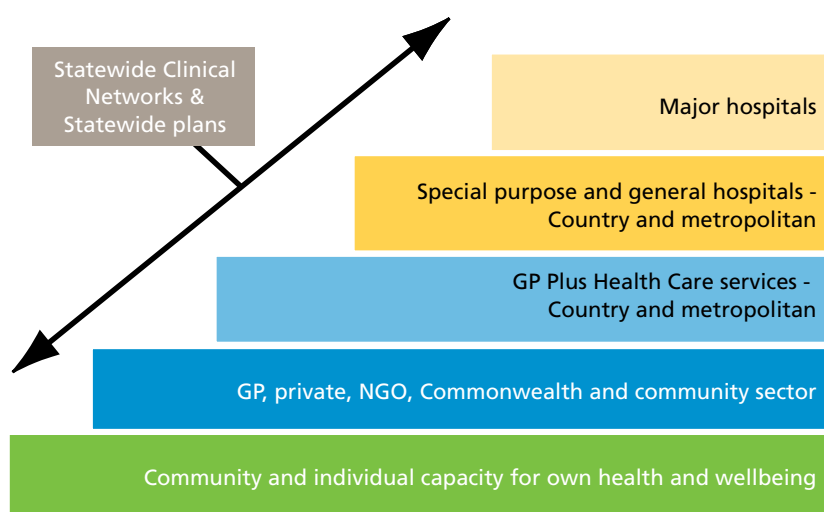


Figure 1: Stepped care architecture of the South Australian health system

1.1 Purpose of the Primary Prevention Plan

The PPP:

- > aims to contribute to improving health and wellbeing and reducing inequities for South Australians
- > describes the rationale for increasing efforts in prevention and some of the challenges
- > outlines a framework comprising underpinning principles; evidence on good practice; and enablers for action, including leadership, coordination and partnerships, monitoring, evaluation and research, and workforce capacity

- > prioritises the consolidation and extension of universal approaches to prevention for the whole population and more targeted approaches as risk increases. This should occur by maintaining effective public health and building healthy public policy to address the determinants of health, and through action directed to the provision of progressively more targeted services for those with increasing need across the life course
- > outlines the next steps for implementation and accountability.

1.2. What is primary prevention?

Prevention is defined as ‘action to reduce or eliminate, or reduce the onset, causes, complications or recurrence, of disease’.²

Primary prevention aims to support and promote good health and eliminate or reduce factors that contribute to poor health. It is directed at both the whole population and certain subgroups (e.g. young people). It also applies in one-to-one clinical settings, for example through the provision of information on how to stay healthy.

Primary prevention involves taking action before a problem arises in order to avoid it entirely, rather than treating or alleviating its consequences.³

Importantly, primary prevention includes actions that reduce the average risk in the whole population as well as for individuals and groups with particular conditions.⁴ Thus, small changes in risk across large numbers of people can reduce the incidence and prevalence of disease.

1.3. Context

The growing burden of chronic disease, increased levels of health care required by an ageing population, consumer demand for care and the cost of new technological improvements in health care delivery have combined to place unsustainable demands on health and state government budgets and on hospital and community services.

Under the SA Health Care Plan, three key measures have been put in place to help address these major challenges and drive health system reform: the PPP, the GP Plus Health Care Strategy (GP Plus) and the Model of Care (see Figure 2).

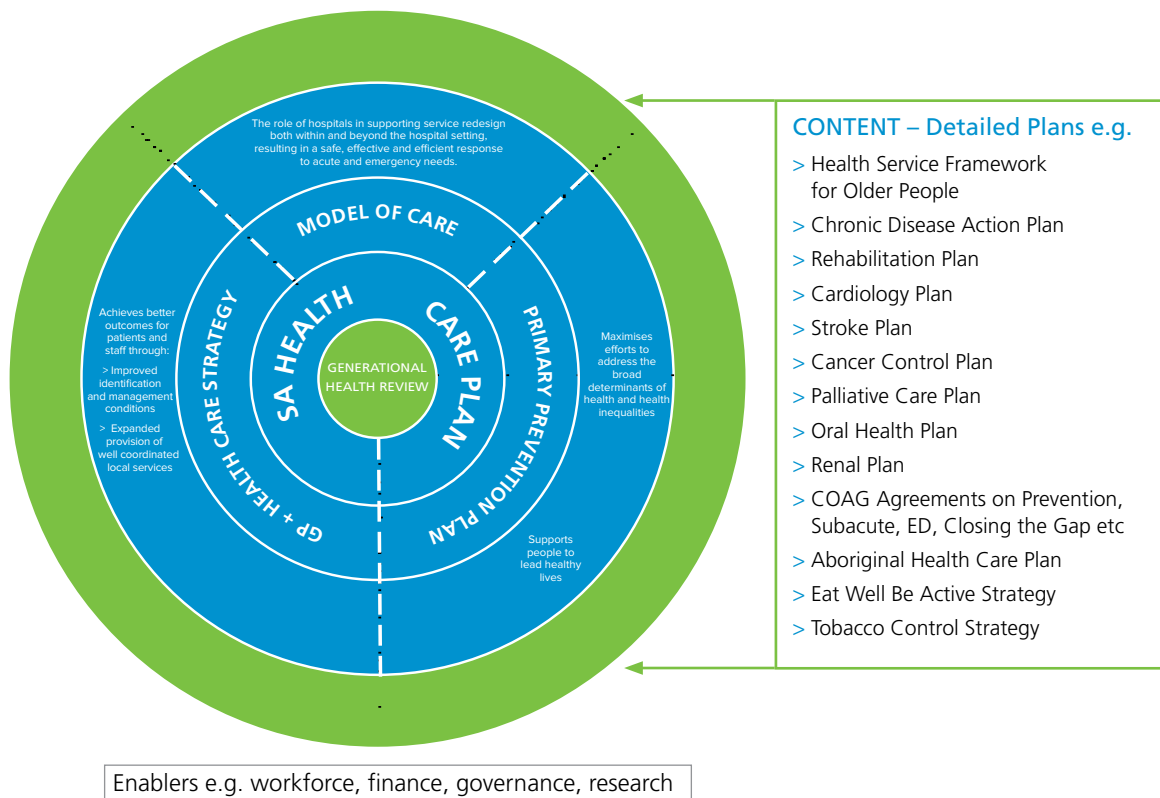


Figure 2: The reform agenda: how it all fits together

Strategies to support good health and prevent illness are complemented by the provision of effective primary health care services through the GP Plus strategy to prevent, treat and manage common conditions, and by access to tertiary hospital services for more specialised care. General practitioners (GPs) are key providers of prevention services to the community, and the proposed establishment of Medicare Locals will offer an opportunity to ensure a good connection between understanding the population's health needs, especially those who are more disadvantaged, and ensuring the best service responses.

There are also state and national policy drivers that require SA Health to set clear directions for primary prevention. The PPP dovetails with SA Health's Clinical Network Plans, outlining the primary prevention actions related to many of these clinical areas (Appendix 1). It provides an overarching framework for statewide strategies such as the Eat Well Be Active Strategy, the South Australian Tobacco Control Strategy, and implementation plans associated with delivering on targets articulated in South Australia's Strategic Plan (SASP).

Nationally, the National Preventive Health Taskforce (NPHT) identified priorities for prevention, particularly smoking, obesity and alcohol.⁵ The Council of Australian Governments (COAG) agreed to the National Partnership Agreement on Preventive Health, allocating up to \$47 million to South Australia (SA) over the 6-year interval 2009–15, partly subject to the achievement of benchmarks.⁶ The Closing the Gap COAG Agreement on Indigenous Health and the Indigenous Early Childhood COAG Agreement also include a number of primary prevention strategies.

The National Health and Hospital Reform Commission⁷ and the National Primary Care Report⁸ both acknowledge the importance of prevention, and the NPHT has made a number of recommendations to the Australian Government related to obesity, tobacco and alcohol.

The World Health Organization's Commission on Social Determinants of Health report, *Closing the Gap in a Generation*, adds weight and evidence to the importance of prevention and a focus on those most in need.⁹

Aboriginal health and wellbeing

SA Health's Aboriginal Health Care Plan (AHCP) gives details on its commitment to closing the gap in health outcomes between Aboriginal people and the rest of the population. Prevention is particularly important for Aboriginal South Australians as much of their poor health is preventable. The AHCP includes *support for good health* as a key component of the model and sets out a range of general and specific prevention-related priority initiatives.¹⁰ It also prioritises the provision of comprehensive primary health care services that can address common issues such as chronic diseases, ear health and infections to maximise their prevention. Prevention services are provided by Aboriginal Community Controlled Health Services (ACCHSs) as part of a comprehensive range of services as well as mainstream services.

The PPP complements the more specific AHCP and identifies many universal strategies that will also support Aboriginal health. See Appendix 2 for more detailed cross-referencing.

1.4 Prevention across the continuum

There are opportunities to promote good health and prevent illness or progression of disease at all stages of the continuum (see Figure 3). Practitioners throughout the health system are also well placed to identify threats to poor health and take action, both with individuals and in the public domain. Every encounter with a health practitioner should be seen as an opportunity to provide positive health messages (e.g. importance of mental health, safe sexual health).

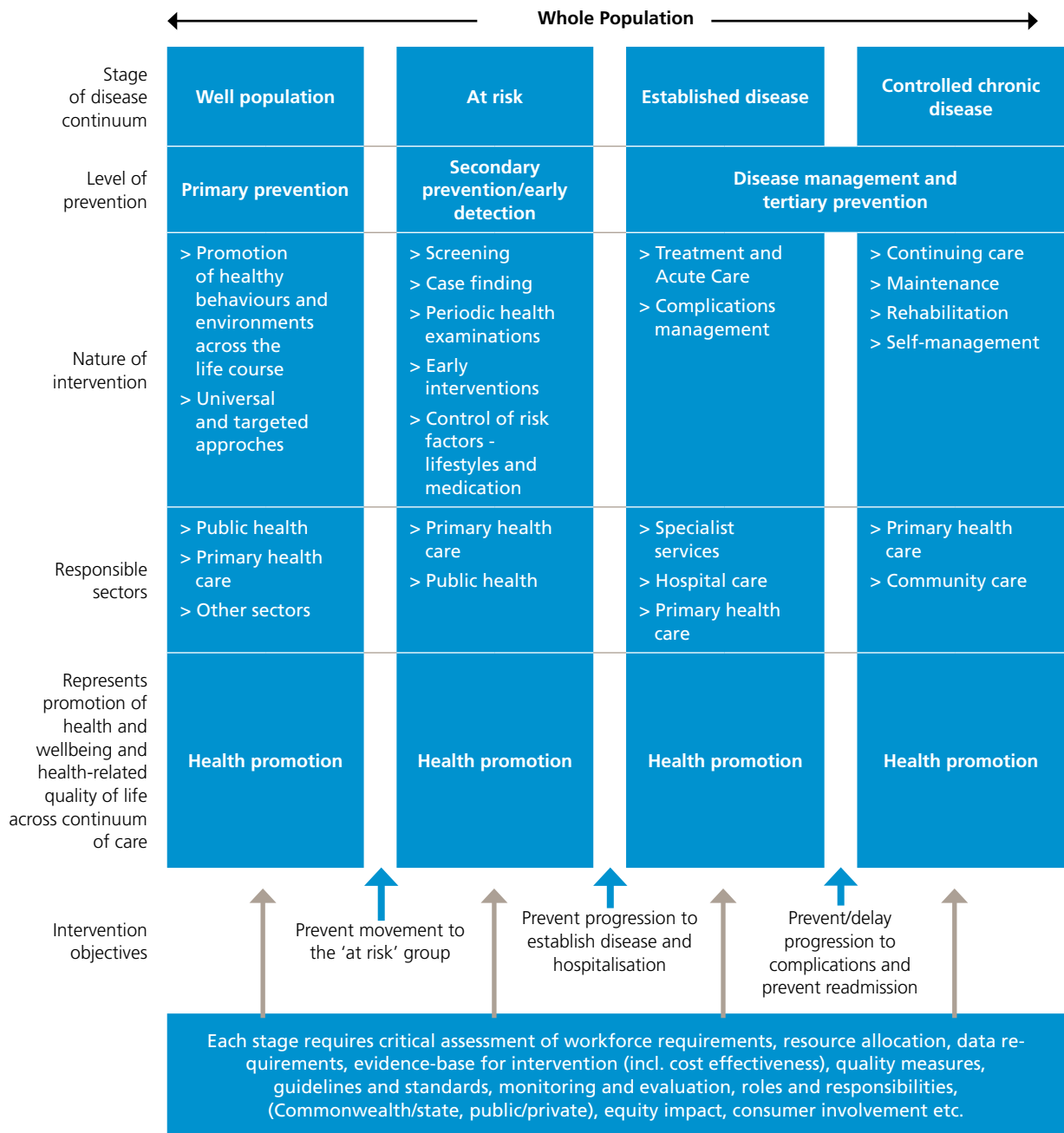
A wide range of players form the primary prevention workforce, including:

- > **primary health care providers**, including physiotherapists, dietitians, pharmacists, GPs, midwives, community and Aboriginal community-controlled health services, environmental health officers and domiciliary care workers
- > **clinical health staff**, who play an important role through prevention-focused advice for individuals, support for the primary health care sector, advocacy for health-promoting public policy and a focus on prevention
- > **other sectors**, including teachers, sport and recreation workers, welfare workers, community development staff and local government officers
- > **individuals and community members**, who identify and address local issues that impact on health, and look after their own health and the health of family and friends
- > **universities**, who train workers and support health-promotion practice and research on current and emerging issues
- > **public, private and non-government organisations**, e.g. South Australian Council of Social Service, pharmacies and health organisations, who play a key role in service provision and advocacy
- > **local, state and Australian governments**, who undertake policy and strategic planning, and fund workforce development and research.

The GP Plus strategy and implementation of models of care for stroke, older persons' health, rehabilitation, cardiology, cancer and others are major areas of reform. Primary prevention action complements and is integrally connected with this work. For example, vascular conditions are preventable through public policy approaches to smoking and obesity and healthy living programs complemented by good blood pressure and cholesterol screening and management, and by cardiac or stroke rehabilitation programs. Individuals with established disease also benefit from primary prevention strategies such as the creation of environments that support affordable healthy food and physical activity. Practitioners working in all areas of the health system are well placed to empower people to know more about their own health and provide appropriate referrals.

Similarly, offering pregnant women and new parents tailored support can build healthy resilient children for the future. However, this needs to be complemented by early intervention for those with risk factors such as drug and alcohol abuse or lack of support, and by intensive management of high-need families such as those identified through the child protection system.

In both cases the outcomes will be better using a combined and integrated approach where prevention is valued and supported. The acute sector will always have pressing imperatives but investment in primary prevention requires ongoing commitment to build partnerships for effective action. No matter where people work in the health system, they should feel confident in their ability to support good health and recognise the across-the-continuum approach to health issues.



Source: Preventing chronic disease: a strategic framework

Figure 3: Prevention across the continuum ¹¹

1.5 Effectiveness of primary prevention

Effective primary prevention interventions have been shown to improve health and reduce and better manage demand for treatment services in both the short and the longer term.⁵ They are an important component of a balanced investment across the continuum of health care.^{12,13} Well-planned prevention programs have resulted in reductions in tobacco use, HIV/AIDS, road trauma, drink driving, skin cancers, cardiovascular disease, childhood infectious diseases and sudden infant death syndrome (SIDS), to name a few.

A 2008 study, *Prevention for a healthier America*, calculated that for every US dollar invested in proven community-based disease prevention programs (increasing physical activity, improving nutrition and reducing smoking levels), the return on investment over and above the cost of the program would be US\$5.60 within 5 years.³ In Australia the 2003 *Returns on investment in public health* report estimated that the 30% decline in smoking between 1975 and 1995 had prevented over 400 000 premature deaths and saved costs of over \$8.4 billion, more than 50 times the amount that was spent over that period on anti-tobacco strategies.¹⁴

Primary prevention has been shown to be particularly effective for heart disease, stroke, diabetes, cancer and injury.¹⁵ For example, in the UK primary prevention was found to have reduced four times as many heart disease deaths as secondary prevention, which focused on individual treatments.¹⁶ This occurred through small decreases in smoking levels and improved diet by large numbers of people. Similarly, in Finland primary prevention of risk factors was found to have prevented two to three times as many coronary heart disease deaths as other activities.¹⁷

However, prevention does not always save money; indeed, it can sometimes add to health care costs, and not all prevention programs are cost-effective.¹⁸ The recent *Assessing cost-effectiveness in prevention* report provides a comprehensive analysis of the comparative cost-effectiveness of preventive intervention options addressing the non-communicable disease burden in Australia, including a specific focus on Indigenous Australians.¹⁹

Consultations on the PPP confirmed strong support for clearer directions on priorities for action in primary prevention and a move away from the '1000 flowers blooming' approach, which included small-scale, short-term and/or one-off initiatives that have little chance of success and are difficult to evaluate.

To be effective, prevention programs need long-term investment, preferably over 5 years, at sufficient intensity to make a difference and with good evaluation to be accountable for the outcomes required.

The next section identifies the challenges and opportunities in selecting primary prevention priorities for action to better focus our efforts in this area. This is followed by the framework for action for the PPP.

2. Understanding the challenges in primary prevention

Consultations in developing this Plan have identified a number of challenges for those planning and implementing primary prevention as outlined below.

2.1 The social determinants of health

Different groups in society face different life circumstances. Disadvantaged groups, who generally have the worst health, are also more likely to experience lower incomes and intergenerational poverty, poor employment conditions, lower housing security, reduced access to or uptake of early learning and other education opportunities, racism, discrimination, isolation or poor neighbourhood conditions. These are often termed the social determinants of health or the 'causes of the causes'.²⁰

These determinants are largely outside the direct control of the health sector. SASP targets many of these determinants, including literacy, employment, housing and early childhood opportunities, with other departments and community organisations leading the action. This action is also furthered through the Health in All Policies (HiAP) initiative (see page 49).

Individual lifestyle behaviour such as smoking, poor diet and heavy drinking cause poor health, but these choices we make as individuals are affected by our social and economic circumstances, which both cause and compound the poorer health outcomes.

Determinants such as social and community networks, early childhood development, personal health behaviours, psychological factors (e.g. resilience) and parenting skills are more amenable to intervention by health services and contribute to supporting healthy lives. Figure 4 illustrates the way various determinants interact on the health of individuals and communities; ideally, determinants are positive or protective rather than having a negative impact.

Health service access is an important determinant of health in its own right and a priority for health reform. The differential experience of illness has direct effects upon how well disadvantaged people are able to act upon the broader determinants of their own health.²¹ For example, in the course of sustained illness, a low-income worker with no financial or housing security may risk losing their job, savings and accommodation, which in turn can negatively affect their recovery, re-entry into housing and future employment chances. These impacts can be mitigated through the prevention and better management of such conditions.

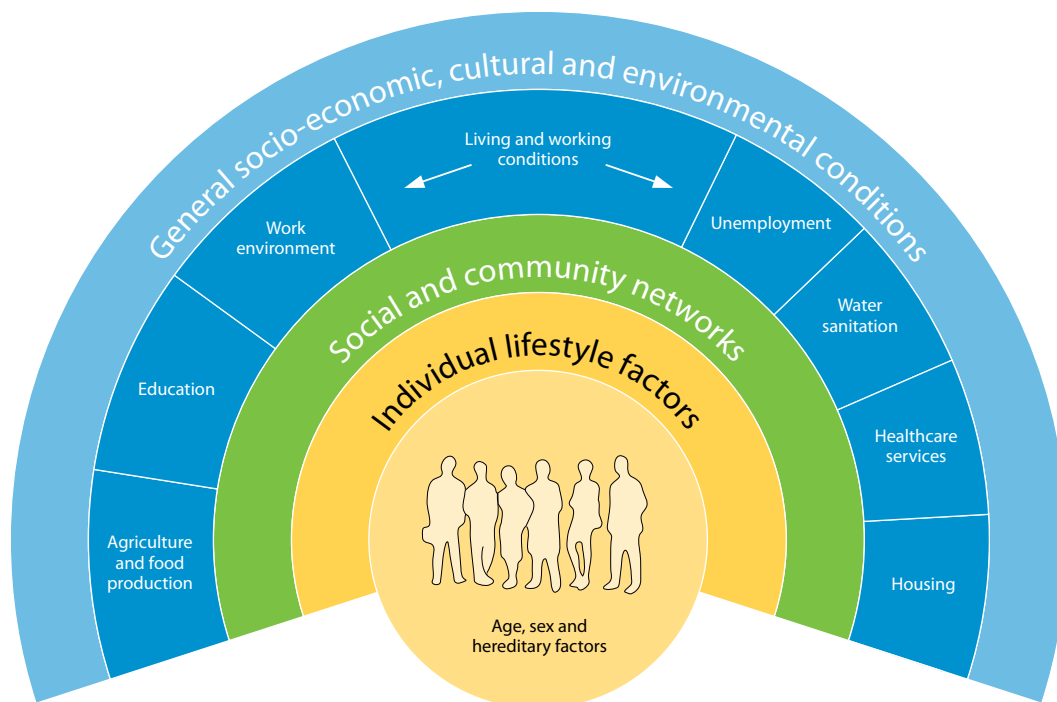


Figure 4: The determinants of health²²

2.2 Inequities in health outcomes

Inequities in health outcomes are persistent but must be a priority. As an example of the entrenched nature of disadvantage, the death rate in the most disadvantaged areas in SA in 2006 was still above the level of the most advantaged areas in 1987—some 19 years earlier. Thus, although death rates have declined for all groups, and dropped by almost one-third (31.9%) for the most disadvantaged group, the gap has widened, from being 49% higher in 1987 to 71% higher in 2006.²³

Recent work has identified a number of causes of death for those aged 0–74 years that are considered potentially avoidable, given what we know about social and economic policy impacts, behaviours and health care. A subset (around 30%) of all premature deaths are particularly amenable to health portfolio interventions, including but not limited to prevention strategies. This includes heart disease, certain cancers, diabetes and some infections.

However, these amenable mortality rates are not equal for all, with the least disadvantaged sectors having the lowest rates and the most disadvantaged sectors having over 1.6 times the rate of amenable mortality. Programs and services that target the more disadvantaged populations may help to reduce this higher rate of premature death.²⁴

Men die earlier than women (79 years for men compared with 84 years for women), and for both men and women there is a reduction in healthy life expectancy with increasing socioeconomic disadvantage, with a difference of 5.6 years for men and 3.8 years for women between the most and least disadvantaged (Figure 5).²⁵

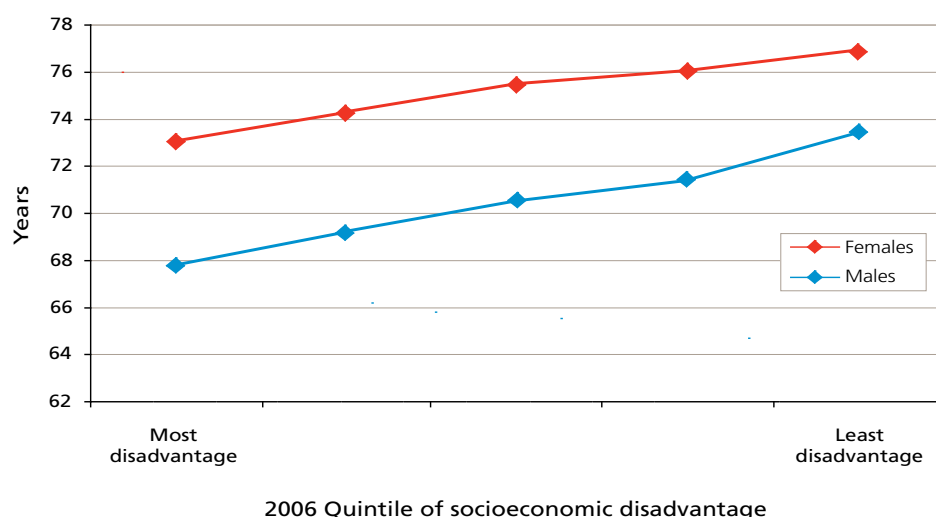


Figure 5: Healthy life expectancy in years at birth, for men and women, by area disadvantage (SEIFA) 2006–08^{26*}

*Provisional results based on 2 years of observed data and 1 year of projections

The picture for Aboriginal Australians is substantially worse, with the life expectancy gap between Aboriginal and non-Aboriginal Australians being 11.5 years for men and 9.7 years for women.²⁷

2.2.1 Universal and targeted approaches

Addressing inequities requires implementation of both universal and more targeted approaches.

At the state level it is important to maintain and extend universal approaches, which reduce the whole population's level of risk. This includes the more traditional but essential public health arena (e.g. reducing toxic exposures from industry or preventing contamination of food) as well as strategies to support good health (e.g. warning labels on cigarette packages, liquor licensing regulation and enforcement, fluoridated water, availability of immunisation and access to healthy foods).

To improve the health of those who are more disadvantaged, the PPP supports the approach of *proportionate or progressive universalism*.

Rather than focusing just on those with the greatest needs, the aim is to have a shallower gradient in health and wellbeing than we have at present. This involves universal actions, services and programs for the whole population combined with the provision of progressively more-intensive support proportionate to the level of disadvantage and need.^{28,29}

Services with restrictive inclusion criteria can cause community members to feel stigmatised, and therefore less likely to use services, especially prevention services. Progressive universalism avoids this problem. While more-intensive services for those with increased needs are more costly, the recipient groups are those who are at higher risk of becoming heavy users of expensive hospital emergency, justice, social and other services—effective prevention can be expected to impact positively on these costs.³⁰

Implementation of a progressive universalism approach in SA requires regional health services to be able to identify those with greater needs (e.g. through health improvement planning) and ensure service responses that meet needs. This might involve changes in opening hours, cultural safety training, provision of outreach services, flexible appointment times or partnerships with other agencies already working with relevant communities. Particular focus on healthy pregnancies, children and young people will afford the best advantage and investment.

GP Plus centres offer a range of services on one site, which may include general practice services and in some instances after-hours GPs, allied health providers, prevention programs and community service information. By providing comprehensive, integrated services and programs, they aim to make access easier for the community.

ACCHSs are based on self-determination and community control, which is, in itself, health enhancing. They have also been shown to provide cost-effective services, with up to 50% more health gain or benefit achieved if health programs are delivered via ACCHSs compared with the same programs delivered via mainstream primary health care services.³¹

2.3 Priority populations

Recognising the social determinants of health and inequities in health outcomes points the way to identifying those population groups that are a priority for the PPP but may also be harder to reach and face many obstacles to adopting preventive practices.

Throughout the PPP there is reference to disadvantaged individuals and groups. The most significant disadvantage is experienced by Aboriginal South Australians. Details are available in the AHCP, but it is sufficient to say here that many Aboriginal people experience poor health outcomes, high levels of risk and fewer protective factors.

Other priority groups include those with lower incomes, education levels or less secure employment, as well as refugees and some recently arrived migrants. Also, those whose circumstances (e.g. disability, mental illness, single unsupported parenthood, drug problems, homelessness or age) make them more vulnerable to poor health are a priority. Those living in remote locations have additional needs, as do some in rural locations. Prisoners of all ages are also at higher risk of health and related problems.

2.4 The burden of disease

2.4.1 Chronic diseases

Chronic or 'lifestyle' diseases are among the most prevalent, costly and preventable of all health problems.¹¹ They are currently the major cause of death and disability among South Australian adults.²⁶ The following chronic diseases account for almost 42% of the total burden of disease: cardiovascular disease (17.5%), diabetes (6.1%), chronic obstructive pulmonary disease (3.7%), musculoskeletal disease (4.0%), lung cancer (3.3%), asthma (2.4%), and breast and colorectal cancers (each 2.3%). Anxiety and depression contribute a further 6.1%.³²

In SA life expectancy is increasing as deaths from cardiovascular and cancer decline. However, from mid-life more people are living with chronic diseases that affect quality of life and productivity and often entail the use of costly medications and services.

Around 46% of South Australian adults have been diagnosed with at least one chronic disease and an estimated 15% suffer two or more chronic diseases.^{33,34} While more common in older people, chronic diseases are becoming increasingly common in children and younger people.

Further, mental health problems are significant for many adults, with one in five aged 16–85 years likely to have a mental disorder at some time in a 12-month period. Comorbidity with chronic conditions is common.³⁵

Chronic disease prevention, including mental health, must therefore be a priority for action.

2.4.2 Risk Factors

The high rates of chronic disease are associated with a common set of behavioural and biomedical risk factors, as shown in Figure 6. These also show a gradient, with higher rates in disadvantaged groups.

Tobacco smoking continues to be SA's largest preventable cause of death (1130 deaths per year) and disease (78 000 hospital bed days per year), costing the community an estimated \$1.7 billion per year.³⁶ Rates are decreasing but reducing Aboriginal smoking rates is a priority for action. Excess weight is also a major concern, with over 60% of South Australian adults being overweight or obese. Poor diet, physical inactivity and alcohol misuse are harmful to health both in their own right and as contributors to obesity, high blood pressure, high cholesterol and other conditions such as violence and abuse.

Disease	Risk factor						
	Behavioural				Biomedical		
	Poor diet	Physical inactivity	Tobacco smoking	Alcohol misuse	Excess weight	High blood pressure	High blood cholesterol
Coronary heart disease	✓	✓	✓	✓	✓	✓	✓
Stroke	✓	✓	✓	✓	✓	✓	✓
Lung cancer			✓				
Colorectal cancer	✓	✓		✓	✓		
Depression		✓		✓	✓		
Diabetes	✓	✓			✓		
Asthma			✓		✓		
Chronic obstructive pulmonary disease			✓				
Chronic kidney disease	✓				✓	✓	
Oral disease	✓		✓	✓			
Osteoarthritis		✓			✓		
Osteoporosis	✓	✓	✓	✓			
Condition							
Excess weight	✓	✓					
High blood pressure	✓	✓		✓	✓		
High blood cholesterol	✓	✓			✓		

Figure 6: Relationship between chronic diseases/conditions and behavioural and biomedical risk factors³⁷

Poor oral health has a significant impact on the lives of many people as well as being a contributor to other health conditions such as cardiovascular disease, pre-term birth and low-birthweight babies. It also contributes to avoidable hospitalisations; for example, dental extractions and restorations are the most common reason for children under the age of 15 years to undergo general anaesthesia in hospital in Australia.³⁸

2.4.3 Environmental determinants³⁹

The physical environment can also impact on health through factors such as air and water quality, food, and the built form, including urban design and safety. Overall, environmental factors no longer contribute significantly to the burden of disease, in part because of the success of preventive interventions, for example for infectious and parasitic diseases.

However, there are exceptions to this. Foodborne disease costs an estimated \$1.2 billion annually, reinforcing the need to maintain vigilance in this area. Air quality significantly impacts on health in some industrial locations, and workplace hazards can cause deaths and injuries. The prolonged drought has resulted in significant hardship for rural individuals and communities, while the impact of climate change on health is uncertain but potentially significant and warrants further investigation.

These determinants are addressed through the maintenance of effective public health practices (section 4.1).

The interest in and need for action on issues such as environmental sustainability, urban design and land use offers opportunities for joined-up approaches between health and other sectors concerning issues such as food, physical activity and community engagement.

2.5 Health literacy

Knowledge, attitudes and beliefs are important determinants of health and behaviour. One way of assessing knowledge is through health literacy surveys, which show that, overall, 41% of Australians aged 15–74 years have an adequate or better level of health literacy (2006 survey). This varied from 26% in low socioeconomic status areas to 55% in high socioeconomic areas.⁴⁰

There is growing evidence that those with poor health literacy are: less responsive to health information; have less understanding of why it is important to be healthy and how; use fewer disease prevention services; ask fewer questions and are less likely to seek help early; are less able to manage chronic conditions; and are more likely to have poorer health outcomes and incur health care costs.^{41,42} Building health literacy is therefore an important focus.

Health literacy

Professor Ilona Kickbusch describes health literacy as ‘the ability to make sound health decisions in the context of everyday life—at home, in the community, at school, in the workplace, in the health care system, in the marketplace and in the political arena. It enables people to increase their control over their health, their ability to seek out health information, to navigate complex systems, take responsibility and participate effectively in all aspects of life’.⁴³

2.6 A life course approach

SA Health information allows identification of the different conditions that impact on health and wellbeing at different ages, informing a more tailored response to prevention priorities across the life course (Figure 7).^a

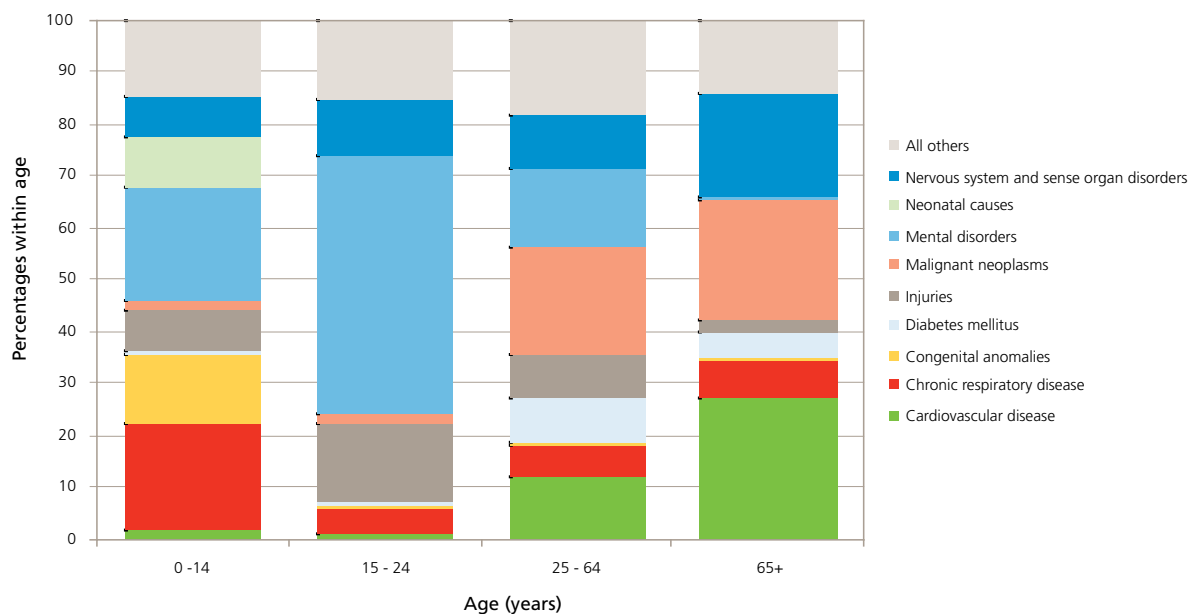


Figure 7: The percentage of disability-adjusted life years (DALYs)^a in South Australia, 2006–08, 3-yearly averages

For example, we know that disadvantage starts during pregnancy and that childhood illnesses including chronic respiratory conditions such as asthma, injuries (many of which are preventable), mental health problems and poor neonatal outcomes are all significant for 0–14 year olds, suggesting that they are priority areas for attention. We also know that there is an opportunity to build strengths and protective factors, so early childhood must be a priority. The health of a mother also affects the development of a baby during pregnancy, the duration of the pregnancy and the expected health outcome of her child.

Mental disorders, particularly anxiety and depression, are the biggest contributors to the disease burden for those aged 15–24 years. This age group, more so than any other, faces the consequences associated with risky use of alcohol, drugs and road trauma, as shown by the high rate of injuries. Of all age groups, young people aged 15–19 years have the highest rate of hospitalisation for acute alcohol intoxication. There is an opportunity to support young people to maximise their potential and reduce the risk of harm through primary prevention. This is a very high priority as it will reduce the cost associated with the morbidity and mortality of road trauma.

For adults, chronic conditions, including cancers, are the key issue, along with mental health problems. Improving the health and wellbeing of adults through prevention strategies can have a positive impact on individuals, families, communities, economic productivity and health service use.

For older people there are opportunities to promote health, wellbeing and independence (more so than preventing illnesses) and so prevent or delay the need for health services and institutional care. Falls are a major contributor to loss of independence and hospital admissions.

^a A disability-adjusted life year (DALY) is the unit measurement used to illustrate the relative contribution of specific conditions and risk factors to overall burden of disease. One DALY is 1 year of 'healthy life' lost either through premature mortality, prolonged illness or disability. DALYs give appropriate weight to health problems that cause great illness and disability, not always resulting in death (Australian Institute of Health and Welfare (AIHW) 2010.³⁵).

The risk of non-communicable disease (NCD) or chronic disease accumulates with age and is influenced by factors acting at all stages of the life course.⁴⁴ The main factors at different stages of life include the following:

- 1 Foetal life: foetal growth, maternal nutritional status, socioeconomic position at birth
- 2 Infancy and childhood: growth rate, breastfeeding, infectious diseases, unhealthy diet, lack of physical activity, excess weight, socioeconomic position
- 3 Adolescence: unhealthy diet, lack of physical activity, excess weight, tobacco and alcohol use
- 4 Adult life: behavioural factors (unhealthy diet, lack of physical activity, tobacco and alcohol use); biological risk factors (high blood pressure, dyslipidaemia, excess weight); socioeconomic position.

In summary, the broad social determinants of health are important at both a population and an individual level. They contribute to the gradient in health outcomes, which varies by level of disadvantage generally and for particular groups. Other determinants including behaviours and psychosocial indicators also exhibit a gradient. Risk and protective factors vary across the life course.

This information assists in understanding higher need population groups and the issues for attention, which inform the framework for action outlined in the next section.

3. Primary prevention framework for action

3.1 The framework

The framework for action by SA Health to support primary prevention is illustrated in Figure 8.

The key longer term outcomes are to:

- > improve health and wellbeing for all South Australians
- > reduce health inequities.

In order to achieve these outcomes, we need to:

- > ensure that policies make it easy to be healthy
- > enable individuals, families and communities to be healthy
- > create healthy and sustainable places.

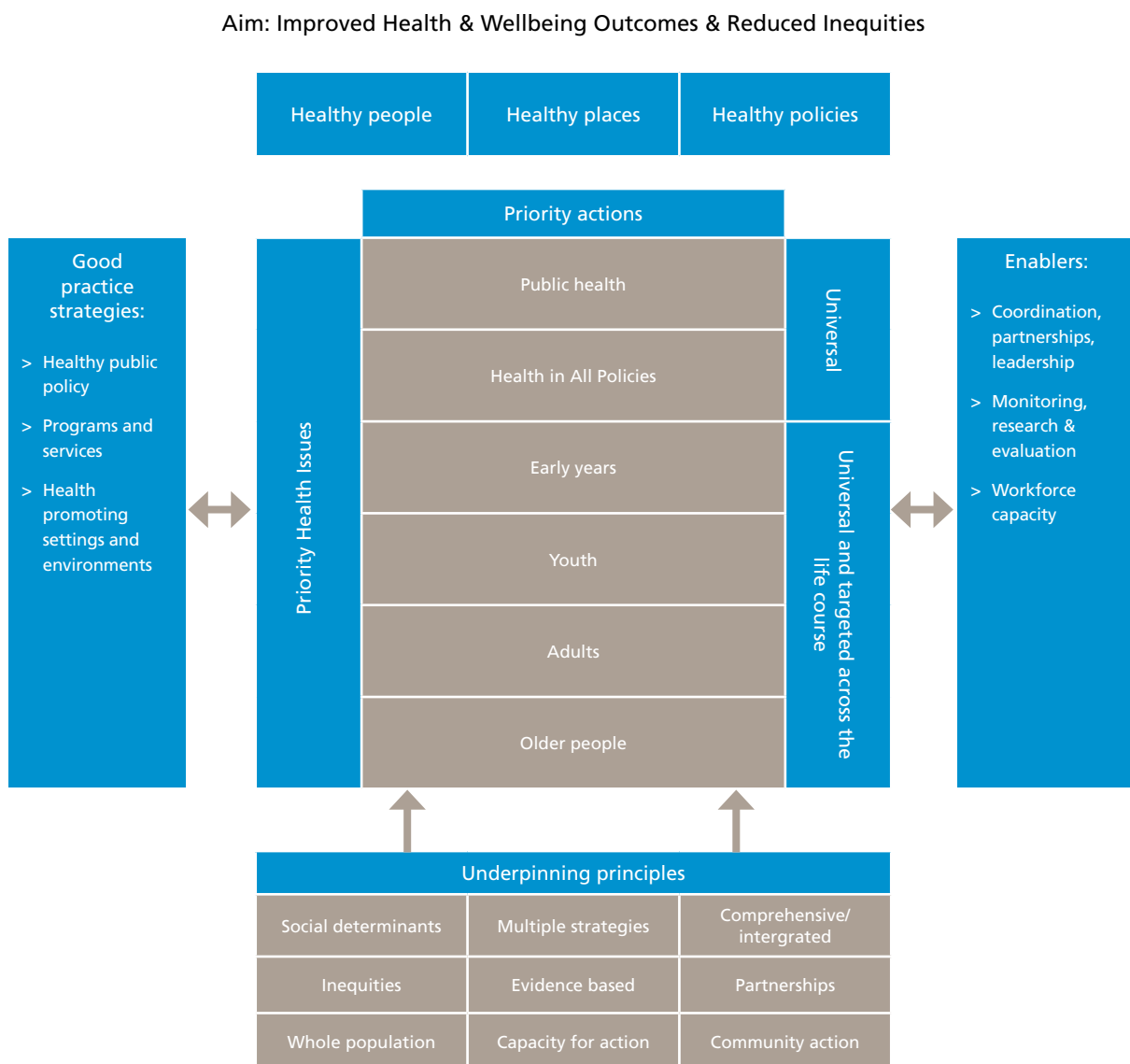


Figure 8: The primary prevention framework

3.2 Principles for effective primary prevention

There are a set of key principles that all SA Health services need to recognise in implementing primary prevention action:

- > Understand and take into account the impact of the **social determinants** of health on the health of individuals and the community.
- > **Address inequities** in health outcomes through the implementation of *proportionate* or *progressive* universalism approaches (see page 10), prioritising higher need communities.^{28, 29}
- > Focus on the **health of the whole population** (e.g. within a region, culturally and linguistically diverse groups, children) as well as particular subgroups (e.g. refugees).
- > Implement **multiple complementary strategies** on priority issues that contribute most to the social gradient in health outcomes to ensure sufficient 'dose' of effort to make a difference; minimise duplication and unconnected strategies.
- > Ensure **comprehensive and integrated approaches** through collaborative planning and delivery at the state level, between states and regions, within regions and across the continuum of care.
- > Use **evidence-based approaches** combined with innovative strategies where evidence may be limited.
- > Develop **partnerships** within health (e.g. between public and private primary health care providers including allied health, general practice), with other sectors (e.g. education, local government, housing, welfare, transport) and with local and federal governments and non-government organisations.
- > Build **workforce and system capacity** for effective primary prevention action.
- > Support **individual and community participation** in their own health and in planning, implementing and evaluating policies, programs and services.

3.3 Good practice primary prevention strategies

Effective primary prevention requires a mix of strategies, as outlined below. They are broadly consistent with the 1986 World Health Organization's Ottawa Charter, which outlined a comprehensive range of approaches that still underpin action to promote health and wellbeing today:

- > build healthy public policy
- > create supportive environments
- > develop personal skills
- > reorient health services
- > strengthen community action.⁴⁵

These strategies require the health sector to *advocate* for factors that promote health, *enable* the equitable achievement of health and *mediate* between competing demands for the pursuit of health.

Healthy public policy

Implementing policies, legislative changes, regulations and standards, or introducing economic instruments such as taxation or pricing measures, can help protect against adverse social conditions and create safer, healthier environments, products and settings. Health policies help to tackle health inequities because they make the healthy choice easier and do not require action by individuals. For example, there is now clear evidence that population-wide approaches to cardiovascular disease prevention through policy measures such as halving the salt in foods and banning smoking in public spaces are more effective than assisting high-risk individuals, as well as saving costs and reducing inequalities.⁴⁶

Policy change can be contentious; for example, the imposition of restrictions on personal freedom or requirements on business must be carefully considered. Often there is community support for policy change before it is introduced (e.g. as with smoke-free dining), but in other cases social norms are stronger and more work may be required to inform the public.

In other instances healthy public policy changes can be achieved through the creation of strong partnerships and investment in a collaborative approach to policy making. Partnerships across state government and between federal

and state governments have produced important public policy changes designed to improve health. In SA the HiAP approach is focusing its efforts on building healthy public policy through working collaboratively across state government.

The development of public policy change will require both these approaches to policy making. Generally, these will be led by DH, with regional health services providing support for policy implementation. Where agencies in health regions have a statewide role to drive policy changes (e.g. on oral health or drugs and alcohol), they will play the lead role.

Examples of successful healthy public policy: ⁵

- > alcohol restrictions for driving
- > smoke-free environments for public spaces
- > restrictions to advertising of cigarettes and pricing policies
- > reducing salt content in processed foods
- > ensuring safe work environments to decrease occupational exposure to risks
- > road safety measures such as speed limits, traffic calming, seat belts
- > standards for products such as safe babies' cots and prams
- > water and air quality controls
- > food safety requirements
- > swimming pool fences
- > fluoridation of water supplies

Programs and services

Individuals and communities, especially those more at risk, need support to be healthy. Evidence-based and innovative programs and services can assist in supporting health literacy, influencing attitudes and behaviours, building personal skills, changing social norms and addressing health risks.

Evidence based approaches include:^{47,48,49}

- > **community-based interventions**—using multiple integrated strategies in higher need locations (of around 30 000 people) or with particular groups at risk makes a difference. Underpinned by strong community engagement and ownership and involving multiple partners, this approach provides an opportunity to implement the intensity of action required to make an impact on health. Examples include the Obesity Prevention and Lifestyle (OPAL) initiative and the HIV prevention strategy
- > **community development / capacity building** approaches, which aim to involve communities in the identification and development of strategies that promote health. They build on community assets, capacity and willingness to work together for common goals. Examples include men's sheds, which build on men's needs for peer support; and the Playford food co-op and social enterprise, which involves peer support, skill building, health literacy and social connection projects based around accessing, sharing and learning about food
- > **social marketing**, which is based on an understanding of people's lives, current awareness of risk, what drives current behaviours, what might motivate behaviour or be a barrier, and who could influence behaviour. It can be a powerful tool for achieving a measurable impact on behaviour. Social marketing typically uses a mix of strategies such as raising public awareness, public relations, face-to-face communications and advertising; and usually includes a call to action, information on what to do and where to get help. Local action through primary health care and other community services support social marketing programs. Traditional message-oriented public information campaigns can widen health inequalities, so only carefully monitored approaches are recommended
- > **community education and support programs**—providing practical support and advice about health as well as skills development and training is a key role for health and community services. Examples include walking groups, self-help and peer education programs and support groups for different populations, e.g. young mothers. These take place in a variety of settings and careful planning is needed to ensure that they reach those who are more in need

- > **health literacy initiatives**—people need timely, clear and accurate advice and information about health and its broader determinants, healthy behaviours, self and family care, health systems and services, and how and where to get help. All parts of the health sector have a role in providing advice tailored to the needs of individuals and the community. For example, encouraging informed and active consumers in relation to literacy around medicines is a national direction. There is also a need to streamline the development of resources and ensure more low-literacy and culturally appropriate materials
- > **preventive health services**—providing preventive health services such as immunisation, counselling, risk assessments, brief interventions and screening programs (see Appendix 3 for more information) to both pre-symptomatic and well individuals is also important

For a range of reasons, those who are most disadvantaged tend to use preventive services least. When services are used, practitioners are faced with the challenge of taking account of the often complex social circumstances in which people live, making compliance with advice difficult where long-term health outcomes are not likely to be a priority and where cost may be a barrier

Primary health care prevention services that are culturally safe; are open for extended hours with flexible appointment requirements and seamless service pathways; and are provided in different community locations with incentives to attend, health advocates and well-trained staff skilled in working with the community will encourage use uptake among those who are harder to reach

GPs are major providers of preventive services and advice to the community. Over 83% of South Australians saw a GP in the last 12 months for their own health.⁵⁰ Community pharmacists and a range of allied health providers are also highly accessible and provide important health promotion and early detection services

- > **advocacy** about health and related issues with other sectors, within health services and beyond. Examples include health workers advocating about the need to address road trauma, hot water burns and prevention of smoking
- > **training** of other health workers, people in other sectors and community members about health and related issues, for example supporting preschool staff to 'lift the lip' and check for indications of dental disease
- > **fostering** community support for and active participation by individuals and communities in identifying problems, developing programs and policies, and evaluating their impact is also essential.

These programs and services will primarily be provided through GP Plus services and other primary health care settings including ACCHSs, and local government and non-government organisations.

Supportive settings and environments

We can support South Australian children and adults to be healthy by ensuring that the places where people live, work, learn and play are health promoting.^{43,51}

Local partnerships underpin the creation of healthy and sustainable settings and communities. Health workers can advise on the evidence about what promotes and protects health and ways in which different settings can reduce risks to health. They can also assist organisations such as workplaces or community groups to plan, implement and evaluate policies and programs. Action might focus on:⁵²

- > built environments, e.g. transport options, pathways, urban design, recreation facilities, location of supermarkets or fast food outlets, child- and youth-friendly spaces
- > social environments, e.g. communities that are welcoming to all members regardless of age, gender, sexual preference; social support activities; acknowledgment of connection to the land; arts and culture; safety
- > natural environments, e.g. climate change, maintenance of open space, air and water conservation
- > economic environments, e.g. enhancing access to work, education and employment.

Health services also need to be health-promoting settings through development of policies (e.g. healthy food policy), support for priority initiatives (e.g. achieving Baby Friendly Hospital Initiative accreditation) and ensuring health and safety for clients and staff (e.g. no smoking policies, provision of immunisation for staff, food safety compliance) or becoming a health-promoting organisation. Supporting the development of such policies in other sectors is important, for example assisting local childcare organisations to develop healthy food policies. Ideally, all health workers need to take personal responsibility for their own physical and mental health and wellbeing, thus acting as role models for the community.

Priority settings for action are:

- > learning institutions, e.g. schools and preschools
- > workplaces, including health workplaces
- > homes
- > neighbourhoods and communities, including community organisations
- > health services.

Examples of healthy settings initiatives:

- > workplaces that support physical activity, awareness about depression and healthy eating options
- > health-promoting schools, e.g. having a comprehensive approach to promoting mental health and addressing mental health problems early
- > environmental design changes to support a dynamic and diverse culture and prevent alcohol-related violence and crime
- > responsible service of alcohol programs (policy, training, information) in hotels
- > urban environments that make it easy to walk and cycle
- > remote shops that support the availability of healthy affordable foods.

3.4 Priority health issues

Promoting health and reducing inequities requires action on a limited number of key health issues for South Australians to ensure 'dose' of effort. The priorities take account of the major contributors to premature death, disability and disease burden as well as the potential to reduce or eliminate risk factors and maximise or increase protective factors for different subpopulations and ages.³⁵ The health issue priorities are:

- > preventing smoking
- > supporting a healthy diet (including breastfeeding), physical activity and healthy weight
- > reducing the misuse of legal drugs (e.g. alcohol and pharmaceuticals) and the use of illegal drugs
- > oral health
- > promoting safe sexual health^b
- > early child development, including building parenting skills
- > promoting mental health and wellbeing, including resilience, social skills and self-esteem
- > preventing falls injuries, violence and abuse.

We also recognise that issues such as asthma; skin cancer; farm, road and work injuries; arthritis and disabilities are important and impose a burden on individuals and communities as well as on health services.

Non-government and community organisations play a significant role in assisting the community to prevent and manage these issues, as do GPs, other service providers and settings-based strategies in schools and communities.

^b An SA Health Sexual Health Action Plan is being developed in recognition of the urgent public health challenge illustrated by the following indicators:

- > the increase in prevalence of sexually transmitted infections (STIs), particularly chlamydia, in SA
- > recognition of the causal relationship between STIs and reproductive and sexual health consequences, such as pelvic inflammatory disease and infertility
- > recognition of the association between HIV and other STIs
- > the major contribution of STIs and infertility to morbidity and associated costs in Australia
- > the fact that sexual ill health disproportionately affects population groups already experiencing inequalities related to gender, cultural background, sexual orientation, disability or other factors.

For this reason sexual health is not addressed in great detail here.

3.5 Summary

In order to achieve the twin aims of improving the health and wellbeing of South Australians and reducing inequities in health outcomes, we need to apply evidence-informed approaches, underpinned by the principles of good practice, to the following priority action areas:

- > consolidation and extension of universal approaches by:
 - maintaining best practice in public health through a combination of policy development, legislation, and regulation development and enforcement, as well as direct service delivery, to protect and promote good health and prevent ill health
 - addressing the social determinants of health through the HiAP and related public policy approaches
- > implementation of targeted approaches across the life course to complement statewide universal strategies by:
 - prioritising a healthy start to life as the best opportunity to support good health and intervene early
 - enhancing support for young people by building protective skills such as confidence, resilience and optimism and reducing risk factors such as leaving school early and poor family relations
 - increasing effective responses for adults through progressive universalism, with a particular focus on prevention of chronic disease and poor mental health
 - supporting healthy ageing, especially around those factors impacting on quality of life.

These action areas are examined in more detail in section 4. To be effective we need to build capacity for effective primary prevention action through the development of a number of enablers. These are addressed further in section 5.

4. Priorities for primary prevention in South Australia

4.1 Maintaining effective public health

Rationale

Public health focuses on whole populations—promoting healthy people, communities and environments; and preventing, minimising and containing adverse health effects from environmental hazards and from communicable diseases and disease outbreaks. These are traditional aspects of public health and remain vital to the maintenance of healthy communities.

Public health functions include a mix of policy development, legislation and regulation enforcement, and direct service delivery. The major responsibility for public health sits with SA Health, whose responsibilities include:

- > communicable disease surveillance and control
- > immunisation
- > protecting the safety of the food supply
- > identification, investigation and management of environmental factors that impact on public health
- > health impact assessment
- > screening for specific conditions
- > enforcement of tobacco control legislation
- > injury prevention.

Partnerships underpin the delivery of many public health services. In particular, partnerships with Divisions of General Practice, GPs and local government are key in supporting public health service delivery. They do this through, for example, the provision of immunisation, management of food safety, wastewater and water recycling management, health risk assessment and management, communicable disease control and reporting, undertaking screening or referring individuals to screening programs, and working with patients to provide health information and advice.

What is the challenge?

SA has a very effective public health system, much of it mandated by legislation under a number of Acts, for example the *Public and Environmental Health Act 1987* (currently being revised) and the *Food Act 2001*. It includes sanitation, immunisation, screening, food and water safety, surveillance, and managing epidemics and outbreaks of communicable diseases.

SA Health needs to ensure that this effective public health system is maintained and that the importance of public health programs, services and infrastructure is promoted.

It is important to effectively engage with local government to build their capacity to plan for local physical and social environments that support good health, particularly in the area of chronic disease prevention. Local councils are major employers of the public health workforce and have a major role to play in protecting public health.

Policy and plans at the local government level, for example safety policies, standards regarding supportive environments for physical activity, and implementation of alcohol management plans, complement state and national policy.

SA faces a number of specific challenges in public health, including:

- > rising rates of some infectious diseases in certain populations, e.g. chlamydia
- > the potential to improve physical environments for Aboriginal communities in remote locations
- > communicable disease control in relation to newly arising epidemics and pandemics
- > meeting community expectations in health protection, particularly in relation to food, environmental contamination and other threats to public health.

What more do we need to do?

It is essential that the commitment to public health is maintained. Duplication of effort through local initiatives addressing public health is not recommended as these are more effectively managed at a state level.

We need to promote and support environments for health by promoting health through the built, social, economic and natural environments; and developing the capacity of, and improving support for, the local government workforce as the key providers of local public health services.

Regional health services can support public health activities at the local level, for example by promoting cancer screening and providing information on immunisation or infection control.

Local government has always had a key role in local public health services, and its role in planning for health will be strengthened by the new Public Health Bill. The scope for planning incorporates but moves beyond traditional health protection measures to include health promotion.

SA Health priority directions:

- > Recognise, support and strengthen the maintenance of effort and investment in public health to protect the health of the population, prevent ill health and promote good health.
- > Develop and implement public health legislation, e.g. Public Health Bill, Safe Drinking Water Bill.
- > Develop, implement and apply health impact assessments.
- > Develop and implement food safety policy and regulations.
- > Implement policy to support health in the built, social, economic and natural environments.
- > With assistance from the Local Government Association, develop, implement and report on state and regional public health plans.
- > Maintain and strengthen existing public health programs and services designed to identify hazards in the environment, and implement programs to eliminate and/or mitigate them.
- > Continue to ensure the maintenance of the communicable disease control system including the capacity to manage new epidemics/pandemics.
- > Promote ongoing strong and effective partnerships with local government and primary care providers (e.g. ACCHSs, general practice).

4.2 Health in All Policies: intersectoral action for health

Rationale

Health in All Policies (HiAP) is about promoting healthy public policy through intersectoral action. This is not a new concept. It was a key strategy of the World Health Organization's Alma Ata Declaration in 1978, which encouraged the health sector to look beyond its role of acute medical care and consider how to deal with the actual causes of people's ill health. The next major evolutionary step—the Ottawa Charter for Health Promotion—talked about developing healthy *public* policy, not just health policy, which required consideration of a range of approaches across all policy environments to bring about improvements in health and wellbeing. The ability to influence the actual causes of *ill health*—the social, economic and physical determinants (described earlier)—tend to lie outside the direct control of the health sector.

HiAP is the most recent innovation in the evolution of this concept. It is a way of working across government to encourage all sectors to consider the health impacts of their policies and practices. At the same time it examines the contribution that a healthier population can make towards achieving other sectors' goals, as increasing population health has positive impacts on productivity, the economy, sustainability and the society as a whole.^{53,54}

HiAP is being implemented across government in SA, with SA Health, in partnership with the Department of the Premier and Cabinet, taking a leadership role. The starting point is South Australia's Strategic Plan (SASP). Government agencies work with SA Health through HiAP to explore the interconnections between SASP targets, identify joint areas of work and examine policy proposals using a population health perspective (a 'health lens').

The SASP target 2.2 on healthy weight has been identified as a priority for a health lens. There is an opportunity for policy changes in other sectors that could help achieve the healthy weight target and also lead to positive outcomes for the other sectors, for example increased use of public transport or healthier and more sustainable workforces. See Appendix 4 for the Adelaide Statement on Health in All Policies.

HiAP is an example of policy-level intersectoral action being undertaken in SA. There are many other examples of working across sectors to achieve improved health outcomes at both program and service delivery levels. For example, the OPAL program in partnership with local government, and the Children's Centres in partnership with the

Department of Education and Children's Services (DECS) and the Department for Families and Communities (DFC). HiAP is a programmatic, comprehensive and systematic approach to healthy public policy making.

What is the challenge?

As HiAP is an innovative approach to building healthy public policy, it will take time to build an evidence-base. Maintaining the commitment to this new approach from the health sector will be challenging in a time of escalating health costs.

There is abundant international and national evidence documenting the impact that determinants have on health and wellbeing, but much less evidence is available about what strategies and/or interventions should be used to build positive determinants and address their impact on health and wellbeing. The strong relationship between policy decisions and health outcomes can take time to become evident.

There is a need to increase the skills and capacity of policy makers from across government and from the health sector to recognise the impacts that their decisions have on health and wellbeing.

What more do we need to do?

The limited available evidence on the impacts of determinants on health and wellbeing directs health systems to work across government to influence the policy settings of other sectors to optimise health outcomes. SA Health needs to support the capacity of the health workforce to work in partnership with other sectors on their policy terrain.

SA Health priority directions:

- > Support the implementation of HiAP across government, with a focus on SASP targets, and provide a biennial report to the Executive Committee of Cabinet.
- > Conduct health lens projects on prioritised public policies in key government sectors in line with SASP targets, including healthy weight as an initial priority.
- > Build capacity within other government sectors so that they can participate in and then conduct HiAP, and adapt the model if required.
- > Develop, in conjunction with the university sector, the evidence-base for HiAP and disseminate the information to assist in regional implementation.
- > Establish a framework to build capacity in regions and the local government sector (in conjunction with the Local Government Association) to incorporate the application of HiAP into their planning.
- > Explore the potential for a Centre of Excellence for HiAP in SA and conduct a summer school on HiAP.
- > Increase the skills and capacity of policy makers from across all government sectors to recognise the impacts that their decisions have on population health and wellbeing.

4.3 The early years: a healthy start in life

Rationale

Health and wellbeing in the early years—from the antenatal period through to 8 years of age, but particularly the first 3 years—is now well understood to lay the foundations for long-term health outcomes. Secure parent-child attachment and positive early childhood experiences enable healthy children to grow into healthy adults. Adverse events and challenges during pregnancy and the early years of life may result in physiological and developmental vulnerabilities such as a weakened immune system, poorer educational achievements and increased risks for obesity, diabetes and cardiovascular disease in later life.⁵⁵

What is now more apparent is the potential contribution of early life experiences and opportunities to reducing health inequalities across the life course. 'To have an impact on health inequalities we need to address the social gradient in children's access to positive early experiences. Later interventions, although important, are considerably less effective if they have not had good early foundations.'⁵⁶

Marmot's recent research has clearly identified that sustained investment in effective early childhood interventions proportionately targeted to those in need will contribute to long-term savings in health care as well as returns to education, employment and social cohesion.⁵⁷

Child- and family-centred approaches that build on individual, family and community strengths, nurture the family's aspirations for their children, and recognise and address various stressors, can impact positively on health, mental health, wellbeing and educational outcomes.⁵⁸

What is the challenge?

Generally, the standard of health for children in SA is very good. Our immunisation coverage is above 90% for young children.⁵⁹ There have been reductions in a range of conditions and disabilities (e.g. SIDS, burns, communicable diseases) that previously impacted adversely on children and their families.

There are, however, persistent and significant inequities for certain groups, including Aboriginal children, those from disadvantaged families, children under guardianship, those in families with mental illness, children of young parents, refugees and children with a disability.

Children living in socioeconomically disadvantaged regions in SA have much higher rates of hospital admissions, greater use of child and adolescent mental health services, poorer dental health and higher rates of substantiated child abuse or neglect compared with children living in more advantaged regions. There is a strong association between the geographic distribution of children with profound and severe disability and socioeconomic disadvantage in metropolitan Adelaide. In addition, children living in disadvantaged regions show much higher rates of developmental vulnerability and lower levels of school readiness, as assessed by the Australian Early Development Index. These differences continue through to primary school, with strong associations between children performing below the national standard (as assessed by the National Assessment Program – Literacy and Numeracy) and socioeconomic disadvantage.⁶⁰

Disadvantaged pregnant women have higher smoking rates (Figure 9) and 49.7% make no antenatal visits, compared with 3.1% for the most advantaged women.⁶¹ For Aboriginal children there are many additional problems: perinatal mortality rates are higher (27.1 compared with 9.0 per 1,000 births for non-Aboriginal women), and there is twice the rate of low-birthweight infants (low-birthweight births include babies small for their gestational age plus premature births). Aboriginal mothers have far higher rates of smoking (59% compared with 15.1% for non-Aboriginal women) and teenage pregnancy rates, and fewer antenatal visits, with associated risks for the babies.⁶¹ These issues are covered in more detail in the AHCP.¹⁰

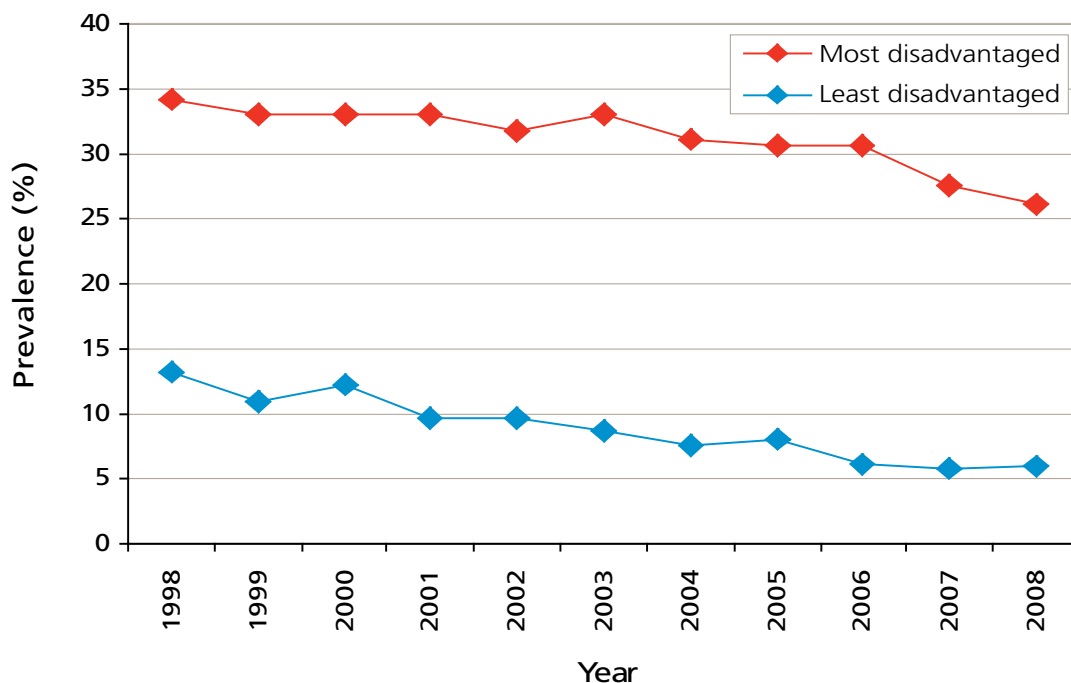


Figure 9: Proportion of smoking during pregnancy—comparison between most disadvantaged and least disadvantaged quintiles, 1998–2008 (2001 SEIFA IRSD)

Data source: SA Health Pregnancy Outcome Unit, 2010

What more do we need to do?

SA already provides a range of widely available universal services such as good antenatal care, safe birthing options, screening, the universal contact visit, Child and Family Health Service clinics and parenting groups, as well as a range of health information literature such as the Blue Book and parenting guides.

There are also health promotion programs in place to support parents in areas such as breastfeeding, good nutrition and quitting smoking, as well as actions to create supportive settings such as child care and Children's Centres. All universal approaches need to be culturally safe for Aboriginal South Australians and other cultural groups.

These strategies need to be maintained and enhanced to ensure full coverage, especially for rural and remote locations, and adapted to the needs of particular groups such as Aboriginal families. The Anangu Bibi and Aboriginal Maternal and Infant Care programs now provide improved antenatal care for Aboriginal women and need to be expanded.

The challenge is to ensure greater reach of programs that successfully provide access and services tailored to the needs of more higher need families. This includes: prevention of unplanned teenage pregnancy, parenting skills, smoking cessation, access to a nutritious and secure food supply (including during pregnancy and breastfeeding), support for families living with disability, preventing and addressing drug and alcohol issues, mental health and child and parent safety, housing stability, and addressing other issues that may impact negatively on the wellbeing of the child and family. Parents with children need ease of access to treatment services, and a whole-family approach is required when parents are being treated, for example for a mental illness.

Services for more vulnerable families need to be strengths-based, developmental and long term. They should build life skills, confidence, capacities and supportive relationships with others in the local community.

SA Health needs to support across-government action on the broader social determinants amenable to change, including access to safe and secure housing, child care combined with outreach to encourage uptake, income support, employment, good education opportunities (including transition programs to school) and a socially supportive community.

The HiAP approach offers an opportunity to do more in this area, as does the Public Health Bill (currently before Parliament) which requires local government to develop health plans. OPAL is an important initiative already underway. Supporting the development of health-promoting policies in other sectors is also important, for example assisting local childcare organisations to develop healthy food policies.

Partnerships with other sectors are also important in relation to two areas—to create safe and supportive settings (e.g. child care, communities); and because many organisations such as non-government organisations (NGOs) are already in contact with those who are more vulnerable and therefore may be able to provide more accessible and acceptable services.

Adopting a stronger public health approach to child protection is important. It requires a focus on increasing community understanding about their responsibility to keep children safe from harm, the provision of a progressive universal approach to providing service, and ensuring that children and young people who are in the care system are provided with additional support so that their wellbeing outcomes improve. Early intervention with children at risk is one important public health strategy for violence prevention. Evidence shows links between early childhood development programs that include parenting education and the prevention of later violence.

SA Health priority directions:

- > Maintain universal good practice antenatal, birthing, postnatal and parenting health promotion programs and services; identify gaps, especially relating to low-literacy approaches, and develop appropriate programs and resources to support parenting and healthy child development.
- > Regional health services and the Children, Youth and Women's Health Service (CYWHS) to prioritise action on the early years including:
 - ensuring that every mother is assessed across all the domains of her life early in pregnancy and offered appropriate assistance according to her level of need
 - improving the provision of antenatal care for those currently not accessing care in line with the Maternal and Neonatal Network review
 - prioritising provision of postnatal support for mothers and infants with higher needs, including the availability of intensive home-based support programs for those mothers in greatest need

- ensuring the provision (through SA Health and key partners) of very targeted programs to parents with high needs, particularly around child abuse and neglect, family violence, child conduct disorders, mental illness, and alcohol and drug misuse
- implementing targeted, quality and intensive home visiting programs for vulnerable children
- ensuring that staff dealing with high-need families are supported to provide appropriate care
- increasing the proportion of overall funding and focusing it proportionately across the social gradient
- reporting on progress to the Portfolio Performance Review Committee.
- > Invest in across-sector partnerships, particularly with local government, DECS and DFC, to support healthy, sustainable and safe communities and settings (e.g. Children's Centres) for children and their families.
- > Invest in linking community services with GPs to complement positive health messages and efforts and reduce duplication and confusion.
- > Support DECS to improve literacy and educational outcomes of children from low socioeconomic status and other vulnerable backgrounds.
- > Identify health issues that may reduce children's ability to learn, and work with DECS to implement effective solutions and services, linking with GPs to ensure that treatments are available where appropriate.
- > Implement the Children's Health and Wellbeing framework in Children's Centres and other preschool settings, including ensuring that Aboriginal and disadvantaged families are actively supported to engage with Children's Centres and receive health services.
- > Invest in program evaluation and monitoring of outcomes.^{62,63}

4.4 Young people: building strengths, reducing risks

Rationale

For the majority of young people the journey from childhood to adulthood is an exciting time—a time for exploration, discovery and learning. Adolescence and young adulthood are critical periods in development characterised by an increase in self-determination and decision making regarding health and life choices that impact on their future. To some extent all young people are vulnerable during their developmental stage but a small proportion face significant challenges, including alcohol and drugs, alienation, homelessness, violence and abuse, mental illness and unemployment.

The PPP aims to help ensure that all young people are supported to be mentally, socially, physically and emotionally healthy. In terms of prevention we aim to provide universal services and programs that use a strengths-based approach, with additional support programs and services available for groups who are more vulnerable and require early intervention. There is an opportunity to prevent these young people from moving into the higher risk and higher need categories that may impact on their life chances.

When schools, families and communities work in partnership they can support the health of young people and reduce the gradient in health, wellbeing and resilience.⁶⁴ The opportunity to improve youth health makes this population group an important focus of the PPP's life course approach.

What is the challenge?

There are around 280 000 young people aged 12–25 years in SA—18.8% of all South Australians.⁶⁵

Many health and social problems affecting vulnerable young people are influenced by a common set of determinants such as a history of physical, sexual or emotional abuse (as a victim or witness); chronic neglect; stigma and discrimination; poverty or disadvantage; adverse childhood experiences; access to drugs; poor urban environments; homelessness; being in the care of the state; cultural norms that support unhealthy behaviours; and low self-efficacy. From 1999–2000 to 2007–08 the rate of children on care and protection orders increased for both Indigenous and non-Indigenous children in all states and territories.⁶⁶

Young people living in socioeconomically disadvantaged areas are 75% more likely to have left school early than those in more advantaged areas.^{67,68} Unemployment for 15–24 year olds in SA in 2010 was 15.6% and worse in rural and remote locations.⁶⁹

Mental health is a major concern. Vulnerability to anxiety and depression is compounded by young adulthood because it is a critical time of transition when people are often leaving home, finding employment and/or studying at a tertiary level. Self-directed violence including self-abuse and self-mutilation is more prevalent among young people, especially young women. In 2005–06 hospitalisation rates for self-harm in young women was more than double that of young men.⁷⁰ 'With one in four young people experiencing a mental disorder and one in three suffering moderate to high psychological distress, and with suicide the leading cause of death for this age group, mental health is, arguably, one of the most significant issues facing young people.' Yet, despite high needs, young people are low users of mental health services.⁷¹

Pregnancy and parenthood while young is a strong predictor of subsequent poverty and social exclusion.⁷² Teenage pregnancy rates are falling (currently 35.4 per 1000 women compared with 47.7 in 2000) but are higher than in most developed countries; they are also higher among Aboriginal and disadvantaged young women.^{72,73} Abortion rates are also falling. Sexually transmitted diseases, such as the rapidly rising rates of chlamydia—63% of the cases reported in 2009 were in young people aged 15–24 years—can have long-term health impacts.⁷⁴

Smoking rates vary with levels of disadvantage, with 35% of the most disadvantaged group of young people smoking, compared with 14% of the most advantaged.⁷⁵ Unsafe use of alcohol by 28.1% of 16–24 year olds⁷⁶ is of significant concern, with young people aged 15–19 years having the highest rates of hospitalisation for acute intoxication among all age groups.⁷⁷ In 2009, 16–24 year olds accounted for 27% of all fatalities and 30% of serious injuries on SA roads.⁷⁸ Almost one-third of young people identify drugs as a major concern⁷⁹; 12.5% of school students have reported having used cannabis, the most commonly used illicit drug among young people in SA.⁸⁰

Young people have poor diets and low levels of physical activity (33% are insufficiently active), with 22.3% of 12–17 year olds and 28.4% of 18–24 year olds being overweight or obese.⁸¹

Young Aboriginal South Australians have many additional challenges (e.g. drug use, smoking, sexually transmitted diseases, road trauma) as well as high levels of juvenile justice detention and supervision.¹⁰ Recently arrived young migrants are also likely to be at higher risk.⁸¹

What more do we need to do?

The evidence suggests that local, state and national governments' public policy action to help change social norms and make the healthy and safe choice easier is important.⁵ This includes action to limit access and availability to alcohol and drinking areas, potentially increasing the drinking age, drug legislation, anti-tobacco initiatives such as plain paper wrapping and price increases, a range of road safety policies, provision of healthy food in schools and community settings, and reducing or eliminating images of violence and discrimination.

The creation of safer, supportive and connected communities through physical and social infrastructure changes (e.g. lighting, pathways, community interaction points, gardens) can reduce violent crime and encourage interaction and connectedness.⁸²

Schools play a vital role in building a positive environment and creating a sense of belonging. They build knowledge, protective skills and positive attitudes in relation to important factors such as parental and peer relationships, conflict resolution, bullying prevention, social and family norms, resilience, communication skills, goal-setting, strong cultural/ethnic identity, health information and help-seeking behaviour.⁸³

Evidence suggests that families are most important in influencing educational outcomes, so the individual–family–school–community interrelationship is important.⁸⁴ For example, encouraging smoking cessation in adults is the most successful way to reduce the risk of initiation of smoking in children. Graphic or emotional health messages targeting adults have also been shown to influence youth to want to quit or not begin smoking for the same reasons that they influence adults.

There is evidence to show that delaying the onset of risk factor uptake can reduce the impact of the risk factor (drugs, smoking, unsafe sex, alcohol). This increases the importance of carefully targetting programs to be age appropriate—the focus for 12–15 year olds will be more around schools, parents and protective and risk factors, whereas for those aged 16 years and older, harm reduction is more important.

At the regional level health practitioners work regularly with schools to deliver programs, support school staff, ensure links to health and related programs, and assist young people at risk. The Better Health Better Learning guidelines provide guidance for schools and health services on how to ensure that this is an effective relationship.⁸⁵ In addition

to universal provision of youth health programs, health services need to work closely with all those in the region who are reaching or can reach the more vulnerable young people, and ensure that they are provided with services and programs to address their needs, especially related to the priorities of mental health, respectful relationships, bullying and prevention of violence and emotional abuse, nutrition and physical activity, smoking, alcohol and other drugs, and sexual health.

There is already considerable work underway by the health sector in areas such as tobacco education and sexual health through the Focus Schools program, but there is value in developing a limited number of additional good practice programs and consolidating these across SA.

Violence prevention and respectful relations initiatives among young people can produce lasting change in attitudes and behaviours. Standards for school-based education have been developed and programs implemented. For example, the 6-week group- (or classroom)-based Relationships Violence No Way program provided in some SA schools is considered to be effective in assisting Year 8 and 9 children to develop a basic understanding of relationships.

Specialist youth health services are available in key locations but we need to enhance access to youth-friendly health services that provide information, counselling and treatment, and develop responsive workforces—both general and youth specific—that are able to support young people. New South Wales has developed guidelines that provide useful advice. CYWHS provides prevention and treatment youth health services for groups at higher risk, including Aboriginal young people, children under the Guardianship of the Minister and others at risk.

Partnerships with GPs (in particular, GPs with youth-friendly practices) play an important role in providing safe health and wellbeing advice.

SA Health priority directions:

- > The Department of Health (DH) to identify and investigate opportunities to implement policy initiatives that create safe and supportive environments for young people, e.g. reduced access to alcohol and tobacco, driver safety, prevention of drug use.
- > DH to support the development of a core set of good practice programs targeting both parents and young people in relation to mental health, respectful relationships, bullying and violence prevention and emotional abuse, nutrition and physical activity, smoking, alcohol and other drugs, and sexual health—to enable the adoption of healthier choices by young people.^{79,86}
- > Based on data, existing effort and consultations with young people, regional health services to implement programs from the suite of good practice programs.
- > Develop and implement guidelines to ensure that regional health services are youth friendly, provide appropriate services and programs, and address the gaps, especially for higher need groups; encourage other primary health care services to be youth friendly.
- > Build partnerships with GPs and others to facilitate improved access to health and wellbeing, and to specific medical information.
- > Ensure that 80% of state schools are providing comprehensive respectful relationships and sexual health programs using the Focus Schools curriculum.
- > Increase the provision of good practice respectful relationships education programs to all schools, prioritising higher need locations.
- > Promote wide access to affordable emergency contraception.
- > Provide specialist youth health programs and services in priority locations and/or designated youth-friendly mainstream programs and services.
- > Provide guidelines on the development of youth-appropriate information materials and support enhanced coordination of the provision of youth health literacy initiatives, including in relation to body image and eating disorders.
- > Explore the use of technology (e.g. SMS text messaging, social networking sites) to engage young people in health-promotion activities and social marketing initiatives.
- > Build partnerships with the youth sector to ensure improved coordination of effort across government using the HiAP approach.
- > Build partnerships with the vocational education and training and university sectors that explore strategies to address the health impacts of transition to adulthood.

4.5 Adults: promoting health and preventing illness

Rationale

Overall, the level of health and wellbeing of the South Australian population is high and has improved substantially over the past decades. However, there are significant disparities in health and wellbeing, with Aboriginal, disadvantaged and other vulnerable people suffering worse health outcomes than the rest of the population and men having poorer outcomes than women.

Simply educating people to take responsibility for their health does not work—we know this from experience. Our decisions are rooted in the social and economic circumstances in which we are born, live and work. Where social norms support poor choices, self-efficacy tends to be lower, and poverty, housing and precarious employment create priorities other than good health. For Aboriginal people and many migrants the impact of discrimination compounds the problems. Risk behaviours (smoking, risky alcohol use, poor diet, inactivity, violence and abuse) tend to cluster together and there are fewer protective factors for disadvantaged families and communities. Men in particular also often seek help later and fail to use preventive health services, leading to higher use of high-cost, emergency and tertiary care services. For these reasons men are a priority for this plan.

What is the challenge?

Essentially, most health behaviours tend to show a gradient between high and low socioeconomic status and are poorer for men. For example, in recent reports men drank at risky levels at more than twice the rate of women (a rate ratio of 2.32⁸⁷) and there were 84% more male smokers in disadvantaged metropolitan areas compared with the least disadvantaged.⁸⁸ Disadvantaged people have the same intention to quit smoking but report less success in doing so. Men in rural areas are at particular risk.

This applies also to health outcomes; for example, there was twice the rate of avoidable deaths from lung cancer between the most and least disadvantaged groups. Male rates for diabetes and heart, stroke and vascular disease were higher than for females (27% and 10% higher, respectively).⁸⁷ Lack of social support and long-term exposure to economic and social stress affects the cardiovascular and immune systems, increasing the risk of multiple preventable health conditions including diabetes, high blood pressure, heart attack, stroke and infections.

Adult mental illness is a significant health concern in Australia, third behind cancers and cardiovascular disease, and accounts for 13% of the total disease burden in Australia. Mental disorders are higher among unemployed Australians, who also report almost double the prevalence of substance use disorders and nearly three times the prevalence of affective disorders compared with Australians in the labour force.⁸⁹

Poor mental health is also associated with experience of discrimination and violence, which are often linked together and to inequalities and social exclusion.⁹⁰ Racism is an important factor in continuing health inequities in Australia.⁹¹ Depression and anxiety among women has been directly associated with family and intimate partner violence and bullying.⁹²

Men access community health services as well as general and specialist medical practitioners at a 56% lower rate than women. Instead, men, especially those over 65 years of age, are high-volume users of the expensive chronic and complex end of the health service spectrum. Low levels of health literacy compound the problems.

There is growing evidence on the benefits of 'arts in health'—community arts projects for improved social cohesion, resilience and health.⁹³ Equally, evidence is emerging that supports 'healthy' urban design, especially when supported by community participation and engagement, as a high-level strategy for building connections to communities and reducing exclusion. It particularly benefits migrants, the elderly and newcomers to neighbourhoods.

What more do we need to do?

Action by SA Health to address the wider determinants of health is fundamental. Actively participating in and/or leading cross-agency efforts to tackle the causes of disadvantage is a legitimate response to preventing poor health. Local government plays a vital role in addressing such things as skills development and employment (re)training programs, and health services are already forming partnerships with such initiatives.

Workplaces offer an excellent setting to reach men and address risk factors for chronic disease; this is a priority under the COAG National Partnership Agreement on Preventive Health (NPAPH). Targeted workplace interventions along with community support services (e.g. walking groups, health information, quit support programs) should help reach disadvantaged men in particular. SA Health, a huge employer in its own right with over 35 000 employees, is

well placed to ensure that staff are supported to be healthy and to return to work as soon as possible following any workplace injury. Other government departments can also support staff through the workplace.

The Healthy Communities initiative, also under NPAPH, will focus on healthy eating and physical activity programs for adults not in the workplace. The first site for this initiative is Playford, where options will be explored for providing good practice and innovative programs for local residents.

SA Health has a role in reducing discrimination and preventing violence because of the cumulative negative effects that both have on health and wellbeing. We need a portfolio approach to combating alcohol-related violence in the community. The capacity of service providers to sensitively screen and support women experiencing violence who access the health system needs to be a priority. We should continue promoting community awareness of positive strategies to combat health-related discrimination.

Service responses need to be more focused on responding to the needs of vulnerable and disadvantaged adults, especially men, culturally and linguistically diverse (CALD) groups and Aboriginal people. This involves an in-depth understanding of who the high-need groups are and where and how to reach them, and provision of innovative responses such as incentives to attend free checks, flexible appointment requirements, extended hours, different locations, health advocates and new partnerships. Partners such as NGOs may be well placed to provide components of services. Clear referral pathways are required.

A deliberative democracy process is proposed to learn more about men's attitudes to looking after their own health, barriers to using health services and ways to overcome these barriers.

The experience of the UK Spearhead communities indicates that improvements in health can be achieved with strong leadership; well-integrated approaches between health services including GPs, NGOs and other partners; and scaled-up service responses that meet the needs of those who do not use services.

SA Health priority directions:

- > Regions to determine the priority population groups, health needs and locations, current action in the region and partnerships to reach those most in need.
- > Implement the Healthy Workers strategy, prioritising higher need workplaces, and ensure that government workplaces act as an exemplar.
- > Identify and implement an intensive and comprehensive set of chronic disease prevention programs in priority disadvantaged locations to test the effectiveness in reducing inequities.
- > Develop criteria to apply to current programs and inform new program development in order to optimise the mix, reach and effectiveness of the state primary prevention program effort.
- > Ensure that all GP Plus services identify and implement good practice prevention programs as well as more-targeted service responses to meet the needs of disadvantaged adults, particularly men, who are low service users.
- > Partner with GPs and Divisions of General Practice to identify and manage high-risk workers.
- > Partner with GPs and Divisions of General Practice when developing chronic disease prevention programs to ensure that they will be sustainable and effective.
- > Implement, as standard practice, screening and brief intervention for chronic disease risk factors and health literacy assessments throughout SA Health, beginning with GP Plus centres.
- > Provide support to regional health services to identify specific strategies to implement evidence-informed equity actions.
- > Examine the feasibility of a healthy living social marketing campaign addressing a range of risk factors.
- > Implement workforce development programs to support regional health staff in their work with disadvantaged adults facing complex issues.

4.6 Healthy ageing

Rationale

There is great diversity in the health and wellbeing of older people, with many remaining healthy and independent well into their eighties and beyond. Healthy ageing will benefit both individuals and society, allow the choice to work longer, contribute to the community and family, have additional years of independence at home and in the community, and reduce costs and other pressures on the health system.⁹⁴ 'Research evidence indicates that there are effective actions that can be taken to enable people to live longer in good health, staying mentally and physically active and able to participate and enjoy life until they die at an advanced old age.'⁹⁵

Normal ageing involves physical and mental changes that may impact on sight, hearing, memory, motor and sensory skills, mobility and balance. Ageing also brings an increased risk of developing chronic diseases, other age-related disorders and injury. The rate of ageing varies among individuals, and is influenced by social, behavioural and environmental factors throughout the lifespan. Where there are socioeconomic disadvantage or environmental threats, there is an increased incidence of disease or disability later in life.

Taking a whole-of-life approach to healthy ageing involves starting early—as identified elsewhere in this plan—and supporting strategies that will maintain healthy lives, independence and social connectedness until the end. Preventive steps taken in middle age and older years can improve health and wellbeing in later years.

The PPP is consistent with the Health Policy for Older People 2010–2016 and dovetails with SA Health's Health Service Framework for Older People 2009–2016, which covers secondary and tertiary prevention strategies that help retain or regain the health and wellbeing of the older person, consistent with their potential capacity.^{96,97}

What is the challenge?

SA's population is ageing faster than other Australian states and the ageing of the population will continue—by 2051 about one-third of the population will be over 65 years of age and the 85 years and older age group will have increased fourfold.⁹⁸

Aboriginal people over 45 years of age are considered to be older and have worse health than other South Australians. Older people in regional areas, CALD people, carers who are older and those caring for older people all have elevated needs. About 23.9% of older people can, by one measure, be considered to be living in poverty and this too impacts on health outcomes.⁹⁹

Injuries are a serious concern for older people and a significant burden on the health system. While most types of injury have a relatively young age profile (e.g. drowning, burns and scalds, road accidents), falls are the most common cause of serious injury among older people in SA, and account for the largest proportion of all injury-related deaths and hospitalisations.¹⁰⁰ Falls contribute significantly to the workload of ambulance services and hospital emergency departments, with the average length of hospital stay being approximately 10 days.¹⁰¹

SA research indicates that falls are associated with a number of factors, including fair or poor general health that had worsened in the previous 12 months, lower socioeconomic status and living in a home in need of repair.¹⁰² Falls are thought to be responsible for up to 80% of all fractures among older people, in part because of reduced bone strength.

Further injury concerns for older people are transport-related injuries (drivers, passengers and pedestrians) and accidental poisonings by pharmaceuticals.

While older people tend to eat more fruit and vegetables than younger people, only 17% of those aged 50–69 years eat the recommended amount of vegetables, and this falls to 13% for those over 70 years of age.¹⁰³ For fruit the figures are around 50%. Many older people have a poor-quality diet and some do not eat enough food and thus struggle to meet their nutritional requirements. This in turn has a negative impact on their health and wellbeing. Factors such as social isolation, poor dentition and limited physical activity exacerbate this. And, while the prevalence of obesity in SA is rising, many older people who are admitted to hospital are malnourished, even if they are overweight.¹⁰⁴

About half of South Australians aged 85 years and older and nearly one in three aged 65–84 years report no physical activity. One-third of men over 65 years of age have risky levels of alcohol consumption.⁹⁹

Good oral health is important in all people but especially in the ageing population. Poor oral health increases the risk of chronic disease.

The prevalence of chronic conditions in middle age is rising, and thus the proportion of older people with poorer health will increase in the future.¹⁰⁵ Physical problems such as poor oral health, arthritis, incontinence, and low vision and hearing levels can impede independence, function and wellbeing. Self-assessed health status decreases with an increase in the number of chronic conditions.¹⁰⁶

Poorer mental health often accompanies physical problems, and depression in older people can also be significant. Dementia is the main disability reported by South Australians over 65 years of age.¹⁰⁷

There is evidence that older South Australians are not maximising their chances of healthy ageing, either through not being engaged with their health care or not knowing what steps may be required. Immunisation, particularly flu injections, are an important preventive strategy. Vaccine coverage rates for South Australians are higher than the national average, with almost 84% annually vaccinated against the flu; however, the target is 95%. Even among those with known osteoporosis, 40% are not taking vitamin D and calcium supplements.¹⁰⁸ This may indicate that there is a need for improved, targeted health messages. A good relationship with a GP who can undertake regular reviews will provide an opportunity for health promotion and illness prevention, with appropriate referrals.

Ageism is a significant barrier to social connectedness, which in turn is linked to mental and physical wellbeing. Elder abuse is a serious issue and an infringement of human rights.

What more do we need to do?

Creating physical and social settings that are older person friendly and promote inclusiveness, strengths and resilience will have many benefits.¹⁰⁹ Planning urban environments that support walking—the preferred form of physical activity for older people—will have advantages for all ages.¹¹⁰ Health services can work with other sectors to ensure the provision of opportunities for social, educational, cultural and physical interaction that meets the needs of all older people. This is important in achieving wellbeing and health outcomes and can allow people to age in their local community.

Many older people will be major health service users, so health services are well placed to ensure that positive ageing is everybody's business. The value and respect shown by health workers towards older people and the ability to refer to appropriate community services is important. Primary care services have a pivotal role to play in reaching out to those who are more disadvantaged and facing barriers to service use. As more services are provided in the home, health workers have the opportunity to think holistically about the needs of the older person around such issues as food safety and diet, security and social networks.

One barrier to good health is poor health literacy. Health services including the GP Plus services are well placed to ensure that older people understand information about their health and their illness and how to navigate the health system. The Ask Me 3 communication tool is useful as it encourages patients to understand three key questions: what is my main problem, what do I need to do and why is it important for me to do this?¹¹¹

Working in partnership with local government, NGOs, sporting clubs and others in the region can help reach different groups and share the provision of programs and services to support good health for older people.

Many prevention strategies also assist those with existing conditions. For example, physical activity programs help prevent chronic conditions and falls, facilitate social connections and help recovery or rehabilitation in many cases.

Maintaining social connectedness and networks is an important aspect of healthy ageing. Social connection in older people has been found to have a protective effect against ill health, mental illness (especially depression) and premature mortality. In general, older adults who are socially connected may have less need to access health and community services.

There is some recognition that middle age (around 45 years of age) is a good time of life to review health (this is supported through Medicare by the 45-year health check) and to promote positive lifestyle changes to establish better health. These include physical activity and diet, bone and skin health, smoking and alcohol use, vision and hearing, screening and vaccinations, and quality use of medicines. For women the onset of menopause can provide an opportunity to advise about osteoporosis prevention.

Given the cost of falls and fall-related injury to the health system, and the cost-effectiveness of prevention of falls and injury, this is a priority. Early recognition of risk of falls and lifelong maintenance of bone health through adequate vitamin D and calcium intake are important. Regional health services need to partner with aged care organisations and local government to continue to improve early recognition of risk factors, such as environmental risks. Physical activity and good nutrition throughout life are two key ways to prevent falls and injury later in life.

SA Health priority directions:

- > Work across government and with key partners to support policies, plans and strategies that promote healthy ageing, supportive environments and positive community attitudes to older people. Ensure the next iteration of the Eat Well Be Active Strategy includes strategies for older South Australians.
- > Implement the SA Health Falls and Fall Injury Prevention Strategic Framework (draft) and the strategies related to older people in South Australia's Oral Health Plan 2010–2017.¹¹²
- > Identify older people who are not using health services and develop strategies to seek their views and improve their access to health information, health care and health promotion programs.
- > Ensure a comprehensive regional approach with partners (e.g. local government) to the provision of programs supporting healthy ageing, including nutrition, physical activity, falls prevention, safe alcohol consumption, social connectedness and health literacy.
- > Promote the health and wellbeing of carers—both in their caring role and caring for themselves.
- > Develop a statewide community education campaign around healthy ageing for older people and carers in relation to issues including physical activity, balance, nutrition, bone health, vision, medication, vaccination, screening, and how to ask questions and navigate the health system; include a review of resources.
- > Develop and maintain strong links with GPs and Divisions of General Practice to ensure that the best health outcomes are achieved in a cost-effective manner.
- > Ensure that regional health staff are trained to provide support for older people to stay healthy, refer appropriately, and recognise and account for circumstances that constrain healthy choices (e.g. low income, isolation, low literacy).

5. Enablers for effective primary prevention practice

5.1 Leadership, coordination and partnerships

‘Vision, leadership, agreed outcomes and coordination across multiple sectors, settings, and levels of government are vital to achieving the goals of prevention and health promotion.’

National Prevention Summit ¹¹³

High-level leadership is critical to success in primary prevention. This involves building support within the health service, from senior management to front-line workers and across clinical and non-clinical services, for the value and importance of prevention—not as a luxury but a vital plank as important as acute care. In particular, prevention action to reduce the social gradient through progressive universalism requires commitment.

The Department of Health (DH) has an important leadership role to play in:

- > setting detailed directions in consultation with partners
- > building capacity for effective prevention practice by SA Health services and other partners through leadership training programs and support for prevention champions
- > advocating across government for public policies and programs that will contribute positively to addressing the social determinants of health.

This coordination or vertical integration requires all of SA Health to work together—DH and the regional health services. Health workers in daily contact with local communities need to know that their work in prevention is valued as an essential component of health reform, that there are clear priorities in SA, and that they are a crucial piece of the jigsaw.

Horizontal integration is also important. Much of the work that needs to be done, as outlined in the PPP, requires the active participation of a range of partners, including health and related NGOs, professional groups, community groups, local and federal governments, and the private sector, as well as regional health services working together and with DH. Consultation has shown strong support for a unified approach to addressing common problems with integrated solutions.

Supporting and promoting action across sectors is also essential to address the major determinants of health. The HiAP work and intersectoral action on issues such as obesity, tobacco control, communicable diseases and child protection gives a strong base on which to build. The relatively small size of SA makes us well positioned for this approach.

Finally, improving health and wellbeing relies on active engagement with and participation by citizens in determining what kind of society and health care they want. This occurs at the local level as well as through formal structures.

5.2 Monitoring, evaluation and research

Monitoring, evaluation and research are essential tools for ensuring support of an effective portfolio of prevention programs and policies in SA.

Monitoring

Monitoring of data informs decision making and priority setting in relation to population groups, settings and locations, as well as assisting in measuring and reporting on progress in achieving health outcomes.

Primary prevention monitoring is concerned with population-level data related to both individual factors (e.g. knowledge, attitudes, behaviours) and structural determinants (e.g. Children’s Centres supporting good health, open space, healthy public policy implementation).

There are multiple sources of data at both national and state levels to monitor population-level health status and trends in risk factors. The Population Research and Outcomes Studies surveys, for example, provide continuous population-level, including regional, information.¹¹⁴ The Public Health Information Development Unit provides good

information on health determinants and inequalities.¹¹⁵ There is more limited information on utilisation of prevention programs, and the diversity of programs makes this hard to measure. Also, there is less information on risk conditions such as adverse social environments.

With Regional Health Improvement Plans, regions now have more detailed population-level information as well as service use data, allowing for better identification of higher need locations and groups.

There are already numerous reporting arrangements on prevention-related indicators, including health and disease outcomes, behaviours and services provided etc. for SASP, COAG's Australian Health Care Agreement, the National Partnership Agreement on Preventive Health benchmarks, the SA Health Care Plan and annual reports etc. The *State of Public and Environmental Health* report provides a good summary of prevention efforts, while national projects such as the National Public Health Expenditure Program report on investment in different components of public health.

Evaluation

Evaluation of primary prevention programs and policies is conducted not only to understand whether an initiative achieved its intended objectives but, importantly, to understand the effectiveness of the process of implementation—how the inputs to the program or policy were implemented. Table 1 sets out the key questions that inform our measurement of progress in primary prevention.

Specific forms of evaluation may need to take place at the outset of program planning, for example health-based and equity-focused impact assessments, to inform directions.

Appropriate time and financial resources need to be allocated to evaluation to build the evidence-base for effective practice and monitor impact (more than the standard 10% for large, complex or innovative programs). All new programs need to be evaluated to assess their potential for further expansion. Once confident of their success, evaluation can be reduced.

The logic model (Figure 10) identifies at a glance the outcomes expected in relation to the actions identified in the PPP.

Table 1 Measuring progress in primary prevention

Measuring progress in primary prevention

Essentially, we are interested in the following questions:

1 Were programs and services implemented as planned? Did they meet objectives? What was implemented? What was not implemented and why?

- > Data source—regular reports on regional and statewide program and service outputs using agreed framework, e.g. youth relationships education programs' attendance, including from target group; assessment of outcomes for individuals; periodic audits of prevention service delivery
- > Responsibility—DH and regional health services; other key providers, e.g. SHine SA (Sexual Health information, networking and education)
- > Logic model—outputs column and short-term impacts
- > PPP direction—core set of priority programs allows measurement across the state of programs with sufficient dose and reach to make a difference.

2 Are our efforts achieving results in changing South Australians' knowledge, attitudes, decisions, behaviours? What impact has there been on the health gradient and for priority population groups?

- > Data source—statewide surveys, e.g. SA Monitoring and Surveillance Surveys, Health Monitor, Health Omnibus; ABS, e.g. National Health Survey; specific surveys, e.g. monitoring of social marketing; youth surveys; regional data provided where sufficient numbers are available
- > Responsibility—DH
- > Logic model—short-term impacts and intermediate outcomes
- > PPP direction—by having a major focus on priority issues and population groups rather than spreading effort too thinly, we expect to see a change in the gradient, with PPP strategies supporting the health of those who are more disadvantaged

Includes but is not limited to SASP targets on smoking, healthy weight and psychological wellbeing; and national benchmarks under the National Partnership Agreement on Preventive Health, COAG's Closing the Gap etc.

3 What changes have occurred in policies and settings? What types of policies have been put in place, are planned or should be put in place? What changes are occurring in our priority settings? What is happening to the social determinants of health? What influence have these changes had on knowledge, decisions and behaviours?

- > Data source—social determinants data such as in the Social Health Atlas; specific collections of policy changes and key settings
- > Responsibility—DH; operational policy changes reported via regional health services
- > Logic model—short-term impacts
- > PPP direction—social determinants impact on health and may assist or impede improvements in health outcomes, and therefore should be monitored; healthy public policy and health-promoting settings are a key focus area.

4 Have our efforts improved the health of South Australians? If so, by how much? What impact has there been on the gradient in health outcomes? What impact has there been for priority population groups? Has there been any variation between locations?

- > Data source—as above in 2. Regional variations provided where sufficient numbers are available
- > Responsibility—DH
- > Logic model—longer term outcomes
- > PPP direction—ultimately aims to impact on health outcomes but measure of change in the gradient is important, as above.

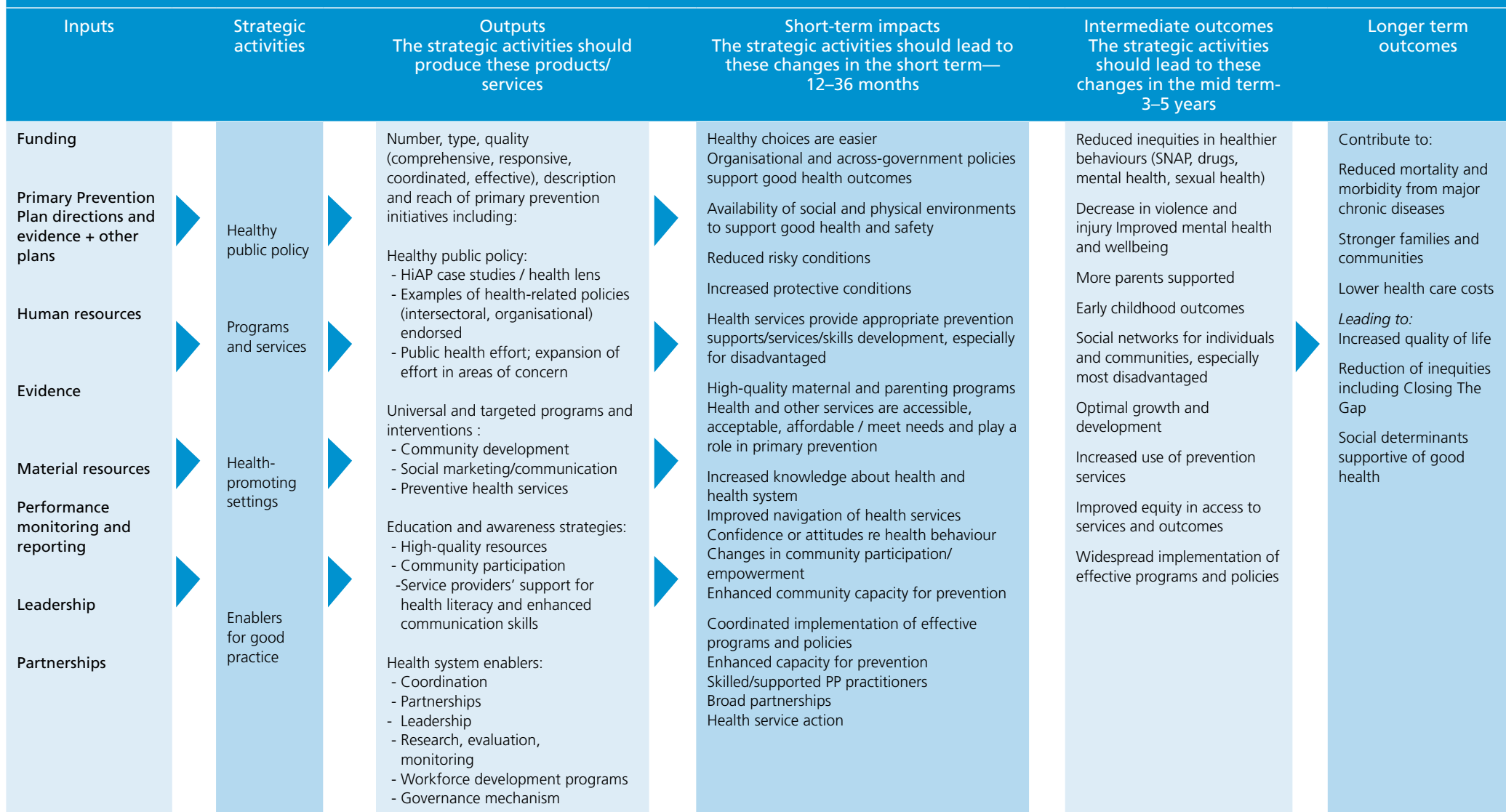
Includes impact in the longer term on SASP targets related to healthy life expectancy and Aboriginal life expectancy as well as the proportion of low-birthweight babies.

5 Have changes been achieved in a cost-efficient way? What has been spent and how many people are being reached?

Further work is required to determine how best to ensure that interventions are delivered in the most cost-effective way to impact on the whole population.

Primary Prevention Plan Logic Model

Overall goals to promote health, prevent illness and reduce inequities in health and wellbeing outcomes



Reach/approach; Coordinated (local, state, national), comprehensive
Priority population groups—life course approach, disadvantaged/vulnerable, see pg 11.
Priority settings—learning institutions, workplaces, homes, neighbourhoods and communities, health services
Priority issues—smoking, diet, drugs, oral health, sexual health, early childhood, mental health, injuries see pg 20.

Context and external factors
 e.g. Socioeconomic conditions, health service policies and plans, social norms, socioeconomic factors

Figure 10. Primary Prevention Plan logic model

Research

Research is essential due to the emerging nature of, and gaps in, population-based, primary prevention evidence. Research builds knowledge in critical areas for intervention, identifies issues and strategies for population groups, and provides the evidence-base for effective public health interventions.

SA Health supports research partnerships with universities on prevention programs. There is an ongoing need to support the translation of research into policy and practice in a timely manner and to target research support to the priority directions in the PPP. For example, both the Tobacco Control Research and Evaluation Unit based at Cancer Council SA and the Physical Activity and Nutrition Observatory: Research and Monitoring Alliance (PANORAMA) at Flinders University have been funded through SA Health to undertake strategic research, monitor trends and evaluate initiatives to inform policies and programs on the respective risk factors of tobacco and obesity prevention.

A priority for future work is to ensure that we better incorporate research evidence on the efficacy of interventions to inform the priority programs to be delivered across the state. The recent *Assessing cost effectiveness in prevention* report provides important information to contribute to this process.¹¹⁶

Further research into the population health needs and service preferences of more at-risk or vulnerable segments of the community would assist regions and other partners to apply both evidence-based interventions and innovative approaches to prevention service and program delivery, especially in relation to redressing inequities.

Examples of established and planned initiatives to support primary prevention interventions include:

- > the online Social Health Atlas of South Australia, which provides geographic mapping and monitoring of key data
- > the Child Health Clinical Network's SA Monitoring Framework for Children and Young People will provide an excellent monitoring resource addressing primary prevention issues
- > the SA/NT Datalink will provide high-quality data linkage service to support research, policy development, and service planning and evaluation to assist in addressing primary prevention issues and health inequities in SA.

SA Health priority directions:

DH, with assistance from the regional health services, will:

- > develop core primary prevention indicators consistent with national indicators for monitoring progress, allocate responsibility for their collection and collation, and ensure that the indicators currently in existence are monitored and reviewed
- > maximise research translation to ensure that all programs are based on the best available evidence and that monitoring and evaluation are set in place to measure impact and inform further development
- > develop criteria to apply to current programs and inform new program development in order to optimise the mix, reach and effectiveness of the state primary prevention program effort
- > develop a more coordinated approach to appropriately monitor and evaluate the core priority programs identified for development in the PPP
- > maximise the use of existing data sources through timely and thorough analysis and reporting, including further analysis where required
- > establish closer links with universities to build policy-relevant research and translation into practice.

5.3 Workforce planning and development

There has been very little longer term research or planning for the workforce who deliver primary prevention. Currently, this workforce is multidisciplinary in nature, with many having entered the prevention field from associated professions such as nursing, teaching or allied health. Some people actively identify as being part of the prevention workforce, while others identify with their primary disciplines and work using a 'health-promoting' approach. There are staff shortages in some professions and in others there are new graduates who are unable to find work. Roles are changing and new roles are being created, for example allied health assistants and the new Aboriginal liaison officers through GP Networks.

There is a mix of professional expertise (process and content) that is required to implement the PPP. This includes, but is not limited to, public health, epidemiology, research, health promotion, partnership development, community

action, content-specific expertise (e.g. nutrition, rehabilitation) and behavioural sciences. Active partnerships with GPs, pharmacists and other primary health care workers and input into the undergraduate curriculum for all health practitioners will maximise the spread of good practice in primary prevention.

The NPAPH workforce audit identified three levels of required competence: large numbers for program implementation; a smaller number for project or program management and delivery, including evaluation; and some for policy-level strategic direction and leadership. There are also validated competencies, plus identification that the major issues for the preventive health workforce within Australia appear to be distributional (i.e. the further from central metropolitan areas, the leaner the workforce—as with the clinical health workforce).

The audit also suggested that mechanisms for workforce management, focusing on improvements to the quality, mobility, competence and capacity of the existing workforce resources, could be developed in the implementation context rather than using traditional national workforce planning methods.

It is also important to acknowledge that many strategies used to promote good health and prevent illness require action by the workforce beyond SA Health, for example:

- > the non-government sector, e.g. multicultural community organisations, agencies working to prevent hepatitis C, Aboriginal community-controlled organisations
- > local government, e.g. conducting health impact assessments, providing services through community houses; leading the OPAL initiative
- > other government departments, e.g. schools providing sexual health education, schools developing health-promoting approaches, sporting organisations dealing with asthma
- > private health providers, e.g. allied health, GPs and GP Networks, practice nurses with roles in prevention.

While these sectors may support prevention, they are unlikely to spend funds training their staff and it will be necessary for the health sector to provide this role.

There is no overarching prevention workforce strategy to ensure that we have the right people in the right place with the right skills to undertake the work required. Now, with a platform of primary prevention in SA Health, the need for systematic planning and consolidation of effort has never been more evident.

In summary, this means that, across SA Health, there will need to be:

- > sufficient numbers in the primary prevention workforce
- > a staff mix with appropriate skills, experience and knowledge, including coverage of relevant professional areas and understanding of population health, primary health care and equity
- > a workforce that is working in a planned and integrated way
- > ongoing workforce education as well as planning for undergraduate courses and entry into the health system
- > a culture of continuous learning and quality improvement, supported by high-level leadership. Such leadership recognises the imperative to strengthen the primary prevention workforce, understands the value of building the evidence-base for workplace learning, fosters communities of practice and provides supervision, especially in new directions.

SA Health priority directions:

- > Examine the implications for SA of the national preventive health workforce audit and identify the requirements for the SA workforce in implementing the PPP, including numbers, locations, professional mix, skills, knowledge etc. Match these requirements against the existing workforce capacity and ways of working, with a view to further defining workforce needs.
- > Strengthen partnerships between Health regions and key organisations, learning institutions, primary health care providers, GP Networks and other sectors to develop and implement a strategy to facilitate an integrated approach to the development of the primary prevention workforce.
- > Support the rollout of Making Connections—a workforce development tool for health reform prepared by Country Health SA and Flinders University.
- > Investigate the current status of and opportunities to support good prevention practice and address determinants of health in current tertiary courses (both vocational and university sectors).

6. Next steps

6.1 Governance, funding and accountability

The following mechanisms will support implementation of the PPP:

- > A Primary Prevention Plan Implementation Committee (PPPIC) will be established to ensure the effective implementation of the PPP and monitor and report on progress to the Portfolio Executive and the Minister for Health. Members will be drawn from regional health services, across government, academia, general practice, local government, the non-government sector and the Department of Health.
- > A committee has been established to oversee the implementation of the AHCP and close coordination will be required.

In addition, the following are in place:

- > establishment of across-agency structures to oversee implementation of key prevention programs, priorities and actions, e.g. the Children's Centres Advisory Committee
- > establishment of local councils as local public health authorities under the *Public and Environmental Health Act 1987*
- > continuation of the sharing of responsibility for public health between central and local authorities
- > periodic round table meetings with key sectors, constituencies and partners to plan and monitor primary prevention actions.

The challenge in measuring primary prevention outcomes due to the long lead time required and the complexity of multi-strategy approaches, including from other sectors of government, has been identified above. However, primary prevention, like all parts of the health system, must be accountable for its actions and outcomes.

This is especially the case given the growing level of investment in primary prevention in SA. There is GP Plus Services funding as well as funding through the NPAPH, the bulk of which commences in 2011–12 and some of which is dependent on achievement in benchmarks on smoking, fruit and vegetable consumption, physical activity and weight indicators for adults and children. In addition, there is funding through the Australian Government, NGOs, the private sector, other government departments and health practitioners working at the population level.

It is very difficult to measure the total investment in prevention as it depends on what is included; however, the National Public Health Expenditure regularly reports investment as about 2% of the budget, of which immunisation is a significant component. Implementation of the directions in the PPP should enable the current funding allocations to be more effective. Clear identification of prevention budgets will help ensure a balanced investment across the health continuum.

In addition to reporting annually on outputs and outcomes against the logic model (Figure 10), the PPPIC will identify a key set of indicators for more regular reporting to the Portfolio Performance Review Committee.

6.2 Implementation and communication

The PPP sets out clear directions for strengthening prevention in SA. This is just the beginning and detailed planning for implementation of the specific strategies and the PPP as a whole is required. Strategies that build a platform for subsequent action will need to be prioritised for short-term action.

Consultation on the PPP suggested that there are barriers to reorienting practice towards prevention. Effective implementation will require communication to:

- > build support for the value of prevention within the health system
- > increase community understanding of the value of prevention and the types of strategies that are most effective.

It will be important to disseminate the PPP and promote its intent. To be effective, primary prevention requires engagement of key stakeholders and maintenance of their involvement. SA Health will develop a communication plan to inform staff and the many groups, organisations, businesses, communities and individuals that could be involved in its implementation about the PPP, the opportunities and achievements arising from it, and its major programs and outcomes. This information should be easily accessible. Different communication approaches will be required to reach the public and other stakeholders.

Increased community understanding of the theory underpinning prevention can also help build a more informed constituency for action to address the causes and the 'causes of the causes' of poor health.

Communicating the aims and achievements of the PPP will engender support from public health management, the community and political representatives; and help secure resources for primary prevention over the long term. It will also help ensure that potential partners are engaged. Communicating the PPP's focus and achievements will require short-term public relations activities, long-term dissemination and periodic renewal.

6.3 Regional action

By the end of 2012 the following will be in place in regional health services:

- > There will be an explicit high-level commitment to promoting the health of both the community as a whole and particular groups at greatest risk. Priorities will be in line with the PPP and local data will inform understanding of the key issues, gaps, determinants, drivers and levers for change on both the long-term causes of poor health and the short-term needs of those who are more disadvantaged.
- > An identified executive-level position will be responsible for leading the implementation of the PPP and will be accountable for outcomes; this person will sit on the statewide PPPIC.
- > There will be a team of dedicated primary prevention staff who have specific responsibility for ensuring implementation of the PPP through:
 - planning the PPP priorities within the region, including ensuring integration within the region with other service priorities as well as across the state through different governance arrangements
 - using the population data to inform program and service priorities, particularly regarding how and where to reach the more vulnerable groups
 - ensuring coordinated implementation of each of the four life course priority areas
 - providing specialist primary prevention advice
 - identifying specific service and practitioner responsibilities for the delivery of the regional actions
 - assisting regional health service units to implement the required changes and troubleshoot problems.
- > A stocktake of current regional action (by health services and other organisations) against the PPP life course priorities will be completed, gaps identified and opportunities for collaborative provision of services and programs agreed; this will form the basis of the regional PPP action plan, which will also include targets and reporting mechanisms developed at the state level. It will be clear how the progressive universalism approach will be applied across the life course.
- > Within the region the principles of primary prevention will be adopted, including: focusing both on the whole population and on those who are more vulnerable, ensuring multiple strategies to address the issue or need, ensuring sufficient dose of effort and sustained levels of investment, and avoiding one-off approaches.
- > Sufficient staff time and senior staff will be allocated to implement primary prevention strategies and there will be a commitment to build the number and capacity of the prevention workforce and ensure best fit with priorities; a workforce training plan will be identified.
- > There will be a clearly identified budget for primary prevention with a commitment to an annual increase.
- > Planning and service delivery for Aboriginal South Australians will be prioritised and well integrated to ensure improvements in outcomes.
- > It will be the agreed role of all health staff to opportunistically support consumers to be healthy and to navigate the health system.
- > Communities will be actively involved in the planning, policies and practices of the regional health services and informed about what constitutes good practice.
- > All information available to the community will support the focus on good health for the community and the evidence-based approaches to practice.
- > There will be a clear commitment to collaborative and respectful partnerships with other sectors (e.g. education and welfare services, other government services), non-government organisations (e.g. GP Networks, SHine SA, Council on the Ageing) and local government. This will be based on shared leadership and responsibility; agreed

- priorities; and the opportunity to collaboratively address community needs in the most efficient way and engage individuals, families and communities (especially those who are seldom involved or use services), including GPs.
- > All senior managers (clinical and primary care) will have a high-level understanding of and commitment to evidence-informed primary prevention practice, why it is important, how it is an integral plank of the operation of the regional health service and the implementation of the SA Health Care Plan, and how it complements and supports reform directions related to sub-acute and ambulatory care and hospital services.
 - > Consideration will be given to becoming a health-promoting health service.¹¹⁷
 - > Regional activity will be supported and complemented by centrally led policy directions and communications strategies.
 - > There will be systematic monitoring of outputs and outcomes including progress on reducing inequalities (absolute and relative).

6.4 Key recommendations

Table 2 outlines the key recommendations for action from the PPP with associated timelines and responsibilities. These will be progressed through the PPPIC.

Table 2 Key initiatives, responsibility and timelines for the PPP

Initiative/recommendation	Responsibility			Time-line
	DH	Regions	Both	
1 Maintain and enhance public health policy, legislation, regulation and services to protect and support good health	✓			O
2 Support the expansion of the HiAP approach across government, within regions and in partnership with local government, with an initial focus on SASP targets	✓			O
3 Support other departments to establish policies and programs that promote good health and reach those who are more in need, using HiAP and other partnerships	✓			O
4 Identify and pursue strategic healthy public policy reforms that promote positive social determinants, make healthy choices easier and create safe and supportive environments for all ages	✓			O
5 Implement the priorities for action by regional health services for the first 2 years, including those relating to leadership		✓		S-M
6 Define a core set of universal good practice programs and services across the life course (for early years, young people, adults and older people) on priority health issues in the PPP and indicators for monitoring implementation			✓	S
7 Review the current regional provision of universal services against key priorities and work to ensure enhanced provision. In the medium term, in line with core program recommendations, identify gaps and consolidate the dose and reach of universal programs and services		✓		S-M
8 Identify higher need populations, current provision of programs and services (by health services and other agencies) and gaps, and work collaboratively with key partners to reorient services to ensure targeted, quality intensive support for those with higher needs		✓		S
9 Work in partnership with local government (through their public health planning), DECS, DFC and NGOs to support healthy, sustainable and safe communities and settings (e.g. Children's Centres)		✓		O
10 Identify barriers to the use of preventive services for PPP target populations, including Aboriginal, young people, men, and disadvantaged groups (short term) and implement strategies (e.g. youth-friendly services, cultural safety training for staff, extended hours, outreach programs) to address them		✓		M
11 Implement, as standard practice, screening and brief intervention for chronic disease risk factors and health literacy assessments throughout SA Health, beginning with GP Plus centres			✓	M

12	In collaboration with key partners, implement priorities from the PPP for enhancing health literacy, including print materials, social marketing priorities, service information and review of use of new technologies			✓	S-M
13	Appoint a position to provide specialist advice to regional health services on the planning, implementation and monitoring of specific strategies to reduce inequities in relation to the priorities in the PPP	✓			S
14	Implement innovative community-based programs to support disadvantaged children and families, young people, men and older people			✓	L
15	Ensure effective integration of the implementation of the PPP with the AHCP, and with primary prevention priorities in related plans, e.g. sexual health, oral health, mental health, falls			✓	O
16	Establish and support a PPP Implementation Committee to monitor and report on implementation and key indicators	✓			S
17	Finalise core primary prevention indicators consistent with national indicators for monitoring progress, and allocate responsibility for their collection and collation			✓	S
18	Continue to enhance the research and strengthen the evaluation, including economic evaluation, of primary prevention to inform future funding decisions and growth			✓	O
19	Examine the implications for SA of the NPAPH workforce audit and identify the requirements for the SA workforce in implementing the PPP, including numbers, locations, professional mix, skills, knowledge etc. Match these against the existing workforce capacity and ways of working, with a view to further defining workforce needs			✓	S
20	Consolidate workforce development programs to support regional health staff and others working in prevention priorities, including the Making Connections workforce development tool for health reform			✓	S

Timeline:

O = ongoing

S = short-term—by end of 2012

M = medium-term—by end of 2014

L = long-term—by end of 2016

Appendices

Appendix 1: Integration of Primary Prevention Plan with other SA Health plans

Statewide Clinical Network	Primary Prevention Plan focus/response
Maternal and Neonatal	<ul style="list-style-type: none"> > achieving healthy weight targets > enhancing the periconceptual and antenatal environment by improving the health of young women through improved nutrition, increased physical activity and reduced alcohol misuse and smoking > implementing policy change e.g. fortifying food with folate > improving access to antenatal and birthing services for disadvantaged groups
Child Health	<ul style="list-style-type: none"> > maintaining high rates of childhood immunisation > maintaining universal screening at birth for metabolic disorders and deafness > incorporating Children's Health and Wellbeing framework in Children's Centres > improving parental health literacy and supporting families > supporting population health approaches to child protection > introducing targeted programs for families at high risk > implementing physical activity and nutrition-focused primary prevention for children and families > maintaining youth health programs (smoking, nutrition, physical activity, alcohol), including exploring use of new technology to enhance engagement > establishing respectful relationship education programs, including sexual health
Mental Health	<ul style="list-style-type: none"> > promoting mental health (e.g. social inclusion, enhancing early childhood experiences, learner wellbeing) > increasing physical activity > reducing stigma, violence and abuse
Cancer	<ul style="list-style-type: none"> > reducing smoking, improving nutrition, increasing physical activity and achieving healthy weight targets > addressing alcohol misuse > maintaining screening programs for cervical, breast and colorectal cancer and immunisation for hepatitis B and the human papillomavirus (HPV) > maintaining cancer registry databases in SA > maintaining SunSmart health promotion initiatives
Cardiology and Stroke	<ul style="list-style-type: none"> > reducing smoking, improving nutrition, increasing physical activity and achieving healthy weight targets > addressing alcohol misuse > using GP Plus strategies to improve primary and secondary prevention of chronic disease, especially for disadvantaged South Australians
Renal	<ul style="list-style-type: none"> > reducing rates of diabetes and hypertension by reducing smoking, increasing physical activity, improving nutrition, reducing alcohol misuse and achieving healthy weight targets > screening for pre-diabetes and early signs of chronic renal disease, especially in Aboriginal South Australians
Rehabilitation and Palliative Care	<ul style="list-style-type: none"> > although primary prevention is not a major focus in these areas, opportunities to support the health and wellbeing of the individual and their family through high-quality palliative care and rehabilitation services are important
Older People	<ul style="list-style-type: none"> > promoting healthy ageing through reducing smoking, improving nutrition (including undernutrition), increasing physical activity and achieving healthy weight targets > improving strength and balance and preventing falls > promoting independence and social connectedness > establishing programs to promote the health and wellbeing of carers

Appendix 2: Aboriginal Health Care Plan and Primary Prevention Plan interface

The Aboriginal Health Care Plan (AHCP) identifies the following four components in the model

1 Supporting good health, covering:

- > maintaining stronger public health—included in the PPP as a priority, recognising challenges such as infectious diseases and environmental health that are significant for Aboriginal health
- > addressing social determinants—underpinning the PPP and addressed throughout it, specifically through the HiAP section
- > health-promoting programs and services—primarily identified in the PPP through the life course approach. Some will need to be tailored to Aboriginal people and communities (e.g. tobacco control); others will successfully use an integrated approach (e.g. Community Foodies); and in some cases general programs will be relevant to all (e.g. some social marketing). All planning and implementation requires collaboration
- > health literacy—identified in the PPP as a specific determinant and a priority for programs and services; culturally appropriate health literacy initiatives will be required.

2 Comprehensive primary health care

The AHCP identifies the provision of comprehensive, culturally safe and secure primary health care services to ensure better prevention, early detection and management of conditions, particularly chronic conditions. It makes a commitment to ACCHSs as well as ensuring culturally safe services through GP Plus strategies. The PPP relies on primary health care services for the delivery of many programs and work on priority health issues, including through ACCHSs. Joint planning and implementation is identified as a priority action.

3 Better care for those with high needs

This is not a focus for the PPP but it does identify that all practitioners have an opportunity to support clients, including Aboriginal people, to be healthy.

4 An integrated and collaborative approach to planning and delivery

The AHCP recommends the set-up of an Aboriginal Health Integrated Planning Process for joint planning between SA Health, ACCHSs and other partners to collectively plan and provide for culturally acceptable services and programs. The PPP also stresses the need for comprehensive and integrated approaches through collaborative planning and delivery. Regional health services will need to decide how they ensure that these processes are best integrated.

The AHCP then identifies six priority action areas:

1 Child health—a healthy start in life

The ACHP places a priority on ensuring that all Aboriginal women have access to best practice core antenatal, birthing, postnatal and parenting programs and services as near as possible to where they live. It also commits SA Health to increasing the number of child health checks for both rural and urban Aboriginal children by ensuring proactive, coordinated screening and comprehensive follow-up services. The PPP identifies the early years as a priority, and supports the development of culturally safe universal programs and services that can be proportionately increased to meet the needs of those who are more vulnerable, a number of whom will be Aboriginal parents.

2 Youth health and safety

The provision of primary health care services and programs—to build protective factors and reduce risk factors, including more intensive responses for vulnerable and high-need young people—is important in both plans and should be developed in tandem. The AHCP includes particular attention to expansion of the mental health and wellbeing supports for young people exiting the juvenile justice system.

3 Chronic diseases

The AHCP commits SA Health to increasing the number of adult health checks of both rural and urban Aboriginal people through a proactive, coordinated screening and follow-up system in primary health care, as well as support for people to adopt and maintain healthy lifestyles, with a focus on alcohol, diet and physical activity, through culturally appropriate services. Chronic disease is also a priority for the PPP, in particular in the section relating to adults.

The creation of healthy public policy and health-promoting settings, including schools, health services and communities, is a priority in the PPP and will benefit South Australians of all ages but particularly those more at risk. Being a health-promoting setting means being culturally safe and welcoming to all.

4 Oral, ear and eye health

Under the AHCP, SA Health will establish a statewide oral, ear and eye health program, prioritising ear and eye health for young Aboriginal children in the first instance. The program will ensure an integrated, locally appropriate response involving increased timely screening, early detection, treatment and follow-up specialist care; development of a database and IT solutions; and liaison with key partners. While ear and eye health problems for Aboriginal people require responses, oral health is identified in the PPP. South Australia's Oral Health Plan 2010–2017 sets clear directions for Aboriginal and non-Aboriginal people.

5 Social and emotional health and mental illness

Poor mental, physical, social, spiritual and emotional health and wellbeing is a central issue for Aboriginal South Australians. Therefore, the AHCP prioritises implementation of recommendations arising from the *Summary Report: Statewide Aboriginal Mental Health Consultation July 2010*, as well as the development and implementation, in conjunction with Nganampa Health, of a Mental Health Plan for the APY Lands. The PPP recognises mental health as a priority issue and identifies a number of initiatives requiring action.

6 Preventable injuries

The AHCP identifies the burden of injuries such as road trauma, alcohol- and violence-related injuries, burns and other environmental hazards. There is some overlap relating to violence and alcohol but falls in older people impose a particular burden on non-Aboriginal people. Creation of safer communities, such as the City of Adelaide, will potentially prevent injuries and other harm for all.

Both the AHCP and the PPP identify a series of enablers and next steps, including leadership; health workforce requirements; safety and quality; research, evaluation and monitoring; health information and management systems; governance and accountability; and funding arrangements. Regional leadership will be essential for successful and integrated implementation of both plans. Workforce capacity is an issue for both Aboriginal health and prevention, with the prevention-focused workforce in Aboriginal health requiring particular attention. Ensuring that organisations become more culturally respectful and competent is a priority for the AHCP, as are some of the information management requirements.

Appendix 3: Screening guidelines

SA supports formal screening programs around cervix, breast and bowel cancer, and participates in national screening programs for the detection of neonatal deafness and inherited metabolic problems in newborn infants. These programs have well-developed surveillance methodology and the ability to recall individuals for definitive testing and treatment. They undergo rigorous and regular quality assurance procedures. Health practitioners and regional health services are responsible for implementation of these programs within defined parameters and for enhancing access for those individuals who consistently miss out on these programs.

Screening for chronic disease is not a simple issue to approach in practice. Appropriate screening must satisfy the following requirements:

- > It must be able to reach the target population, with case finding being a continuing process rather than a one-off project.
- > It should be equally available for every eligible individual such that health inequalities are not worsened.
- > The screening test should be acceptable and not cause more harm than benefit.
- > Facilities and systems for diagnosis and treatment should be available and there should be an agreed policy on who should be treated as patients.
- > The statistical likelihood of false positives and negatives should be clearly understood and this information given to individuals prior to screening.

There are other diseases and risk factors such as hypertension, obesity and type II diabetes for which screening can be justified because of the health benefits and cost-effectiveness of such an approach. While other sites of screening for these diseases and risk factors have been suggested, general practice and other primary health care settings allow for adequate counselling, definitive testing, treatment and follow-up of individuals. A limitation of such settings is that not all individuals in the population seek health care on a regular basis. Within the health care system, primary health care centres; community care centres; and medical, paramedical and community workers all have a role in assisting early detection and screening of these 'lifestyle' risk factors. This provides an effective pathway for referring at-risk or screen-positive individuals to further assessment for diagnosis and/or treatment.

Occasionally, screening for 'lifestyle' risk factors is conducted in non-clinical settings (e.g. community events, shows and field days) as a prevention strategy in response to the burden of chronic disease. The effectiveness of screening initiatives in these settings is largely unknown and is therefore not recommended. There is, however, some scope to enhance awareness of recommended screening in clinical settings at these events. Given the limited resources and the need to prioritise, intervening to enhance healthier lifestyles would be preferred over early detection of risk factors in non-clinical settings.

Appendix 4: The Adelaide Statement of Health in All Policies

Adelaide Statement on Health in All Policies: moving towards a shared governance for health and wellbeing

Report from the International Meeting on Health in All Policies, Adelaide 2010

The **Adelaide Statement on Health in All Policies** is to engage leaders and policy-makers at all levels of government—local, regional, national and international. It emphasises that government objectives are best achieved when all sectors include health and wellbeing as a key component of policy development. This is because the causes of health and wellbeing lie outside the health sector and are socially and economically formed. Although many sectors already contribute to better health, significant gaps still exist.

The Adelaide Statement outlines the need for a new social contract between all sectors to advance human development, sustainability and equity, as well as to improve health outcomes. This requires a new form of governance where there is joined-up leadership within governments, across all sectors and between levels of government. The Statement highlights the contribution of the health sector in resolving complex problems across government.

Achieving social, economic and environmental development

A healthy population is a key requirement for the achievement of society's goals. Reducing inequalities and the social gradient improves health and wellbeing for everyone.

Good health enhances quality of life, improves workforce productivity, increases the capacity for learning, strengthens families and communities, supports sustainable habitats and environments, and contributes to security, poverty reduction and social inclusion. Yet escalating costs for treatment and care are placing unsustainable burdens on national and local resources such that broader developments may be held back.

This interface between health, wellbeing and economic development has been propelled up the political agenda of all countries. Increasingly, communities, employers and industries are expecting and demanding strong coordinated government action to tackle the determinants of health and wellbeing and avoid duplication and fragmentation of actions.

Need for joined-up government

The interdependence of public policy requires another approach to governance. Governments can coordinate policymaking by developing strategic plans that set out common goals, integrated responses and increased accountability across government departments. This requires a partnership with civil society and the private sector.

Since good health is a fundamental enabler and poor health is a barrier to meeting policy challenges, the health sector needs to engage systematically across government and with other sectors to address the health and wellbeing dimensions of their activities. The health sector can support other arms of government by actively assisting their policy development and goal attainment.

To harness health and wellbeing, governments need institutionalised processes which value cross-sector problem solving and address power imbalances. This includes providing the leadership, mandate, incentives, budgetary commitment and sustainable mechanisms that support government agencies to work collaboratively on integrated solutions.

Health in All Policies approach

The approach described above is referred to as 'Health in All Policies' and has been developed and tested in a number of countries. It assists leaders and policy-makers to integrate considerations of health, wellbeing and equity during the development, implementation and evaluation of policies and services.

Health in All Policies works best when:

- > a clear mandate makes joined-up government an imperative
- > systematic processes take account of interactions across sectors
- > mediation occurs across interests

- > accountability, transparency and participatory processes are present
- > engagement occurs with stakeholders outside of government
- > practical cross-sector initiatives build partnerships and trust.

Drivers for achieving Health in All Policies

Building a process for Health in All Policies requires using windows of opportunity to change mindsets and decision-making cultures, and to prompt actions. Key drivers are context specific and can include:

- > creating strong alliances and partnerships that recognise mutual interests, and share targets
- > building a whole of government commitment by engaging the head of government, cabinet and/or parliament, as well as the administrative leadership
- > developing strong high-level policy processes
- > embedding responsibilities into governments' overall strategies, goals and targets
- > ensuring joint decision-making and accountability for outcomes
- > enabling openness and full consultative approaches to encourage stakeholder endorsement and advocacy
- > encouraging experimentation and innovation to find new models that integrate social, economic and environmental goals
- > pooling intellectual resources, integrating research and sharing wisdom from the field
- > providing feedback mechanisms so that progress is evaluated and monitored at the highest level.

It is not unusual that such a process can create tensions within government as conflicts over values and diverging interests can emerge. Resolution can be achieved through persistent and systematic engagement with political processes and key decision-makers.

New role for the health sector

To advance Health in All Policies the health sector must learn to work in partnership with other sectors. Jointly exploring policy innovation, novel mechanisms and instruments, as well as better regulatory frameworks will be imperative. This requires a health sector that is outward oriented, open to others, and equipped with the necessary knowledge, skills and mandate. This also means improving coordination and supporting champions within the health sector itself.

New responsibilities of health departments in support of a Health in All Policies approach will need to include:

- > understanding the political agendas and administrative imperatives of other sectors
- > building the knowledge and evidence base of policy options and strategies
- > assessing comparative health consequences of options within the policy development process
- > creating regular platforms for dialogue and problem solving with other sectors
- > evaluating the effectiveness of intersectoral work and integrated policy-making
- > building capacity through better mechanisms, resources, agency support and skilled and dedicated staff
- > working with other arms of government to achieve their goals and in so doing advance health and wellbeing.

Tools and instruments that have shown to be useful at different stages of the policy cycle include:

- | | | |
|---|---|-------------------------------------|
| > inter-ministerial and inter-departmental committees | > cross-cutting information and evaluation systems | > partnership platforms |
| > cross-sector action teams | > joined-up workforce development | > Health Lens Analysis ² |
| > integrated budgets and accounting | > community consultations and Citizens' Juries ¹ | > impact assessments |
| | | > legislative frameworks |

¹ Citizens' Juries - www.jefferson-center.org/

² Health Lens Analysis - www.health.sa.gov.au/pehs/HiAP/health-lens.htm

Next steps in the development process

The Adelaide Statement is part of a global process to develop and strengthen a Health in All Policies approach based on equity. It contributes to a critical debate that Member States and Regions of the World Health Organization (WHO) are now engaged in. The Statement reflects the track record of countries that have already gained experience in implementing such an approach.

The Statement provides valuable input into the World Conference on Social Determinants of Health in Brazil 2011, the 8th Global Conference on Health Promotion in Finland 2013, and preparations for the Millennium Development Goals (MDGs) post-2015.

Background and acknowledgements

Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector but goes beyond healthy lifestyles to wellbeing and supportive environments.

The Adelaide Statement was developed by the participants of the *Health in All Policies International Meeting, Adelaide 13–15 April 2010*. The Government of South Australia together with WHO invited 100 senior experts from a wide range of sectors and countries to discuss the implementation of the Health in All Policies approach. The main aim of the meeting was to move the agenda forward by identifying key principles and pathways that contribute to action for health across all sectors of government, and engage the health sector in contributing to the goals of other sectors.

The 2010 meeting drew on the report of the WHO Commission on Social Determinants of Health 2008 and other significant documents from the ILO, OECD, UNDP, UN-ECOSOC, UNESCO, UNICEF, World Bank and the World Economic Forum. It was also able to build on earlier work by WHO including the Declaration of Alma-Ata on Primary Health Care 1978; the Ottawa Charter for Health Promotion 1986; the Adelaide Recommendations on Healthy Public Policy 1988 and subsequent global health promotion conferences; the Gothenburg Consensus Paper on Health Impact Assessment 1999; and the Declaration on Health in All Policies, Rome 2007.

Since 2007 the State Government of South Australia has been playing a leading role in promoting knowledge exchange on Health in All Policies within Australia and internationally. Their initiatives have included holding a Health in All Policies conference in 2007 to launch their work; providing continuing support to central and other agencies across their State Government; publishing guidance materials on their methods for Health in All Policies; and holding the International Meeting on Health in All Policies, co-sponsored with WHO, in April 2010.

Examples of joined-up government action

Sectors and issues	Interrelationships between health and wellbeing
Economy and employment	<ul style="list-style-type: none"> > Economic resilience and growth is stimulated by a healthy population. Healthier people can increase their household savings, are more productive at work, can adapt more easily to work changes, and can remain working for longer. > Work and stable employment opportunities improve health for all people across different social groups.
Security and justice	<ul style="list-style-type: none"> > Rates of violence, ill-health and injury increase in populations whose access to food, water, housing, work opportunities and a fair justice system is poorer. As a result, justice systems within societies have to deal with the consequences of poor access to these basic needs. > The prevalence of mental illness (and associated drug and alcohol problems) is associated with violence, crime and imprisonment.
Education and early life	<ul style="list-style-type: none"> > Poor health of children or family members impedes educational attainment, reducing educational potential and abilities to solve life challenges and pursue opportunities in life. > Educational attainment for both women and men directly contributes to better health and the ability to participate fully in a productive society, and creates engaged citizens.
Agriculture and food	<ul style="list-style-type: none"> > Food security and safety are enhanced by consideration of health in food production, manufacturing, marketing and distribution through promoting consumer confidence and ensuring more sustainable agricultural practices. > Healthy food is critical to people's health and good food and security practices help to reduce animal-to-human disease transmission, and are supportive of farming practices with positive impacts on the health of farm workers and rural communities.
Infrastructure, planning and transport	<ul style="list-style-type: none"> > Optimal planning for roads, transport and housing requires the consideration of health impacts as this can reduce environmentally costly emissions, and improve the capacity of transport networks and their efficiency with moving people, goods and services. > Better transport opportunities, including cycling and walking opportunities, build safer and more liveable communities, and reduce environmental degradation, enhancing health.
Environments and sustainability	<ul style="list-style-type: none"> > Optimising the use of natural resources and promoting sustainability can be best achieved through policies that influence population consumption patterns, which can also enhance human health. > Globally, a quarter of all preventable illnesses are the result of the environmental conditions in which people live.
Housing and community services	<ul style="list-style-type: none"> > Housing design and infrastructure planning that take account of health and wellbeing (e.g. insulation, ventilation, public spaces, refuse removal, etc.) and involve the community can improve social cohesion and support for development projects. > Well-designed, accessible housing and adequate community services address some of the most fundamental determinants of health for disadvantaged individuals and communities.
Land and culture	<ul style="list-style-type: none"> > Improved access to land can support improvements in health and wellbeing for Indigenous peoples as Indigenous peoples' health and wellbeing are spiritually and culturally bound to a profound sense of belonging to land and country. > Improvements in Indigenous health can strengthen communities and cultural identity, improve citizen participation and support the maintenance of biodiversity.

Abbreviations

ACCCHS	Aboriginal Community Controlled Health Service
AHCP	Aboriginal Health Care Plan
CALD	culturally and linguistically diverse
COAG	Council of Australian Governments
CYWHS	Children, Youth and Women's Health Service
DECS	Department of Education and Children's Services
DFC	Department for Families and Communities
DH	Department of Health
GP	general practitioner
GP Plus	GP Plus Health Care Strategy
HiAP	Health in All Policies
NCD	non-communicable disease
NGO	non-government organisation
NPAPH	National Partnership Agreement on Preventive Health
NPHT	National Preventive Health Taskforce
OPAL	Obesity Prevention and Lifestyle
PPP	Primary Prevention Plan
PPPIC	Primary Prevention Plan Implementation Committee
SA	South Australia
SASP	South Australia's Strategic Plan
SHine SA	Sexual Health information, networking and education SA
STI	sexually transmitted infection

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