

# Health promotion priorities for Victoria

A discussion paper



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## Foreword

Health promotion and prevention programs emphasise approaches that work to address the root causes of ill health by focusing on changing the conditions and environments in which people live, work and play. There is growing evidence worldwide of the benefits and effectiveness of investing in these approaches. This investment is amplified when individuals and organisations work together to tackle our biggest health challenges. A strong economy and prospering community can only be built on a healthy and active society.

In Victoria, the Rural and Regional Health and Aged Care Services (RRHACS) Division of the Department of Human Services and the Victorian Health Promotion Foundation (VicHealth) together invest over \$176 million annually to support quality health promotion/prevention programs and practice. To make the most of this investment, the RRHACS Division, in partnership with VicHealth, is leading the development of new health promotion priorities for 2007-12. These priorities will guide our actions into the future although won't exclusively determine the many important health issues we will still continue to work on.

The RRHACS Division and VicHealth are committed to an evidence-based approach to health promotion policy setting, planning, implementation and evaluation. For this reason, it was considered important that we model a health promoting approach to priority setting and that we consult widely during this process.

This discussion paper sets the groundwork for consultation forums that will be held across Victoria from February to April 2006. These consultations will provide an opportunity for the diverse range of people involved in health promotion in Victoria to participate in setting the health promotion agenda for 2007-12. The consultations will also provide the opportunity to think towards the future and explore how health promotion can be better managed and organised systematically to achieve the best possible outcomes.

We value your participation and look forward to hearing your views and continuing to work together into the future to improve the health of Victorians.



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## 1. Introduction

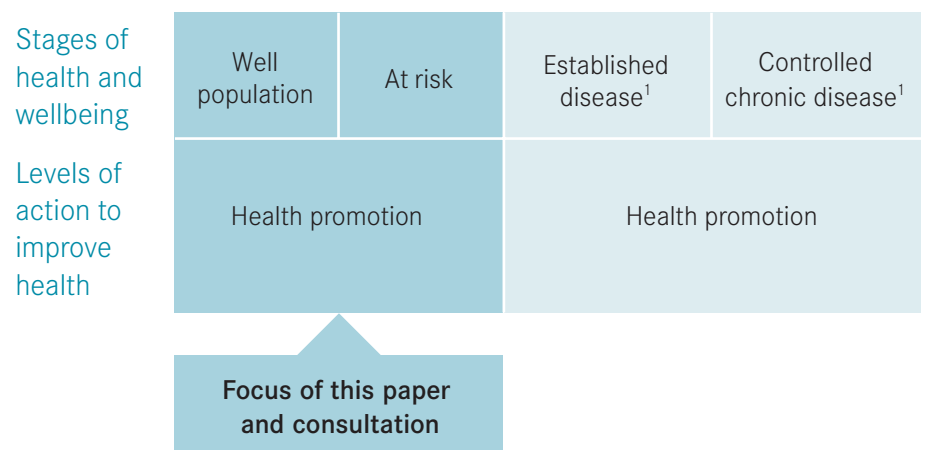
The United Nations recognises that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, without discrimination. Health promotion action is based on this critical human right (World Health Organisation 2005a).

Health promotion is the process of enabling people and populations as a whole to increase control over their health and those things that determine health. It is an effective investment in improving health and human development (World Health Organisation 2005a).

The defining features of health promotion include actions that are:

- implemented across the whole population, not just those at risk of specific diseases (see Figure 1)
- directed towards improving people's ability to control the factors that determine their health
- part of a process, involving a mix of individual and population responses from a number of stakeholders, which aim to improve health.

**Figure 1: Levels of action and stages of health** (National Public Health Partnership 2001)



A strong economy can only be built on a healthy and active society. For human capital to be maximised, there needs to be a greater emphasis on promoting health, preventing ill-health, and a more efficient and evidence-based service system. Given that health is often created outside of the traditional health care system, this requires all levels of government to work cooperatively to shift the focus towards prevention and promotion of wellness across the life stages (Department of Premier and Cabinet and Department of Treasury and Finance 2005). Health promotion, therefore, has a significant role to play in creating not only a healthy society but also an economically strong society.

<sup>1</sup> The way in which disease is managed and treated can also be influenced by health promoting principles. These actions are not however the focus of this paper.

## 2. Purpose of discussion paper

This discussion paper and the consultation forums are focused on reviewing current health promotion priorities and developing priorities for 2007-12.

The **objectives** of the consultation are to:

- provide opportunities for the diverse range of stakeholders<sup>2</sup> to participate in setting the health promotion agenda for Victoria
- gather information that will assist in defining health promotion priorities for 2007-12 for the Rural and Regional and Aged Care Services (RRHACS) Division of the Department of the Human Services, the Victorian Health Promotion Foundation (VicHealth) and other key stakeholders, and to inform systematic strategic planning for health promotion
- contribute to and support key government initiatives such as the Primary Care Partnership (PCP) Strategy, Community Health Policy, Neighbourhood Renewal Strategy, Ambulatory Care Framework, Go For Your Life strategy, Aboriginal Health Promotion and Chronic Care (AHPACC) program, Environments for Health and Municipal Public Health Planning, the Well for Life initiative and the Victorian Oral Health Promotion Strategy 2005–10.

### Outline of discussion paper

The discussion paper includes:

- a. **Introduction and Purpose** – set the context for the paper.
- b. **Health promotion priority setting process** – outlines the framework and steps of the process.
- c. **The spotlight on health promotion in Victoria** – gives an overview of the current health promotion stakeholders in Victoria.
- d. **The health report card and priority setting** – summarise the available population health data and supporting evidence for the preliminary priority issues.
- e. **Questions for the consultation.**
- f. **The next steps in the process.**
- g. **Contact details** for further information, appendices and references.

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<sup>2</sup> It is expected that those participating in the consultation forums or forwarding submissions will do so in a capacity where the views expressed are those of the organisations or communities they represent and/or the communities they work with.

### 3. Health promotion priority setting process

Since 2000, policy reform lead by the department has emphasised quality health promotion. Examples of this include the PCP Strategy (particularly the Integrated Health Promotion Framework), Municipal Public Health Planning using *Environments for Health* and the Small Rural Health Services Strategy.

For 2004–06, health promotion priorities were set for the primary and community health sector, which includes community and women’s health services, PCPs and some statewide health agencies. The five priorities included:

- physical activity
- food and nutrition
- mental wellbeing and social connectedness
- tobacco, alcohol and other drug issues
- healthy weight.

The priority setting was Neighbourhood Renewal sites and these will remain priority settings for 2007–12. Neighbourhood Renewal is a new approach that brings together the resources and ideas of residents, governments, local businesses and community groups to tackle disadvantage and build more cohesive communities. For more information about Neighbourhood Renewal program see [www.neighbourhoodrenewal.vic.gov.au](http://www.neighbourhoodrenewal.vic.gov.au)

PCP community health plans and funded agency health promotion plans were used to formulate the priorities for 2004–06; there was no consultation. To improve on this process and model best practice, the RRHACS Division, in partnership with VicHealth, is leading the development of health promotion priorities for 2007–12. The RRHACS Division and VicHealth are committed to an evidence-based approach to health promotion policy development, planning, implementation and evaluation. Integral to this are clear priorities for action and an open process for setting priorities.

Increasing the number of program areas that will participate in the consultation process will, in turn, inform to a greater extent how the department funds health promotion practice and prioritises other support resources. This includes health promotion practice across community and women’s health, PCPs, funded statewide agencies, dental health, aged care, public health, rural and regional health, drug policy and Premiers Drug Prevention Council. The outcomes will be used to guide collaborative work with Local Government. VicHealth is currently developing their 2006–09 strategic plan and will aim to align the consultation outcomes. Other parts of the department, such as Neighbourhood Renewal, have also expressed interest in participating in this process. The policy setting process is incremental—participation by all interested parties is welcomed.

Working in collaboration to agreed priorities enhances the capacity of health promotion stakeholders and reduces duplication and fragmentation of health promotion effort and investment. These priorities will guide our actions into the future although won’t exclusively determine the many important health issues we will still continue to work on.

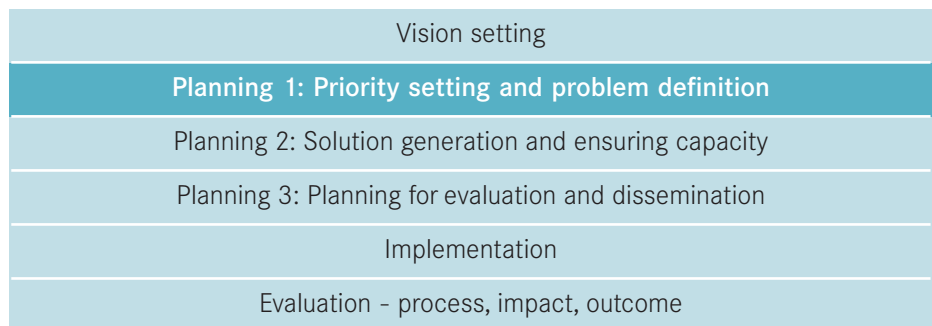
The consultation will also provide the opportunity to look to the future and explore how health promotion can be managed and organised to achieve the best possible outcomes. This is the second major focus of the consultation forums.

## Putting theory into practice

Given the many competing health, wellbeing and disease issues, a health promotion priority setting process can be very difficult. It is, therefore, important for the RRHACS Division and VicHealth to demonstrate, by example, a thorough and consultative priority setting process to support strengthened health promotion action by both internal and external stakeholders.

The planning framework first introduced in the Integrated health promotion kit (Department of Human Services 2003a) provides the basis for the priority setting process and how it fits within the broader cycle of planning, implementation, evaluation and dissemination (Figure 2).<sup>3</sup>

**Figure 2: Planning framework for health promotion** (Department of Human Services 2003)



## Vision

The department’s vision and objectives support the State Government’s policy directions expressed in *Growing Victoria Together*. This includes:

- building sustainable, well managed and efficient human services
- providing timely and accessible human services
- improving human service safety and quality
- promoting least intrusive human service options
- strengthening the capacity of individuals, families and communities
- reducing inequalities in health and wellbeing (Department of Premier 2001).

VicHealth’s vision statement envisages a community where:

- health is a fundamental human right
- everyone shares in the responsibility for promoting health
- everyone benefits from improved health outcomes (Victorian Health Promotion Foundation 2003).

<sup>3</sup> *Environments for Health* was released in 2001 and is the planning framework that guides the development of Municipal Public Health planning in Local Government. The Planning framework explained above draws on available evidence for program planning and management. While the language is slightly different it does have the same intent as the planning framework explained in Section 6 of the *Environments for Health* framework. There are plans underway to update the two planning frameworks and introduce a common language. This will happen as new editions of the two resources are produced.

## Priority setting and problem definition

Consultation forums will be held across Victoria to discuss issues raised in this discussion paper and to seek feedback from organisations (Appendix 1). This discussion paper presents a summary of available population health data and supporting evidence to begin the priority setting process. It asks questions for discussion during the consultation and provides references for interested readers to access more information. This paper does not constitute a government policy paper.

The consultation forums will provide opportunities for all stakeholders<sup>4</sup> to discuss the proposed priorities for 2007-12 and bring additional perspectives to the process.

Decision making criteria will be used to finalise the priorities, including:

- the **significance of the impact and scale of the issue** – using burden of disease data and other supporting evidence
- the **degree of health inequalities** – considering differential distribution of socioeconomic status and other factors, such as gender, ethnicity, being Indigenous, rurality
- evidence that indicates that these issues are **amenable to change** through health promotion and prevention action
- the **strategic opportunities and capacity**, for RRHACS, VicHealth and/or other key stakeholders, present now and over the next three years to address these issues.

These selection criteria have been chosen because of their relevance to the vision, mission, aims and objectives of VicHealth and the department's health promotion values (Appendix 2).

The consultation forums will also focus on what we need to do to create a systematic approach to health promotion in Victoria. Three core components are thought to be required to ensure coordinated and good quality health promotion action—a mandate to act, a framework for action, and the capacity to act (Harris 1995; Bowen 2001). The capacity of RRHACS, VicHealth and participating organisations to reorient the current system to better support the 2007-12 health promotion priorities will be the focus of this part of the consultation. Practical and realistic actions to build and enhance this capacity will be discussed. The NSW Health Promotion Capacity building framework will be used to guide this discussion (NSW Health 2001)(Appendix 3).

Written submissions in response to the consultation questions, in section seven, will also be accepted. Further details about written submissions are given in section eight.

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<sup>4</sup> It is expected that those participating in the consultation forums or forwarding submissions will do so in a capacity where the views expressed are those of the organisations or communities they represent and/or work with.

## 4. The spotlight on health promotion in Victoria

Health promotion has grown exponentially over the last 20 years (Catford 2004; Howat 2003) moving from limited activities and projects to a broader field of practice of increasing sophistication, involving a range of players and sectors. While the health sector plays a role in advocating and partnering with other sectors to influence the factors that determine health, it cannot do it all.

Health promotion in Victoria reflects the diversity of stakeholders and the focus on intersectoral action and partnerships. There are six broad groups of health promotion stakeholders in Victoria:

- citizens and communities
- the three tiers of government—Commonwealth, State and Local—which play key roles in developing health promotion policy and resourcing, implementing and evaluating health promotion programs (in partnership with the funded sectors)
- VicHealth, which plays a key role in developing innovative responses to existing and emerging health issues and working with government to embed successful strategies into ongoing policy and programs
- organisations that work in settings including community services and health, education, workplace, housing, transport, justice, transport, arts, sport and recreation
- universities and academic sector
- statewide and non-government organisations (NGOs).

Within the Victorian State Government, the Department of Human Services *Strategic Plan 2005–06* (Department of Human Services 2005a) identifies health promotion as a core component of a high performing human services system.

The RRHACS Division of the department, in partnership with VicHealth, is undertaking this consultation. The RRHACS Division is responsible for policy development, funding and monitoring of service delivery in the key areas of rural and regional health, aged care, public health, primary and community health, dental health and drug services. The division's health promotion and prevention funding represents a significant component of the division's total budget. While all RRHACS branches have a role in health promotion, this differs depending on the program area responsibilities and respective funded service providers. Public Health also works in partnership with Local Government who have a legislated role in public health planning, that is based on a health promoting approach.

VicHealth fosters change in the social, economic and physical environments that influence the health of Victorians. VicHealth works across many sectors and with many partners in the community to build opportunities for people to be informed, learn new skills and have greater access to activities, as well as create environments that enable people to enjoy healthier living. This work focuses on innovative responses and evidence-based approaches, adding value to the work of government and community organisations. VicHealth is continually scanning the environment for, and investing in, new knowledge and approaches to help lead the discipline of health promotion. VicHealth seeks to contribute to the larger public health system by adding to the knowledge base and disseminating evaluation data and new evidence to practitioners and policy makers.

As a conservative estimate, RRHACS and VicHealth together invest over \$176 million annually to support quality health promotion/prevention programs and practice.

The health promotion priority setting process for 2007-12 is the first step in a planned incremental process. The aim is to increase the number of partners from across government and at the local level to establish statewide priorities for 2012 onwards. Other parts of the government, such as the Office for Children and the Department for Victorian Communities, have a clear health promotion function and will be invited to participate in the upcoming consultations.

## 5. The health report card

This section gives the broad population health data for Victoria, introducing the major midstream risk factors for the highest burden of disease. This risk factor approach is enriched by using a health equality lens to examine where health is experienced differently by different groups of people in Victoria.

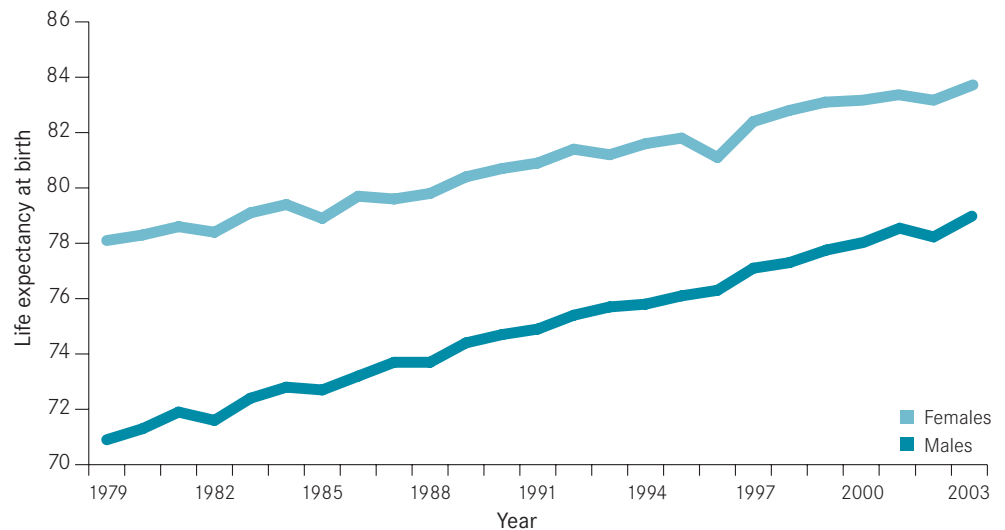
People living in Victoria and Australia generally enjoy good health. In fact, health outcomes, in terms of both morbidity and mortality, of Australians rank among the best in the world (Department of Premier and Cabinet and Department of Treasury and Finance 2005). For example life expectancy for a child born in Victoria in 2003 has reached 78.8 years for males and 83.8 years for females. Victoria has the second highest life expectancy for both males and females in Australia in 2003 (Figure 3).

Australian mortality rates have improved by almost two-thirds over the past century. This improvement in the health and life expectancy of Australians has delivered an enormous dividend to governments in terms of the reduced cost of medical treatments and the extension of productive, disability-free life for the community.

For example:

- The net value to society of tobacco control programs in Australia is estimated to be \$8.6 billion, at a cost of just \$0.2 billion.
- Lung cancer would cost the nation \$58 million more in 1998 to treat and the number of deaths would be double if these investments in tobacco control programs had not occurred.
- The estimated national cost of cardiovascular disease would be 50 per cent higher (around \$0.5 billion in 1998) and deaths would be four times higher today if we experienced the same level of this disease as 30 years ago (Commonwealth Department of Health and Ageing 2003).

**Figure 3: Life expectancy at birth Victoria, 1979 to 2003, by sex** (Department of Human Services. 2005b)



These achievements can, however, mask the increasing burden that chronic disease places on individuals and families. Similarly, they can mask the estimated increases in health care costs expected in the coming decades (Allen Consulting 2005). About 70 per cent of the total burden of disease in Australia and almost 78 per cent of all deaths have been attributed to just seven conditions. These include:

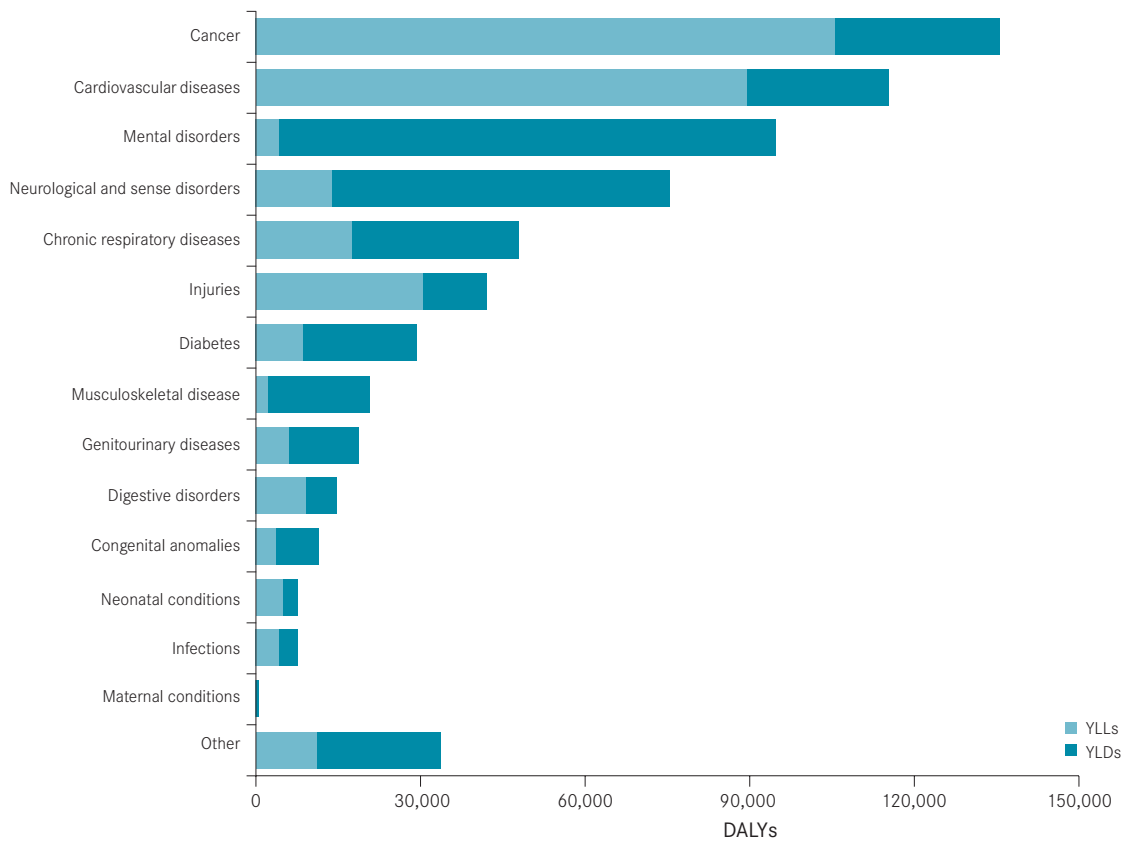
- **asthma**
- **cardiovascular health** including coronary heart disease, stroke, heart failure and peripheral vascular disease
- **cancer** including lung cancer, melanoma, non-melanocytic skin cancers, cancer of the cervix, breast cancer, colorectal cancer, prostate cancer and non-Hodgkin's lymphoma
- **diabetes mellitus** including Type 1 diabetes, Type 2 diabetes and gestational diabetes
- **illness caused by injury** including falls in older people, falls in children, drowning and near drowning, and poisoning in children
- **mental health conditions** including depression, and depression as a co-morbidity or complication of the other disease groups
- **arthritis and other musculoskeletal conditions** (Australian Institute of Health and Welfare 2002).

These National Health Priority Areas (NHPA) are the focus of major action by the Australian Health Ministers Conference (AHMC), involving collaboration between the Commonwealth, State and Territory governments.

## The Burden of Disease

In Victoria, the burden of disease, not surprisingly, follows a similar pattern (Figure 4). For each of the conditions, a certain amount can be prevented or its impact on overall health and wellbeing at least reduced, through a stronger focus on health promotion and prevention (Australian Institute of Health and Welfare 2002).


**Figure 4: Burden of disease (Years of Life Lost {YLL}, Years of Loss due to Disability {YLD} and Disability Adjusted Life Years{DALY}) for major disease groups, Victoria 2001 (Department of Human Services 2005c)**



**Midstream risk** factors refer to behavioural and psychosocial factors that can cause certain biological reactions that create disease (Figure 5). Clusters of midstream risk factors (such as smoking, physical activity, nutrition) as well as downstream biological factors (such as high blood cholesterol, high blood pressure) are associated with chronic diseases and all are modifiable.

In understanding the cause of disease, attention must also be given to the things that contribute to the midstream risk factors. These so called **upstream determinants** include a range of social, physical, economic and environmental factors that are the precursors of the midstream risk factors which, in turn, are the precursors of the downstream factors that ultimately cause disease (Figure 5). These upstream determinants are also well represented in the four dimensions of the Environments for Health framework- built, social, economic and natural.

**Figure 5: Factors affecting health – upstream determinants, midstream and downstream risk factors**  
(NSW Health 2002)

Upstream determinants of health	Midstream risk factors	Downstream factors
<b>Social, physical, economic, and environmental factors</b>	<b>Psychosocial factors</b>	<b>Physiological systems</b>
Education	Control	Endocrine
Employment	Stress, demand-strain	Immune
Occupation	Depression and self-esteem	
Working conditions	Hopelessness	<b>Biological reactions</b>
Income	Social support and networks	Hypertensions
Housing	Isolation and marginalisation	Fibrin production
Area of residence		Adrenalin
	<b>Health behaviours</b>	Blood lipid levels
	Food and nutrition	Body mass index
	Smoking	
	Physical activity	
	Alcohol	
	Self-harm	
	Preventative health care use	
		
Main direction of influence		

Midstream risk factors act together in causing chronic conditions and diseases, they do not operate independently of each other. **Reducing the impact of just one risk factor, without attention to the others, will result in a relatively small health gain.** Action to target risk factors needs to be directed at the areas with greatest potential for gain and where the joint effects of interventions targeting multiple risk factors will be maximised. Table 1 presents a picture of the links between conditions, the associated risk factors and upstream determinants.

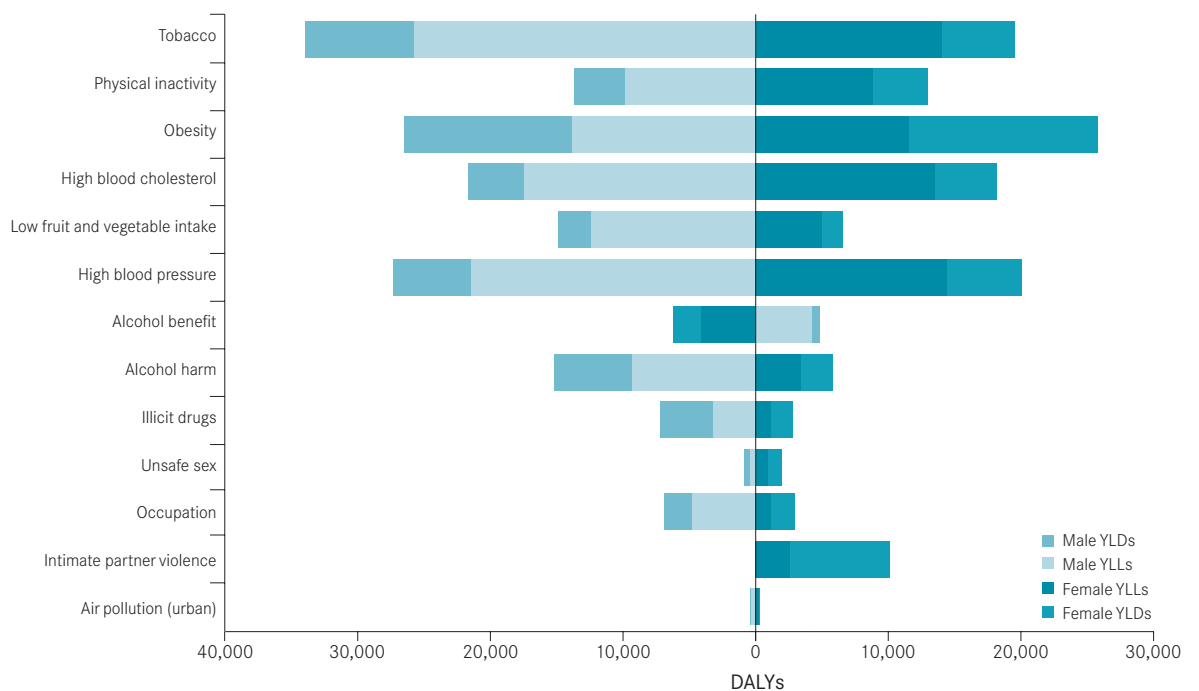
**Table 1: Links between conditions, the associated risk factors and upstream determinants** (adapted from Australian Institute of Health and Welfare 2004a and Deakin University 2004)

Conditions	Cardio-vascular Health	Diabetes	Cancers	Asthma	Mental Health	Arthritis	Injury
<b>Factors</b>							
Tobacco use	✓	✓	✓	✓	+	✓	
Alcohol misuse	✓		✓		✓ +	✓	✓
Hypertension	✓	+			+		
Dyslipidemia	✓	+					
Nutrition	✓	✓	✓	?	+		
Physical activity	✓	✓	✓		✓	✓	✓
Excess weight	✓	✓	✓		+	✓	?
Chronic stress	?	?	?	?	✓		
Social support	✓	?			✓		
Depression	✓	? +	+	+	✓		✓
Early life (incl low birth weight)	✓	✓	?	✓	✓		?
Low socio-economic status	✓	✓	✓	✓	✓		✓

✓ ESTABLISHED    + ASSOCIATED/COMORBIDITY    ? POSSIBLE

Recent population health data for Victoria gives a clear picture of the risk factors that have the greatest impact on the disease burden in Victoria (Figure 6).

**Figure 6: Risk factors that have the greatest impact on the disease burden in Victoria 2001, by sex** (Department of Human Services 2005c)



## Health inequalities

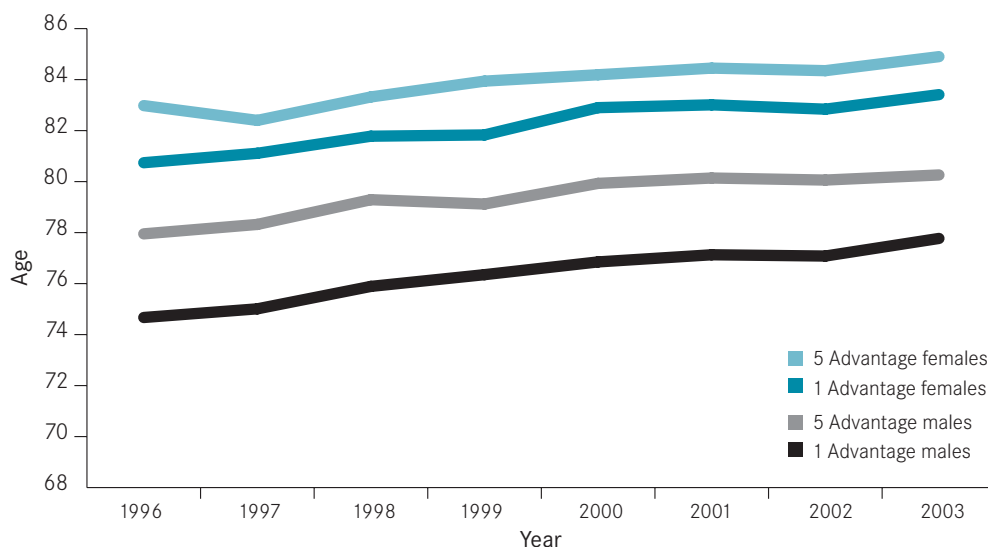
Health is experienced differently by different groups of people in Victoria—health is not equal for all (Allen Consulting 2005). A burgeoning volume of research identifies that the upstream determinants of health described above are at the root of much of these inequalities in health (World Health Organisation 2005a). There are substantial and systematic health inequalities that cannot be explained by individual make-up or behaviour.

The most pressing inequalities in Victoria are those experienced by Indigenous Australians and others who are socioeconomically disadvantaged. Regardless of how health is measured, by risk factors, use of services or health outcomes, these groups are consistently disadvantaged in regard to life expectancy and health more generally (Figure 7). Alarming, good health also reflects a gradient of advantage: the higher your position on the socioeconomic gradient, the better your health.

Health inequalities represent a significant barrier to effective action to address chronic disease and prevent the realisation of health gains made by the broader population in such areas as smoking, immunisation and road safety.

There are also substantial economic costs arising from health inequalities. Simulation data estimates that if the health status of all Australians were the same as those in the top socioeconomic quintile, one million fewer Australians would be disabled, more than 180,000 life years would be saved, and health care costs would be \$3 billion lower (Australian Government Productivity Commission 2005). For example, oral disease is a major indicator of inequality and is amongst the most costly diet related disease in Australia, representing \$4.4 billion spent in 2002-03 (Stewart 1999). Seventy-three per cent of sixty five year old persons who are health care cardholders suffer from complete tooth loss compared with forty-four per cent of sixty five year old persons who are not health care cardholders (Australian Institute of Health and Welfare 1998).

**Figure 7: Life expectancy in Victoria by Socio-Economic Indexes for Areas 2001 (SEIFA 2001) quintiles (q1:q5) Males and females 1996-2003**  
(Department of Human Services 2005d)



The known interaction between health inequality and social disadvantage requires government to pursue health inequality strategies in tandem with broader social initiatives. *A Fairer Victoria's* attention on social disadvantage creates this complementary opportunity (Department of Premier 2001).

Action to reduce health inequalities is, therefore, critical in reducing the risk factors associated with chronic disease, as well as a means to effectively target the defence and extension of established, successful health interventions. Focusing on the midstream risk factors with just a individual behaviourist responses fails to fully plan for and implement strategies that with change the upstream factors that determine health and disease. Initiatives to address the major chronic diseases requires a multi-focused approach that aims to decrease vulnerability and exposure to the **midstream risk factors** in tandem with strategies that positively change the **upstream determinants** that impact on these midstream risk factors (Figure 5).

## 6. Priority setting—addressing midstream and upstream factors that determine health

This section introduces a preliminary list of priority issues, which has been compiled after applying the decision-making criteria from section three. The priority issues are:

1. **Physical activity and active communities**
2. **Accessible nutritious food**
3. **Promoting mental health and wellbeing**
4. **Reducing and minimising the harm from tobacco, alcohol and illicit drugs**
5. **Preventing injury**

This preliminary list of priorities is the starting point for the consultation.

For each midstream risk factor, the impact and scale of effect on population health is explained, a summary is provided on the degree of inequality related to this risk factor and recommended action for effective change. This information will enable assessment of whether the issue is amenable to prevention. For each broad priority issue, where enough information is available to recommend sub-priorities, these are given. These suggested sub-priorities are provided to enable decisions as to whether we need general overarching priorities, or whether we should be specific if the sub priorities are more amenable to prevention and likely to bring about the most targeted health gain.

The information provided is a summary and is based on the best available evidence or the known relationship between disease, midstream risk factors and upstream broader determinants. Investment in evaluating these interventions is essential to establish a stronger evidence base.

The consultation will examine this preliminary list and seek feedback on:

- the proposed priorities, the arguments presented here for each, and any further information or arguments that need to be considered in setting priorities
- current action undertaken to address these priorities and participants' capacity to make organisational changes that will strengthen future action on these
- how health promotion can be systematically organised across Victoria to achieve the best possible outcomes for this prioritised effort.

For new priorities raised (either verbally or through written submissions), the same decision making criteria will be applied in establishing a finalised priority list for 2007–12.

## Promoting healthy weight

### Obesity

#### a) Impact and scale of the issue

- Obesity is ranked second as a cause of premature death and disability in Victoria contributing 8.0 per cent of the overall burden of disease (Department of Human Services 2005c).
- Of 30 Organisation for Economic Cooperation and Development (OECD) nations, Australia has the fourth highest rate of obesity, behind the United States, Mexico and the United Kingdom (Organisation for Economic Cooperation and Development 2003). Approximately 3.3 million Australians are obese with another 5.6 million overweight (Australian Institute of Health and Welfare 2003b).
- During the last decade, the prevalence of overweight Australian children almost doubled, while levels of obesity more than tripled (Booth et al. 2001; Margarey et al. 2001). Conservative estimates indicate that 23 per cent of Australian children are overweight or obese (Booth et al. 2001).
- Obese women in Australia are four times more likely to have diabetes than women of a healthy weight. Obese men and women have double the rate of high blood pressure than people of a healthy weight. Obese women are more likely than healthy weight women to have visited a hospital, day clinic or consulted a doctor in the last fortnight (Australian Institute of Health and Welfare 2004a). In addition to the health impacts, overweight or obese people may also be subject to discrimination and negative attitudes in response to their body weight.

#### b) Degree of health inequality

- Women in the most disadvantaged socioeconomic group had nearly double the rate of obesity (22.6 per cent) of those in the most advantaged group (12.1 per cent) (Australian Institute of Health and Welfare. 2003b). Body Mass Index has been demonstrated to be significantly higher for women who are food insecure (Kendall 1996).
- Aboriginal and Torres Strait Islanders have higher rates of obesity than non-Indigenous Australians. In 2001, almost one third (31 per cent) of Indigenous Australians were obese, compared to non-Indigenous Australian rates of 16 per cent (Australian Bureau of Statistics. 2002).

#### c) Action areas that are amenable to change through health promotion and prevention action

- Many lifestyle and environmental factors can contribute to being overweight and obese, such as the rise of car ownership which has led to less people walking or cycling; the modernisation of household appliances has led to a decrease in manual labour; increased consumption of high fat and high sugar convenience foods; and a decrease in time spent on active leisure time activities. Even in public places, people are encouraged to use escalators and elevators rather than climb stairs (American Obesity Association 2005).

- The density of takeaway outlets is higher than that of fresh food stores in more disadvantaged neighbourhoods, with significantly more fast food outlets per head of population in these areas (Reidpath et al. 2002). Land use mix has a strong association with obesity (Frank et al. 2004).
- Weight gain and obesity develops when energy intake (from food and drink) exceeds energy expenditure (from physical activity and other metabolic processes) over a prolonged period of time. Rare cases of obesity include hormonal problems, genetic defects and drug-related problems (Australasian Society for the Study of Obesity 2005). Preventing obesity involves promoting healthy eating and physical activity. The normalisation of body weight or body fat is not necessary to improve the health of overweight and obese individuals. Improved nutrition and physical activity levels are associated with a range of health benefits independent of body weight (Garrad et al. 2004).

For more information see the VicHealth fact sheet on Obesity downloadable from <http://www.vichealth.vic.gov.au>

**Given the actions required to effect changes in obesity, there are two main priority issues:**

- **Physical activity and active communities**
- **Accessible nutritious food**

### Poor body image

Research links body image dissatisfaction to mental health and physical health concerns especially in women (Department of Human Services 2002).

Body image dissatisfaction and extreme dieting is associated with depression and low self-esteem in adolescents and adults. Australian research has documented body dissatisfaction and weight loss behaviours in adolescent boys and girls. In high school girls, 70-76% choose an ideal figure thinner than their own, and over half have tried to lose weight (Department of Human Services 2002).

Research suggests a strong causal link between body image dissatisfaction and disordered eating. In adolescent girls, extreme dieters are 18 times more likely to develop symptoms of eating disorders than non-dieters (Department of Human Services 2002).

Poor body image can also make participation in physical activity difficult. Through its effects on eating behaviour and physical activity, body dissatisfaction can lead to unhealthy weight gain and the development of overweight (Department of Human Services 2002).

**Given the actions required to effect change in body image, the priority areas for action include nutrition, physical activity and promoting mental health and wellbeing. Information about required intervention and strategic opportunities is included within each area.**

## 1. Physical activity and active communities

### a) Impact and scale of the issue

- In Victoria, physical inactivity is responsible for 4.1 per cent of the overall burden of disease. (Department of Human Services 2005c)
- Evidence suggests that Australians are becoming increasingly inactive. The 2000 National Physical Activity Survey showed that 54 per cent of Australians aged 18–75 years did not undertake leisure time physical activity at the levels recommended to achieve health benefit (National Public Health Partnership, 2005).
- In the 12 months to April 2003, an estimated 38 per cent of children aged 5–14 years did not participate in organised physical activity outside of school hours. Twenty-two per cent of 15–24 year olds reported no physical activity in the two weeks preceding the 2001 National Health Survey (National Public Health Partnership 2005). The ABS Children’s Participation in Cultural and Leisure Activities Survey revealed that 97 per cent of children aged 5–14 years reported that the most popular leisure activity outside of school hours was watching television and videos. (Australian Institute of Health and Welfare 2004c)
- Overseas evidence suggests that children under five years of age appear to be increasingly sedentary (National Public Health Partnership 2005)

### b) Degree of health inequality

- The inequality associated with physical activity mirrors that noted for obesity. Indigenous Australians are more likely to report no physical activity in their leisure time, compared with non-Indigenous Australians. (Australian Institute of Health and Welfare 2004)

### c) Action areas that are amenable to change through health promotion and prevention action

- To turn around trends in physical activity, information on who is most inactive needs to be considered.

Those most inactive are:

- women who are married
- women with two or more children under school age
- women aged 30 years or over
- men and women aged over 40–50 years
- men and women with less than 12 years of education (Garrad et al. 2004).

Additionally there is clear evidence that people who are physically active at an early age, especially through adolescence, are most likely to be physically active adults (Bull et al. 2004)

- The most effective physical activity interventions are those that combine multiple strategies at multiple levels and involve a range of key stakeholders and the community. The way forward involves using capacity building strategies for developing leadership, building partnerships and facilitating cooperation (Garrad et al. 2004).
- The National Physical Activity Guidelines and Recommendations form the basis for physical activity interventions. Key recommendations are that adults participate in at least 30 minutes of physical activity every day, with children and youth participating in at least 60 minutes. It is also recommended that children and youth do not spend more than two hours per day using electronic media for entertainment.

There is potential to **increase** levels of physical activity and **reduce** sedentary behaviours:

- at work (through the promotion of incidental physical activity)
- as a form of transport (active commuting through walking or cycling)
- at home (doing the housework and promoting active play)
- during leisure time (participating in sports or active recreational activities).

Recommended **interventions** for physical activity include:

- Build public policy for physical activity: promote, develop and support public policy that facilitates and encourages physical activity.
- Promote, develop, support and initiate actions for increased and equitable access to environments that support people to be active.
- Promote and support individuals, communities and organisations to encourage and influence social and cultural norms that support physical activity.
- Increase awareness and understanding of the benefits of participation in physical activity, develop skills to be active as part of daily life and support individuals, families and communities to overcome barriers to physical activity.
- Building the health sector's capacity for sustained and coordinated action by strengthening skills, competencies and infrastructure, including funding, workforce, leadership and organisational support. (Garrad et al. 2004; Victorian Health Promotion Foundation 2005)

## 2. Accessible nutritious food

### a) Impact and scale of the issue

- Poor nutrition accounts for up to 10 per cent of the total burden of disease in Australia (based on the number of DALYs), due to obesity (4.7 per cent), inadequate consumption of fruits and vegetables (3.3 per cent) and high blood cholesterol (2.1 per cent) (Garrad et al. 2004).
- Inadequate fruit and vegetable consumption (fewer than two serves and five serves per day respectively) is also responsible for an estimated 11 per cent of the total cancer burden (Mathers et al. 1999).
- The costs of diet related diseases in Australia in 1989–90 was estimated at \$1.5 billion in direct health care costs and \$2.3 billion in total costs (National Health Strategy 1993).
- Increasing fruit and vegetable levels in Australia by just one serve a day would save between \$8.6 million and \$24.4 million per year in direct health care costs relating to cancer and a further \$150 million relating to direct health costs associated with cardiovascular disease (Australian Chronic Disease Prevention Alliance 2004).

### b) Degree of health inequality

- In 2004, the Australian Bureau of Statistics reported that almost 60,000 Australians from low-income working families had gone without meals in the past 12 months (Australian Bureau of Statistics 2002b).
- Lower socioeconomic groups are less likely to eat a diet consistent with the dietary guidelines (Department of Human Services 2003b).
- People with income constraints are more likely to consume energy-dense foods (World Health Organisation 2003).
- The risk of obesity is 20–40 per cent higher in women who have low incomes and are experiencing food insecurity. This was observed consistently across the United States, Europe and Australia (Burns 2004).
- Indigenous Australians are less likely to eat a diet consistent with dietary guidelines and more likely to suffer from both over-nutrition and under-nutrition (Garrad et al. 2004).

### c) Action areas that are amenable to change through health promotion and prevention action

Health promotion interventions most effective at addressing healthy eating include those coordinated to ensure good quality food is accessible in terms of regular food supply, geographical availability and affordability, as well as providing for food safety which is collectively known as food security. There is also value in targeting key nutrition issues with strategic and multifaceted interventions.

Areas for action most likely to ensure adequate nutrition across the population include:

1. Nutrition in the early years – promoting breastfeeding
2. Promoting increased consumption of vegetables and fruits
3. Reducing the consumption of energy dense food and sweetened drinks
4. Working at the local level to reduce structural barriers to improve food access and supply in disadvantaged communities

(National Health and Medical Research Council. 2003; Australian Chronic Disease Prevention Alliance. 2004)

The following are examples of health promotion interventions that address the determinants of the key nutrition issues.

#### **Health education and skill development**

- Peer education and support strategies to engage hard to reach groups.
- Community kitchens as centres for nutrition education, food skills and food sharing.
- Breastfeeding support within antenatal programs and first time mothers groups, including strategies to engage high risk groups such as indigenous and culturally and linguistically diverse (CALD) families.

#### **Social marketing and health information**

- Social marketing campaigns promoting fruit and vegetable consumption and drinking water in preference to sweet drinks.

#### **Community action**

- Edible community gardens and school kitchen gardens.
- Promote relationships with local fruit and vegetable retailers or wholesalers to promote access and exposure to seasonal produce in local settings, such as schools.

#### **Settings and supportive environments**

- Cross-subsidise healthy foods in workplaces.
- Healthy eating and active play policies in children's settings.
- Support school canteens to adopt healthy food policies.
- Fruit and water policies and programs for early childhood services and primary schools.
- Ensure all new public buildings have breastfeeding facilities.
- Support residential aged care facilities to adopt healthy eating, increased activity and hydration awareness for residents.
- Integrated planning approaches at the local level.

#### **Capacity building**

- Training and resourcing of public health practitioners and dieticians to effectively plan and evaluate health promotion nutrition programs.

#### **d) Strategic opportunities for RRHACS, VicHealth and other key players present now and over the next few years to promote physical activity and accessible nutritious food.**

Strategic opportunities exist at both national and state levels, given recent strategies that have been developed to tackle obesity, nutrition, physical activity and the promotion of positive body image. These include:

- The Go for Your Life strategy – the Victorian Government invested \$21.9 million into increasing physical activity, improving eating habits and supporting volunteering. For further information see [www.goforyourlife.vic.gov.au](http://www.goforyourlife.vic.gov.au)
- *Well for Life* is a departmental initiative promoting improved nutrition and increased physical activity within the older population group to assist in overall quality of life and improved activities of daily living.
- *Melbourne 2030* and related planning provisions (such as review of sustainable neighbourhood's clause 56)- these provide an opportunity to ensure future planning considers food access see [www.dse.vic.gov.au/melbourne2030online](http://www.dse.vic.gov.au/melbourne2030online)
- *Be Active Australia: a framework for health sector action for physical activity 2005–2010*. For further information see [www.nphp.gov.au](http://www.nphp.gov.au)
- Eat Well Australia (including National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan). For further information see [www.nphp.gov.au](http://www.nphp.gov.au)
- *Healthy Weight 2008 – Australia's future: the national action agenda for children and young people and their families*.
- In 2005 the Family and Community Development Committee-Parliament of Victoria presented its *Final Report on its inquiry into Issues relating to the Development of Body Image among Young People and Associated Effects on their Health and Wellbeing*. This report outlines a number of key recommendations for the Victorian Government.

There are obvious partnerships with oral health promotion initiatives given they share common midstream risk factors and upstream determinants. This is timely given a recent increase in oral health funding in Victoria.

The subject of overweight and obesity, particularly in children, has been the focus of much media attention in recent months indicating the significance of this issue to the broader community.

For further information about evidence based practice refer to:

- *Planning for healthy communities: reducing the risk of cardiovascular disease and type 2 diabetes through healthier environments and lifestyles*.
- *Shapes. Body Image Program Planning Guide*
- *Best Bets: Body Image programs Overview*

Copies of the publications can be accessed from the DHS Health Promotion website at:

[www.health.vic.gov.au/healthpromotion/quality/cd.htm](http://www.health.vic.gov.au/healthpromotion/quality/cd.htm)  
[www.health.vic.gov.au/healthpromotion/body\\_image.htm](http://www.health.vic.gov.au/healthpromotion/body_image.htm)

### 3. Promoting mental health and wellbeing

#### a) Impact and scale of the issue

An estimated one in five people in Australia are affected by a mental health problem (Commonwealth Department of Health and Aged Care 2000). Mental illness is responsible for about 12 per cent of the total disease burden in Victoria (Department of Human Services 2005c).

Mental disorders accounted for annual health expenditure of \$3 billion in Australia in 2000–01, which represents 6.1 per cent of total allocated health expenditure (AIHW 2004b).

Research continues to link our physical and mental health. A range of studies show that many physical diseases, including coronary heart disease, may be the consequences of emotional distress (Bunker et al. 2003). This indicates that we may not yet be fully aware of the impact and scale of mental illness.

#### b) Degree of health inequalities

The mental health burden is not spread evenly across communities; there is considerable difference amongst population groups. Below is a snapshot of those groups most affected:

- Adverse mental health outcomes are 2–2.5 times higher among those experiencing greatest social disadvantage compared with those experiencing least disadvantage (Astbury 2001).
- Depression is 1.5–2 times more prevalent among low income groups (World Health Organisation 2000).
- Younger people are more likely to experience a mental disorder and prevalence declines with age (Australian Bureau of Statistics 1998).
- Studies have found same sex attracted youth were, on average, three times more likely to attempt suicide than heterosexual youth (Howard 2002).
- In 2001–02, Aboriginal and Torres Strait Islander people were hospitalised for conditions classified as ‘mental and behavioural disorders’ at a higher rate than the general population. The rate of hospitalisation for Indigenous people diagnosed with mental disorders due to psychoactive substance use was four to five times the rate for the non-Indigenous population (Australian Institute of Health and Welfare 2004c). Suicide rates for Indigenous Australian males and females are over twice the rate for non-Indigenous males and almost twice the rate for non-Indigenous females.
- Intimate partner violence has wide ranging and persistent effects on women’s physical and mental health. It contributes 9 per cent to the total disease burden in Victorian women aged under 44, the proportion is less for older women and represents 3.2 per cent of overall disease burden in Victorian women. (Department of Human Services 2005c)

### c) Action areas that are amenable to change through health promotion and prevention action

Mental health promotion action is a new and developing field of activity. There is a need for a better understanding of effective interventions.

VicHealth has identified three upstream determinants of health that form the basis for sub-priorities for action including:

1. Building a socially inclusive society
2. Being free from discrimination and violence
3. Improving access to economic resources.

Extensive evidence clearly identifies the link between these determinants and mental health and wellbeing outcomes. Population groups, health promotion action areas and settings for action are clearly defined and detail is provided about outcomes indicators to influence change.

The range of health promotion action areas that need to be implemented to address the mental health burden include communication and social marketing campaigns, workforce development, organisational and community development, advocacy, legislative reform and research and evaluation (Victorian Health Promotion Foundation 2005). Examples of recommended interventions include facilitating social inclusion through participation in community activities, working against discrimination through communication and marketing strategies and legislative and policy reform, promoting positive body image through whole of school health promotion programs, reducing violence through incorporating strategies into local government health planning, and increasing economic participation through development of supportive educational environments.

Partnerships with individuals and organisations in a range of sectors, such as housing, employment, sport and recreation, education and income security, are pivotal to effective health promotion.

VicHealth and the Department of Human Services are soon to release *Mental health promotion: an evidence based resource for intersectoral action*. This resource will review the evidence on mental health promotion from determinants of health approaches and highlight further strategies for policy and practice consideration. See

[http://www.health.vic.gov.au/healthpromotion/quality/evidence\\_index.htm](http://www.health.vic.gov.au/healthpromotion/quality/evidence_index.htm) for more information.

Other resources of use are:

*VicHealth Mental Health Promotion Evidence Review: A literature review focusing on the VicHealth 1999-2002 Mental Health Promotion Framework.*

*Promotion Mental Health: Concepts, Emerging Evidence and Practice*, Summary Report of World Health Organisation, Department of Mental Health and Substance Abuse in collaboration with VicHealth and Melbourne University.

These are accessible from

<http://www.vichealth.vic.gov.au/default.asp?level=2&tid=421>

#### **d) Strategic opportunities for RRHACS, VicHealth and other key players, present now and over the next few years, to promote mental health and wellbeing**

In the early 2000s, the burden of disease data for Victoria highlighted the significant impact of mental health and wellbeing on morbidity. Prior to this, the focus of action on population health was on disease mortality. Since then, the interest in mental health and wellbeing has been building.

*The National Mental Health Strategy 2003–2008* (Australian Health Ministers 2003) identifies promotion and prevention as one of four priority themes. The *National Action Plan for promotion, prevention and early intervention for mental health 2000* (Commonwealth Department of Health and Aged Care 2000) calls for increased support for mental health promotion at government and community levels and identifies the need to consolidate the evidence base for the prevention of mental health problems and mental illness. These are both downloadable from <http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/mental-pubs>

VicHealth has recently launched *A Plan for Action 2005–2007*, Promoting mental health and wellbeing, furthering interest in the issue of mental health. There is also a growing voice from a range of organisations to tackle the issue of intimate partner violence after the release of the report *Health costs of violence* (Victorian Health Promotion Foundation 2004). This is downloadable from <http://www.vichealth.vic.gov.au/rhadmin/articles/files/Final%20Report.pdf>

## 4. Reducing and minimising the harm from tobacco, alcohol and illicit drugs

Drug use—both licit and illicit—carries high health and social costs to individuals, communities and families (The National Drug Research Centre and the Centre for Adolescent Health 2004). Based on the significant impact of these risk factors and the different actions required to effect changes, this priority issue is divided into three sub-priorities:

- tobacco
- alcohol
- illicit drugs.

### 4.1 Tobacco

#### a) Impact and scale of the issue

Tobacco smoking is the leading cause of preventable death and is the highest risk factor responsible for the greatest amount of ill health in Victoria. Tobacco smoking represents 8.2 per cent of the overall burden of disease, 10 per cent of the total burden in males and 6.2 per cent in females. While there is an interaction with other risk factors, the income lost by 25–64 year-old Victorians due to poor health associated with smoking, obesity and high blood pressure, is estimated to be more than one billion dollars per year (Department of Human Services 2005c).

#### b) Degree of health inequality

People from the most disadvantaged socioeconomic areas are twice as likely to smoke than people from the least disadvantaged areas. Smoking is more prevalent among unemployed adults and people without a tertiary qualification. Rates of smoking among Indigenous men (49 per cent) and women (50 per cent) are more than twice the rate for all Australian men and women (Australian Institute of Health and Welfare 2003b).

Until the mid-1980s, the socioeconomic status disparity in smoking rates increased, however, since the mid-1980s smoking rates in all socioeconomic groups have declined at similar rates. Most of the differences are due to higher smoking commencement rates among lower socioeconomic status groups, rather than differences in cessation rates (Borland and Balmford 2004).

#### c) Action areas that are amenable to change through health promotion and prevention action

A comprehensive range of individual and population-wide interventions has proved to be effective in significantly reducing the smoking rate in Victoria in recent decades. These interventions were designed to reduce tobacco use initiation, increase tobacco use cessation, and reduce exposure to environmental tobacco smoke. This comprehensive approach combined three core elements:

- **Clinical intervention and management** – for example, nicotine replacement therapy.
- **Health education and social marketing campaigns** – for example, TV, radio and print advertisements that seek to change perceptions of smoking and promote support services for smokers to quit, such as Quitline.
- **Legislation** – including legislation to outlaw the sale of cigarettes to minors, to reduce the marketing of tobacco products, to increase health warnings on tobacco products and to ban smoking in particular places.

There is evidence that further reductions in smoking rates are possible by extending the size and scope of programs under each of these three elements (Mercer, Green & Rosenthal 2003).

## 4.2 Alcohol

### a) Impact and scale of the issue

- Excessive alcohol consumption is estimated to account for 3.2 per cent of the total burden of disease for Victoria. However the net harm associated with alcohol consumption is 1.5 percent of the total burden, because the injury and chronic disease burden associated with harmful and hazardous levels of alcohol consumption is offset by the burden of cardiovascular disease prevented by alcohol consumption. The protective effect is relevant only after age 45 years, however, the harmful effects of alcohol are apparent at all ages (Department of Human Services 2005b).
- The 2004 National Drug Strategy Household Survey found that alcohol consumption varies among age groups, with the proportion of daily and weekly drinkers increasing with age. The peak for daily drinkers was in the 60+ age group at 17 per cent, followed by the 50-59 age group at 12.9 per cent. The peak for weekly drinkers was in the 40-49 age group at 48.6 per cent, the proportion of weekly drinkers in the 20-29 age group was 47.6 per cent and the proportion of weekly drinkers in the 14-19 age group was 24.4 per cent. (Australian Institute Health Welfare 2004b).
- The 2004 National Drug Strategy Household Survey found that persons in the 20-29 age group were the most likely to consume alcohol in a manner considered risky or high-risk to health in the long and short terms. Young men aged 20-29 were reported as being more likely than any other group to drink at risky or high-risk levels at least weekly, at 17.4 per cent, which is an increase from 14.6 per cent since 2001 (Australian Institute Health Welfare 2004b).
- An estimated 21,706 inpatient hospitalisations in Victoria were attributable to alcohol consumption during 2003-04. This represents a 6 per cent increase on the previous year's figures, much of this being attributable to a 13 per cent increase in female alcohol-related hospital admissions. Overall, these hospitalisations resulted in a total of 88,618 hospital bed days, which is an average of around four bed days per alcohol-related hospitalisation (Turning Point Alcohol and Drug Centre 2005).

## **b) Degree of health inequality**

There are defined groups in Australia that are over-represented in the statistics relating to alcohol use and related harms. These groups are usually also overrepresented in statistics on general ill health (National Drug Research Centre and the Centre for Adolescent Health 2004) including:

- Being male and being young are each independently highly predictive of involvement in risk drug use.
- Almost any measure of disadvantage is associated with increased risk and harm from drugs, regardless of gender and age.

While a lower proportion of Aboriginal and Torres Strait Islander people drink alcohol and drink less frequently (42 per cent) than non Aboriginal and Torres Strait Islander people (62 per cent), those Aboriginal and Torres Strait Islander people who do drink, generally consume at much more harmful levels (Australian Bureau of Statistics 2003).

## **c) Action areas that are amenable to change through health promotion and prevention action**

Two main patterns of drinking have been identified as creating the greatest risk of health problems:

- excessive alcohol intake on a particular occasion
- consistent high-level intake over months and years (Department of Human Services 2004b).

While it is important to address harmful patterns of drinking to reduce the short and long term harms among individual drinkers, from a public health perspective it is also important to address overall per capita consumption. There is a direct relationship between levels of per capita consumption and alcohol-related harms. Evidence indicates that drinking populations behave as a collective and that increases or decreases in overall consumption are likely to result in shifts across the entire spectrum of drinkers (Global Alcohol Policy Alliance 2002).

According to WHO and others (Babor et al. 2003; WHO 2005), the best practice policy approaches for minimising alcohol-related harms at local and national levels include:

- changing the minimum legal age to buy alcohol
- restricting hours or days of sale of alcohol in licensed premises and retail outlets
- restricting the density of licensed premises and retail outlets within a local area
- using pricing policies and taxation on alcohol
- having random breath testing
- lowering the limits for blood alcohol concentration of alcohol
- imposing administrative suspensions of licences for driving under the influence of alcohol

- reducing the government monopoly of retail sales
- graduating licensing for novice drivers (issuing licences with initial limitations on driving privileges, such as zero limit for blood alcohol concentration)
- implementing brief interventions for hazardous drinkers.

The least effective and most expensive strategies identified include public education and awareness campaigns. While such campaigns can be effective in creating awareness of alcohol-related harms, they do not create behavioural change. However, if included as part of a comprehensive health promotion program, public education and awareness campaigns can contribute to effective public health outcomes.

### 4.3 Illicit drugs

#### a) Impact and scale of the issue

- Overall, illicit drugs cause about 1.5 per cent of the overall burden of disease, with the burden in males (2.1 per cent) more than double that of females (0.9 per cent). More males use illicit drugs and are also more likely to adopt drug habits that put them at risk of dying (Department of Human Services 2005b).
- The percentage of young people aged 16–24 who reported recent or ever use of illicit drugs fell from 54 to 50 per cent for ‘lifetime’ use and from 34 to 30 per cent for recent use. Use of illicit drugs appears to peak at around 20–21 years of age (Premier’s Drug Prevention Council 2004).
- Cannabis continues to be the most frequent and widely used illicit drug by young people. Reported use of cannabis showed the most significant fall, with lifetime use down 5 per cent in the last 12 months to 48 per cent and recent use down 4 per cent to 27 per cent (Premier’s Drug Prevention Council 2004).
- Lifetime use of ecstasy increased slightly from 16 per cent in 2002 to 18 per cent in 2004. There was no change from 2003 in lifetime use of amphetamines (15 per cent) and cocaine (6 per cent) (Premier’s Drug Prevention Council 2004).
- A reduction in use of illicit drugs coincided with a change in attitudes towards their use. In particular, there was an increase in the proportion of respondents (from 56 per cent to 61 per cent) who felt it was ‘wrong’ or ‘very wrong’ for young people to use cannabis. Eighty-four per cent of people surveyed felt the use of drugs such as ecstasy, speed and LSD was either ‘wrong’ or ‘very wrong’ (an increase from 82 per cent in 2003) (Premier’s Drug Prevention Council 2004).
- The non-medical use of pharmaceuticals is also a problem in Australia. Just over 3 per cent of the population reported recent non-medical use of painkillers/analgesics and 6 per cent reported non-medical use at some point in their lifetime. In school surveys, 22 per cent of 17 year olds reported recent use of tranquillisers for non-medical purposes (The National Drug Research Centre and the Centre for Adolescent Health 2004).

## **b) Degree of health inequality**

- Patterns of drug use and related harms are not distributed randomly across the population; there are defined groups in Australia that are over-represented in the statistics. These are covered below.
- Being male and young are independently highly predictive of involvement in risky drug use and harm. Female teenagers were slightly more likely than male teenagers to have ever used an illicit drug (Australian Institute Health Welfare 2004b).
- Almost any measure of disadvantage is associated with increased risk and harm from drugs, regardless of gender and age. This association is strongest for illicit drugs and for more problematic patterns of drug use, including dependence (The National Drug Research Centre and the Centre for Adolescent Health 2004).
- There are indications that levels of social inclusiveness is a common upstream determinant of drug use and related harm (The National Drug Research Centre and the Centre for Adolescent Health 2004).

## **c) Action areas that are amenable to change through health promotion and prevention action**

- Strategies to prevent illicit drug use depend on the particular drug use being targeted. Whole of population or universal strategies are important in reducing harms associated with alcohol and tobacco use. Targeted strategies are more effective in preventing the harms associated with high-risk illicit drug use.
- The National Drug Diversion Initiative demonstrated the importance of law enforcement in the apprehension of early users and the diversion to drug education, treatment and support (Council of Australian Governments 1999).
- Lack of social, vocational and community connectedness also contributes to illicit drug use. Programs that address these issues are very important in assisting people with problematic substance use (The National Drug Research Centre and the Centre for Adolescent Health 2004).
- Selected risk factors for illicit drug use that are amenable to prevention include: availability of drugs, poverty, mobility, community disorganisation, detachment from school, academic failure, early antisocial behaviour, low parental interest in education, family conflict and history of problematic alcohol and drug use, harsh/coercive or inconsistent parenting, alienation from peers, rebelliousness, friends engaging in problem behaviour.

**d) Strategic opportunities for RRHACS, VicHealth and other key players, present now and over the next years, to reduce and minimise the harm from tobacco, alcohol and other drug use**

There are a number of strategic opportunities relating to tobacco, alcohol and other drug issues within Victoria and Australia. Work being undertaken on behalf of the Ministerial Council on Drug Strategy includes the development of a National Alcohol Strategy, the work of National Inhalant Abuse Task Force, and work on a National Intentional Misuse of Pharmaceuticals Prevention Initiative.

In Victoria, a Parliamentary inquiry into strategies to reduce harmful alcohol consumption is underway, along with a review of the *Drugs, Poisons and Controlled Substances (volatile substances) Act 2003*. A range of tobacco reforms will be introduced in Victoria over the next two years following introduction of the *Tobacco Amendment Act 2005*.

Drug and alcohol related stories regularly feature in the media, indicating drug and alcohol issues are of ongoing interest to the broader community.

## 5. Preventing Injury

### a) Impact and scale of the issue

- In 2002 in Victoria, there were an estimated 1,715 deaths and 96,235 hospital admissions (incident cases) due to injury. Almost two-thirds of the deaths and 90 per cent of admissions were for unintentional injury.
- Premature mortality due to injury meant that 30,240 years of life were lost in 2002. The average number of years of life lost was 18.7 years; 14,413 years were lost to disability in 2002.
- In 2002, the cost of injury was at least \$3.3 billion (unintentional injury \$2.5 billion). Unintentional hospitalised injuries alone contributed \$2 billion (VISAR et al. 2002; Cassell 2005).

### b) Degree of health inequality

Burden associated with injury is not evenly distributed throughout the population. Injury decreases with rising socioeconomic status. Lower socioeconomic status was associated with increased risk of injury at all levels, deaths, hospital admissions and emergency department presentations. Socioeconomic status is a risk factor for injury, however, the causes of injury vary with socioeconomic status (VISAR et al. 2002).

### c) Action areas that are amenable to change through health promotion and prevention action

A broad range of interacting factors affects how many injuries occur. The factors that contribute to an injury event can be described as being related to:

- **midstream risk factors** – shaped by attitudes, knowledge, access to safer choices, health status including issues relating to fitness and mobility, physical health and mental health
- **upstream determinants** – including the physical environment, such as roads, buildings, leisure and work settings, products; the socioeconomic environment, such as education, income, employment status and housing; and the socio-cultural environment which can influence choices associated (Commonwealth Department of Health and Aged Care 1999).

The *National Injury Prevention Plan* states that effective injury prevention action:

- is based on a strong understanding of the problem and its contributory factors
- addresses the multiple factors that contribute to injury
- is based on evidence of effective interventions
- encourages environmental and behavioural change
- engages the people who are most at risk
- involves action across sectors (for example, health, police, education)
- is sustained and reinforced over time (for example, through policies, laws, engineering and influencing the influencers in a community).

Recent reviews of the literature define the following as areas for effective intervention:

- **Falls:** There are considerable opportunities for effective investments in this area, including combinations of consumer product-related and environmental solutions, education, exercise and focusing on high risk target groups in defined settings, such as schools, playgrounds, nursing homes and occupational settings.
- **Poisoning in children 0–4 years**
- **Burns and scalds:** There are some proven effective strategies that reduce the risk of house-fire and scald-related burns. The focus of intervention should be on gaining universal adoption of these strategies, through legislation, throughout Australia.
- **Sports and leisure:** There are proven intervention strategies for specific sport and leisure activities.
- **Self-harm:** While at this stage only a ‘promising strategy’, focusing first on this issue, and conducting thorough evaluative research, the way would be paved to consider, more systematically, other suicide prevention initiatives.
- **Violence:** Refer to section on mental health and wellbeing.
- **Alcohol related injury:** Alcohol has been shown to have a causative role in many types of injury, including road trauma, falls, fire injury, drowning, assault and, to a lesser extent, suicide. Lessons from the road safety and violence prevention initiatives targeting alcohol offer promise for the prevention of these other injury areas. Refer to section on alcohol.

(National Injury Prevention Advisory Council 1999)

#### **d) Strategic opportunities for RRHACS, VicHealth and other key players, present now and over the next few years, to reduce injuries.**

The National Public Health Partnership (NPHP) has just released the *National Injury Prevention and Safety Promotion Plan: 2004–2014*.

The Department of Human Services is collating information on injury prevention priorities (including recent work undertaken by Monash University Accident research Centre (MUARC) for the development of a coordinated, strategic response. The information collected to date describes the problem. The next step will be to incorporate information regarding existing activities and capacity to determine evidence-based interventions. The aim is to achieve a strategic approach to injury prevention with action against prioritised issues across all relevant sectors. This work will provide a sound base for concentrated efforts on injury prevention in Victoria.

## 7. Consultation questions

### Question 1:

What is your organisation's response to the proposed priorities?

Are they realistic?

What in your view have we missed?

Using the selection criteria, what is the rationale for the inclusion of other issues?

### Question 2:

The paper has focused on midstream risk and protective factors and uses an upstream determinants of health lens to discuss these factors. Do you have any comments or suggestions on this approach? Do you have any other suggestions on how to achieve this balance in finalising the health promotion priorities for 2007-12?

### Question 3:

Of these priorities, which ones are current priorities for your organisation?

### Question 4:

What would it take for your organisation to shift to new priorities?

### Question 5:

What steps will your organisation need to take to shift its focus and its practice?

### Question 6:

What support (information, workforce development, policy environment) would your organisation benefit from RRHACS/VicHealth to assist in addressing these priorities?

## 8. Next steps and further information

The consultation period runs from February to April 2006. It is anticipated that the finalised list of priorities will be published in July/August 2006.

This consultation process and the ultimate list of health promotion priorities for 2007-12 will not provide answers to issues raised immediately or even in the next few years. There are three distinct steps, including:

1. **Awareness** - knowing what the priorities are
2. **How-to-knowledge** - the information about priorities and the interventions that have been shown to make a difference
3. **The principles knowledge** - how to apply this evidence of good practice (Roger 1983)

An important lesson from past priority setting processes is that an implementation framework designed to support the priorities is vital to enable change over a period of years (Richardson 1995). This consultation will start at the first step and ask questions of agencies and organisations about steps two and three to assist the RRHACS Division and VicHealth in strategic planning and solution generation. A key action for RRHACS and VicHealth in 2006 will be the next step in the planning framework (Figure 2) - solution generation and ensuring capacity.

### Further information and written submissions

Further information on this discussion paper and forthcoming consultations is available from:

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This paper is also downloadable from

<http://www.health.vic.gov.au/healthpromotion/role/index.htm#hpps>

If you wish to make written submission, addressing the consultation questions in Section seven, you can forward your submission to:

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Written submissions are due by **21 April 2006**

## Appendices

### Appendix 1: Consultation timelines

Date	Time	Where
Tuesday February 21	Registration 9:45 10 – 2pm including lunch	Quality Inn Latrobe Convention Centre 5601 Princes Highway Traralgon
Monday March 6	Registration 9:45 10 – 2pm including lunch	Foundry Hotel Complex 366 High Street Bendigo
Thursday March 9	Registration 9:45 10 – 2pm including lunch	Sandown Regency Melbourne 477 Princes Highway Noble Park
Friday March 10 <b>Please note priority will be given to statewide organisations</b>	Registration 9:45 10 – 2pm including lunch	VicHealth 15-31 Pelham Street Carlton
Thursday March 30	Registration 9:45 10 – 2pm including lunch	Doherty Ballarat Lodge 613 Main Road Ballarat
Friday March 31	Registration 9:45 10 – 2pm including lunch	Darebin Arts and Entertainment Centre Corner Bell and St Georges Road Preston
Monday April 3	Registration 9:45 10 – 2pm including lunch	The Victoria Hotel 42 Bank Street Corner Bank and James Streets Port Fairy
Thursday April 6	Registration 9:45 10 – 2pm including lunch	Elizabethan Lodge 604 – 610 Middleborough Road Blackburn North
Wednesday April 12	Registration 9:45 10 – 2pm including lunch	Department of Sustainability and Environment 89 Sydney Road Benalla
Thursday April 13 <b>Please note there will be the NMPCP meeting prior to this</b>	10:30-12:30pm	Sunraysia Community Health Services Ramsay Court, (Off 10th St) Mildura

## Appendix 2: Values that guide RRHACS health promotion policy and planning

1. **Addressing the broader determinants of health**, recognising that health is influenced by more than genetics, individual lifestyles and provision of health care, and that political, social, economic and environmental factors are critical.
2. **Basing activities on the best available data and evidence**, both with respect to why there is a need for action in a particular area and what is most likely to effect sustainable change.
3. **Acting to reduce inequalities and injustice**, helping to ensure every individual, family and community group may benefit from living, learning and working in a health promoting environment.
4. **Emphasising active consumer and community participation** in processes that enable and encourage people to have a say about what influences their health and wellbeing and what would make a difference.
5. **Empowering individuals and communities**, through information, skill development, support, advocacy and structural change strategies, to have an understanding of what promotes health, wellbeing and illness and to be able to mobilise resources necessary to take control of their own lives.
6. **Explicitly considering difference in gender and culture**, recognising that gender and culture lie at the heart of the way in which health beliefs and behaviours are developed and transmitted.
7. **Work in collaboration**, understanding that while programs may be initiated by the health sector, partnerships must be actively sought across a broad range of sectors, including those organisations that may not have an explicit health focus. This focus aims to build on the capacity of a wide range of sectors to deliver quality and to reduce the duplication and fragmentation of health promotion effort.

### Appendix 3 NSW Health Capacity Building Framework (NSW Health 2001)



## Appendix 4 Indicative commitments to health promotion priorities

Appendix 4 gives indicative commitments from RRHACS and VicHealth as to how the priorities will inform their planning for 2007-12. These will be reviewed following the consultation process.

RRHACS Division	Indicative commitments to health promotion priorities 2007-12
Aged Care	<p>Inform development of strategic aged care health promotion directions and initiatives with a focus on older frail people who are living in their own homes and in residential aged care facilities, including areas of disadvantage.</p> <p>Enhance current initiatives in partnership with department regions and Local Government.</p>
Drug Policy and Services Branch	<p>Inform the development of:</p> <ul style="list-style-type: none"> <li>• policy in relation to public licit and illicit drug prevention and education campaigns and strategies</li> <li>• the design and development of effective education, prevention and treatment interventions.</li> </ul> <p>This is in the context of recognising and addressing the complex needs of the client group and mainstreaming the alcohol and drug response within the broader department program activities, such as mental health, disability, housing, Juvenile Justice and child protection services.</p>
Premiers Drug Prevention Council	<p>Development of community-based drug prevention training across the state.</p> <p>Development and dissemination (in conjunction with the training) of a drug prevention resource guide for practitioners.</p> <p>Commissioning research to investigate strategies to address risk factors associated with later harmful alcohol and drug use and to promote health-related protective factors in vulnerable children and their families.</p> <p>Implement targeted actions promoting healthy decisions around alcohol and drug use.</p>
Public Health Group	<p>The Public Health Group will reorient its health promotion capacity building program and other program area resources based on the 2007-12 priorities. This will include:</p> <ul style="list-style-type: none"> <li>• incorporating the priorities into any new resources developed, such as health promotion guidelines for RRHACS program areas.</li> <li>• in partnership with local government, consider methods to incorporate priorities into Municipal Public Health Plans and related initiatives.</li> <li>• reviewing the health promotion workforce development program, currently based on the Core Health Promotion Short course, to develop complementary training in the priority areas, and working with other RRHACS program areas to ensure consistency in workforce development as much as possible across the division.</li> <li>• reorganising the evidence-based health promotion program to support the development and collation of practitioner advice for each of the priority areas, including providing advice and support for developing approaches to the systematic management and development of an evidence base of health promotion effectiveness.</li> </ul>

RRHACS Division	Indicative commitments to health promotion priorities 2007-12
Public Health Group (cont)	<ul style="list-style-type: none"> <li>• updating communication tools to reflect the health promotion priorities (for example, department health promotion website, statewide Health Promotion Strategies Bulletin).</li> <li>• using the results of the consultation process to inform the priority setting framework of the Public Health Branch research program.</li> <li>• producing reports on health status of Victorians and risk factor prevalence and commentary on indicator trends (surveillance function).</li> <li>• reviewing data gaps and seeking to add value to existing data.</li> <li>• providing small area indicators where feasible (such as ACSCs, BoD, life expectancy).</li> <li>• providing indicators on health inequalities and their determinants.</li> <li>• providing education and support role for regions and other key stakeholders (internal, RRHACS, selected external) in the access and interpretation of evidence/data generated by the Public Health Group and review of other data where appropriate.</li> <li>• providing advice and support for development of health promotion evaluation strategies for RRHACS.</li> <li>• informing the ongoing development and implementation of public health nutrition, physical activity and injury prevention programs.</li> <li>• informing additional opportunities/scenarios for the future development of the Go For Your Life strategy.</li> </ul>
Primary Health Branch	<p>The health promotion priorities for 2007-12 will be used to inform primary and community health programs and PCP catchment planning and will be reflected in the upcoming Primary Health Funding Guidelines.</p> <p>Dental Health will review the evidence base for oral health promotion and review the implementation of the Victorian Oral Health Promotion Strategy 2000-04. These learnings and the broad health promotion priorities for 2007-12 will influence future initiatives, including policy direction for Dental Health Services Victoria.</p>
Rural and Regional Health Services	<p>The policy statement Rural directions - a framework for health service delivery in rural Victoria (November 2005) will provide a vehicle to promote the current focus on health promotion. This statement provides a service planning framework for the future to further enhance health service roles in the system of care across rural Victoria and recognises the interdependence of each individual rural health service.</p> <p>Through the area-based service planning process, the health promotion priorities will be supported and promoted to rural health services. Area-based service planning requires services to take into account all health services and providers in the service catchment in line with Primary Care Partnership planning processes.</p> <p>Information gathered from the consultation will be integrated (where relevant) into the:</p> <ul style="list-style-type: none"> <li>• population health workshops being conducted for small rural health services (2005-07)</li> <li>• review of the data collection processes of bush nursing centres</li> <li>• ministerial rural and regional health forums and the Victorian Rural Health Conference 2006.</li> </ul>

<b>RRHACS Division</b>	<b>Indicative commitments to health promotion priorities 2007-12</b>
Planning and resources	Information gathered from the consultation will inform (where relevant) the current review of health promotion activity in the RRHACS Division and the associated accountability requirements, and identify opportunities for further integration and development.
VicHealth	<p>VicHealth is currently developing their 2006-09 strategic plan. This consultation process will allow us to hear from a broad range of health promotion practitioners and people interested in health promotion across the state.</p> <p>Issues raised during the consultation process may inform the type of support and information provided and/or the strategies by which VicHealth addresses various issues.</p>

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