

1. Building good health and wellbeing into our communities and our lives

Key messages

- Health is everybody's business. Good health has intrinsic value. A healthy population also helps support a healthy economy. Action to protect and promote health may also support our efforts to save the health of our planet.
- Despite universal entitlement to health services, there are still some groups in our population who have unacceptably poor health status and reduced access to health services. These health inequities are experienced particularly by Aboriginal and Torres Strait Islander peoples, but other groups also face significant disadvantage.
- Prevention can and should occur across the whole health system. Every 'curative' visit or intervention should also have a prevention component. Similarly, prevention and health promotion applies to people of all ages, no matter what their health status is.
- Many factors contribute to building healthier communities. Over and above our use of health services and our personal health behaviours, social and economic factors, including the built environment, play a strong role in influencing the health of our population. Access to employment, education, housing, early childhood development, clean air, and safe food and water contribute to our health.
- There is opportunity to translate the talk about prevention into clear action that enables individuals, communities, workplaces, schools, private health insurers, health services and governments to all play a part in boosting the role of health promotion and prevention. While prevention should be everybody's business, there is a vacuum in national leadership on health promotion and prevention.
- There is a lack of evidence about 'what works' in prevention and health promotion. Unlike many other parts of the health system, we do not have a systematic process to assess the evidence on preventive interventions and there is no readily identifiable funding mechanism for prevention and health promotion.
- For many people, healthy choices are not currently easy choices. Many Australians have very low levels of health and general literacy, and are not well equipped to take personal responsibility for improving their own health.

Our reform directions

- 1.1 We affirm the value of universal entitlement to medical, pharmaceutical and public hospital services under Medicare which, together with choice and access through private health insurance, provides a robust framework for the Australian health care system. To promote greater equity, universal entitlement needs to be overlaid with targeting of health services to ensure that disadvantaged groups have the best opportunity for improved health outcomes.
- 1.2 We propose that public reporting on health status, health service use, and health outcomes by governments, private health insurers and individual health service providers identifies the impact on population groups who are likely to be disadvantaged in our communities.
- 1.3 We propose the preparation of a regular report that tracks our progress as a nation in tackling health inequity.
- 1.4 We support the development of accessible information on the health of local communities. This information should take a broad view of the factors contributing to health of communities, including the 'wellness footprint' of communities and issues such as urban planning, public transport, community connectedness, and a sustainable environment.
- 1.5 We support the delivery of wellness and health promotion programs by employers and private health insurers. Any existing regulatory barriers to increasing the uptake of such programs should be reviewed.
- 1.6 We propose that governments commit to establishing a rolling series of ten-year goals for health promotion and prevention, to be known as Healthy Australia Goals, commencing with Healthy Australia 2020 goals. The goals should be developed to ensure broad community ownership and commitment, with regular reporting by governments on progress towards achieving better health outcomes under the ten-year goals.
- 1.7 We propose the establishment of an independent national health promotion and prevention agency. This agency would be responsible for national leadership on the ten-year health goals, as well as building the evidence base, capacity and infrastructure that is required so that prevention becomes the platform of healthy communities and is integrated into all aspects of our health care system.
- 1.8 We propose that the national health promotion and prevention agency would also collate and disseminate information about the efficacy and cost effectiveness of health promotion and prevention interventions.
- 1.9 We support strategies that help people take greater personal responsibility for improving their health through policies that 'make healthy choices easy choices'. This includes individual and collective action to improve health by people, families, communities, health professionals, employers and governments.
- 1.10 We propose that health literacy is included as a core element of the National Curriculum and that it is incorporated in national skills assessment. This should apply across primary and secondary school.
- 1.11 We encourage all relevant groups (including health services, health professionals, non-government organisations, media, private health insurers and governments) to provide access to evidence-based, consumer-friendly information that supports people in making healthy choices and in better understanding and making decisions about their use of health services

A healthy population is everybody's business.

We care about health as a community because:

The way we live is making people sick. It is also making our planet sick. It is not sustainable. We can do better.¹

We care about health as a community because:

Health is unequally distributed across socio-economic groups; those with poorer indices of socio-economic participation have poorer health.²

We care about health as a community because:

Health is major sector in the economy and a significant employer and generator of economic activity yet the discussion around health is always about it being a burden on the economy. A healthy population underpins our economy.³

We care about health as a community because:

There are no magic tablets in the laboratory. It will require all of us as individuals and families to make healthier choices.⁴

We begin our report by considering the role of health in our lives and the strategies we need to build healthier communities and healthier people. We apply two lenses to the way in which we examine these issues.

First, we take a population health perspective in identifying issues that are relevant to building healthier communities. In Sections 1.1 to 1.6, we:

- examine the links between health and our national wealth;
- present evidence on the challenge we face concerning health inequities whereby some groups in our community have much worse health outcomes or poorer access to services than the general community;
- consider the social determinants that influence the health of our communities and inequities in health outcomes;
- propose how better health can be promoted in all settings – including our local communities and workplaces – over and above our contact with health professionals and health services; and
- identify strategies to create both national leadership and local action on prevention and health promotion.

Second, we take a consumer empowerment perspective in considering how individuals can take greater responsibility for their own health. In Section 1.7, we report the views from our submissions and consultations about what health means and how to stay healthy. In Section 1.8, we discuss how to strengthen health literacy, one essential element that consumers need if they are to make informed decisions and choices about their health and use of health services.

1 The Oxford Health Alliance (2008) The Sydney Resolution: Healthy people in healthy places on a healthy planet, at: <http://www.oxha.org/meetings/08-summit/sydney-resolution>

2 VicHealth (2008), Submission 187 to the National Health and Hospitals Reform Commission.

3 Government official (24 June 2008), National Health and Hospitals Reform Commission consultation meeting with government agencies in Melbourne.

4 National Preventive Health Taskforce (2008), Australia: the healthiest country by 2020, Discussion paper, at: <http://www.preventativehealth.org.au/internet/preventativehealth/publishing.nsf/Content/discussion-technical-1>

While this chapter is largely about how we can improve health through strategies outside the health system, we believe that it is also important to stress the integral role of prevention and health promotion within the health care system. Health professionals have the opportunity to treat each visit by a patient as a potential health promotion and prevention intervention. Moreover, consistent with our life course approach to health (outlined further in Chapter 2), we agree with the views of Aged and Community Services Australia who argue that:

Many discussions of prevention are not cognisant of the fact that effective preventative services and practices can be valuable at any age. It's not too late for older people to benefit from exercise programs, a good diet or ceasing substance abuse.⁵

1.1 Recognising the importance of healthy communities

Health and wealth go hand in glove, both for nations and for individuals

■ Health and wealth go hand in glove, both for nations and for individuals.

The World Health Organization (WHO) acknowledges the dual importance of healthy communities: first, as a priority goal in its own right; and, second, as a central input into economic development and poverty reduction.⁶ WHO's Commission on Macroeconomics and Health identified that:

Countries with higher levels of health grow faster and, indeed, improvements in health may account for a significant fraction of the rapid economic growth of much of the world in the 20th century.⁷

Similarly, in Australia, the Council of Australian Governments' National Reform Agenda was grounded on the then radical view that the path to greater economic prosperity lay with a new 'human capital' agenda. The 'three Ps' agenda linked prosperity to greater productivity and higher labour force participation (see Figure 1.1).

Improving health, learning and work outcomes is the path to building a healthy, skilled and motivated society, and an economy that is among the world's best ... The ability of our health system to improve public health, and to prevent and manage ill-health, directly shape the economy's productive capacity. A strong economy can only ever be built on a healthy active society ... Improving health and limiting the incidence and impact of ill-health would enable both more people to work, and those who do so to work more productively.⁸

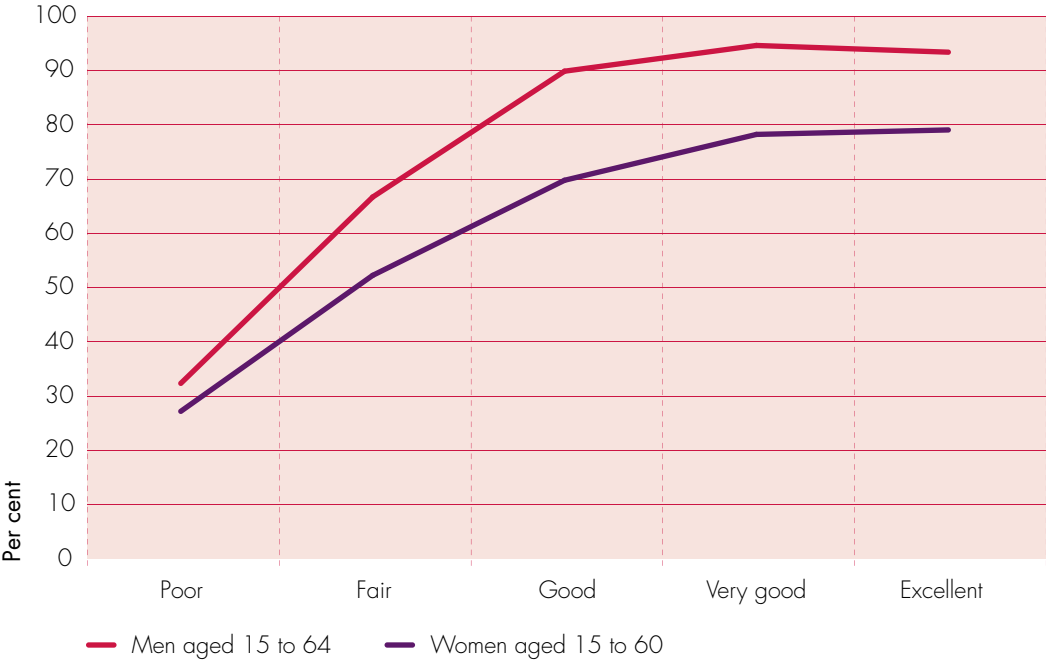
5 Aged and Community Services Australia (2008), Submission 6 to the National Health and Hospitals Reform Commission.

6 World Health Organization (2001), Macroeconomics and health: Investing in health for economic development, Final report: Executive summary, at: <http://whqlibdoc.who.int/hq/2001/a74868.pdf>

7 World Health Organization (2000), Commission on macroeconomics and health: background, at: <http://www.globalhealth.ie/information-archives/article/19>

8 Victorian Department of Premier and Cabinet (2005), Governments working together: A third wave of national reform, at: [http://www.dpc.vic.gov.au/CA256D800027B102/lookup/A_Third_Wave_of_National_Reform/\\$file/A%20Third%20Wave%20of%20National%20Reform.pdf](http://www.dpc.vic.gov.au/CA256D800027B102/lookup/A_Third_Wave_of_National_Reform/$file/A%20Third%20Wave%20of%20National%20Reform.pdf)

Figure 1.1: Participation in the workforce increases as health status improves



Source: Victorian Department of Premier and Cabinet (2005), *Governments working together: A third wave of national reform*.

In recent years, there has also been an increasing interest in linking the health of our communities with the health of our planet. In February 2008, the Oxford Health Alliance issued an international call to action through its Sydney Resolution, titled *Healthy People in Healthy Places on a Healthy Planet*.⁹ The alliance argued that urgent action was needed, bringing together dedicated stakeholders from all parts of society, to tackle the epidemic of preventable chronic diseases.

There is now widespread recognition of the importance of global warming, and the importance of changing what we do now to save the health of our planet. Many of the things we need to do to address global warming, such as reducing carbon emissions from cars by making it easy to go to work or school by bicycle, are the same things we need to do to reduce the risk of future chronic disease.

1.2 Facing inequities in health

Following a three-year multi-national study, the WHO Commission on the Social Determinants of Health recently found that:

Our children have dramatically different life chances depending on where they were born. In Japan or Sweden they can expect to live more than 80 years; in Brazil, 72 years; India, 63 years; and in one of several African countries, fewer than 50 years. And within countries, the differences in life chances are dramatic and are seen worldwide. The poorest of the poor have high levels of illness and premature mortality. But poor health is not confined to those worst off.

⁹ The Oxford Health Alliance (2008), *The Sydney Resolution: Healthy people in healthy places on a healthy planet*, at: <http://www.oxha.org/meetings/08-summit/sydney-resolution>

*In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health.*¹⁰

Many of us may believe that these findings mainly apply to 'Third World' countries, but not to Australia. We like to think of ourselves as a 'classless', egalitarian society where everyone has equal opportunity. We may also believe that, with our mix of Medicare and private health insurance, there are few barriers or inequities in regard to gaining access to necessary health care and that health is evenly distributed across our population.

The appalling health status of our Aboriginal and Torres Strait Islander peoples provides the most clear-cut repudiation of that position.¹¹

- Aboriginal and Torres Strait Islander men have a life expectancy of 59 years, compared with 77 years for all men; life expectancy is 65 years for Aboriginal and Torres Strait Islander women compared with 82 years for all women.
- In 2005–06 Aboriginal and Torres Strait Islander peoples were hospitalised at 14 times the rate of other Australians for care involving dialysis.
- Aboriginal and Torres Strait Islander peoples were hospitalised for potentially preventable conditions at five times the rate of other Australians.
- In 2004–05 Aboriginal and Torres Strait Islander adults were twice as likely as other Australians to report their health as only fair or poor.

The extent of disadvantage and poor health outcomes among our Aboriginal and Torres Strait Islander peoples is well known. In Chapter 8 of this report, we return to this issue in proposing strategies to 'close the gap' for Aboriginal and Torres Strait Islander peoples.

However, we sometimes fail to recognise that there are also major disparities in health outcomes and access to health services for other population groups in our community. This concern was clearly expressed through some of our submissions, including:

*In being inclusive, responsive and equitable, it is important that our health system acknowledges the specific issues that face different population groups, and does not treat all Australians as fitting within a homogenous group. Invisibility within the health system does not equate to equity being achieved.*¹²

People with a long-term disability are among the most disadvantaged, and invisible, groups in our community

- People with a long-term disability are among the most disadvantaged, and invisible, groups in our community, with very poor health status and a health system that often fails to meet their special needs. This includes people with an intellectual disability (see Figure 1.2), as well as people with other long-term physical and mental conditions, whether present at birth or acquired later in life.

10 Commission on social determinants of health (2008), Closing the gap in a generation: Final report executive summary, at: http://www.who.int/social_determinants/en/

11 Australian Bureau of Statistics and Australian Institute of Health and Welfare (2008), The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2008, at: <http://www.aihw.gov.au/publications/ihw/hwaatsip08/hwaatsip08.pdf>

12 National GLBT Health Alliance (2008), Submission 124 to the National Health and Hospitals Reform Commission.

Figure 1.2: There are stark health and access inequalities for people with an intellectual disability

There are currently over 300,000 Australians with intellectual disabilities, many of whom have health outcomes at least as bad as our Aboriginal and Torres Strait Islander peoples. Published research on the health outcomes for people with an intellectual disability identifies that:

- Life expectancy may be up to 20 years lower for people with a severe intellectual disability than the general population.
- There is a huge burden of undiagnosed illness. Only 29 per cent of health conditions are diagnosed and treated appropriately in this population. Some 42 per cent of health conditions go undiagnosed. And, even when health conditions are diagnosed, half of those patients still have their conditions inadequately managed.
- Psychiatric disorders are among the conditions that are frequently not well diagnosed or managed in people with an intellectual disability.
- Dental disease is up to seven times more common than in the general population.

Some of the many factors that contribute to poorer health outcomes for people with an intellectual disability include:

- 'Diagnostic overlay' – health professionals may assume that the symptoms are part of the intellectual disability, not a separate health condition that requires treatment.
- Communication challenges – there will often be a need to spend much more time with people with an intellectual disability and many health professionals may not have sufficient training in how best to communicate with such patients.
- Workforce challenges – few health professionals will have specialised training or exposure to people with intellectual disabilities, recognising that there is a wide array of disabilities, often accompanied by other health problems.
- There is a lack of targeting of people with intellectual disabilities in health promotion and prevention strategies.
- Other challenges include the high cost of providing comprehensive and holistic care for some people with an intellectual disability, the lack of support for families and carers, and the lack of societal value attached to people with intellectual disabilities.

Source: Australian Association of Developmental Disability Medicine Incorporated and the National and NSW Councils for Intellectual Disability (2008), Submission 450 to the National Health and Hospitals Reform Commission.

People from other countries, and people with other languages and other cultures, may also be at a significant disadvantage in our health system. We heard through our submissions of the challenges faced by health professionals to respond appropriately to 'an increasing diversity of culture with diverse languages, cultural practices and ethical frameworks'.¹³ While migrants, who are screened for health status prior to migration, are generally healthier¹⁴ – with lower rates of hospital use, fewer health risk factors and lower death rates – they may face an uphill battle in getting access to services that meet their needs. Although not all refugees have access to Medicare¹⁵, refugees generally have lower rates of hospital admissions, including preventable admissions, than Australian-born people.¹⁶ At the most basic level, however, communication for many migrants can remain a major challenge, with one of our submissions suggesting that there was a need for a review of national interpreter and translation service standards and credentialing of these services.¹⁷

■ People from other countries, and people with other languages and other cultures, may also be at a significant disadvantage in our health system

13 B Hayes (2008), Submission 235 to the National Health and Hospitals Reform Commission.

14 Australian Institute of Health and Welfare (2002), Australian health inequalities: 1. Birthplace, AIHW Bulletin No. 2, at: <http://www.aihw.gov.au/publications/index.cfm/title/7722>

15 I Correa-Velez, S Gifford and S Bice (2005), 'Australian health policy on access to medical care for refugees and asylum seekers', Australia and New Zealand Health Policy (2):23, at: <http://www.anzhealthpolicy.com/content/pdf/1743-8462-2-23.pdf>

16 I Correa-Velez, Z Ansari, V Sundararajan and colleagues (2007), 'A six-year descriptive analysis of hospitalizations for ambulatory care sensitive conditions among people born in refugee-source countries', Population Health Metrics, at: <http://www.pophealthmetrics.com/content/pdf/1478-7954-5-9.pdf>

17 Doutra Galla Community Health Service (2008), Submission 79 to the National Health and Hospitals Reform Commission.

We have identified 'facing inequities' as one of our four major pathways to reform. In talking about equity, we want to be clear that equity does not necessarily mean 'equal' access or 'equal' outcomes for all people. When we consider, for example, the 17-year life expectancy gap between Aboriginal and Torres Strait Islander peoples and other Australians, it should be obvious that providing 'equal' access to services or 'equal' levels of funding will simply not be enough. In this situation, the concept of 'vertical equity' comes into play: meaning we need 'unequal but equitable access for unequal need'.¹⁸ As we discuss in Chapter 8, the level of resources needs to be proportionate to the greater health problems and disadvantage faced by this population.

We believe that there is an urgent need to tackle inequities in access to health services, health status and health outcomes. In Chapters 8 to 11 of this report, we propose reform directions to tackle inequities affecting Aboriginal and Torres Strait Islander peoples, rural and remote communities, people with mental health conditions, and people with poor access to dental services.

We cannot simply assume that universal entitlement to health care services equates to a health care system that fosters equitable health outcomes for all groups in our community

Also, because some, but not all, of the causes of inequity in health outcomes relate to the affordability of services, we examine in Chapter 13 the costs of health services for different households, and outline further work on the development of integrated safety nets. We cannot simply assume that universal entitlement to health care services equates to a health care system that fosters equitable health outcomes for all groups in our community.

Reform direction 1.1

We affirm the value of universal entitlement to medical, pharmaceutical and public hospital services under Medicare which, together with choice and access through private health insurance, provides a robust framework for the Australian health care system. To promote greater equity, universal entitlement needs to be overlaid with targeting of health services to ensure that disadvantaged groups have the best opportunity for improved health outcomes.

The WHO Commission on Social Determinants of Health has expressed this concept as follows:

Most governments tend to have a mixture of both universal and targeted social policies. However, in the more successful countries, overall social policy itself has been universalistic, and targeting has been used as simply one instrument for making universalism effective; this is what ... [is] referred as 'targeting within universalism', in which extra benefits are directed to low-income groups within the context of a universal policy design and involves the fine-tuning of what are fundamentally universalist policies.¹⁹

In other words, we need to move beyond the 'she'll be right' passive version of universal entitlement to a new paradigm that recognises our responsibility to target groups whose health outcomes, and access to health services, may be worse than average. Many strategies could contribute to this renewed paradigm of universalism and we welcome feedback on this approach. For example, some submissions identified the need for targeting and outreach strategies for some populations:

Every publicly funded health education and screening program should be required to include those citizens who cannot present themselves.²⁰

If the Commonwealth Government is committed to achieving equity, it is essential that they commit further health resources according to need, rather than simply applying a one-size-fits-all approach to healthcare.²¹

Another important approach which we identified in our first report, *Beyond the Blame Game*, is to report, separately and publicly, on benchmarks for the health of particular populations. We

18 G Mooney (2008), Submission 275 to the National Health and Hospitals Reform Commission.
 19 World Health Organization Commission on Social Determinants of Health (2007), A conceptual framework for action on the social determinants of health: Discussion paper, at: http://www.who.int/social_determinants/resources/csdh_framework_action_05_07.pdf
 20 Australian Association of Developmental Disability Medicine Incorporated and the National and NSW Councils for Intellectual Disability (2008), Submission 450 to the National Health and Hospitals Reform Commission.
 21 ACT Council of Social Services & Women's Centre for Health Matters, Submission 4 to the National Health and Hospitals Reform Commission.

suggested in our first report that this could include separate reporting on Indigenous versus non-Indigenous populations, rural versus metropolitan, and lower socio-economic status versus higher socio-economic status groups in our population. Since 1998, the Australian Institute of Health and Welfare has set a positive example in its biennial *Australia's Health* report, analysing and reporting on patterns of health across different sub-populations. It argues that this is important, first, for the 'basic social issue of fairness' and, second, because understanding different patterns of health is necessary to identify opportunities to improve the health system and wider social improvements.²²

Reform direction 1.2

We propose that public reporting on health status, health service use and health outcomes by governments, private health insurers, and individual health service providers identifies the impact on population groups who are likely to be disadvantaged in our communities.

1.3 Tackling the social determinants of health

Many of the factors contributing to health inequities sit well and truly outside our health system. In the words of a GP attending one of our consultation meetings:

*Health ... cannot be separated from social issues, issues of wealth, issues of infrastructure at all levels in Australia, be that in a metropolitan, outer-metropolitan, regional, remote [setting] etc. and so on. You will not solve a lot of the health problems in this country if you look at health in isolation. You have to look at socio-economic groups, you've got to look at social welfare, you have to look at self-empowerment and education which begins in schools.*²³

Similarly, the Public Health Association of Australia has argued that:

*There is now a significant body of evidence about the direct impacts of the social determinants of health on individuals, communities and populations. Social determinants of health are the strongest predictors of people's health, structuring our opportunities in life and lifestyle choices. Taking account of social conditions that underlie health and how they translate into health impacts is critical for overcoming the deep divide between 'haves' and 'have-nots' and the social unrest that arises from such disparities.*²⁴

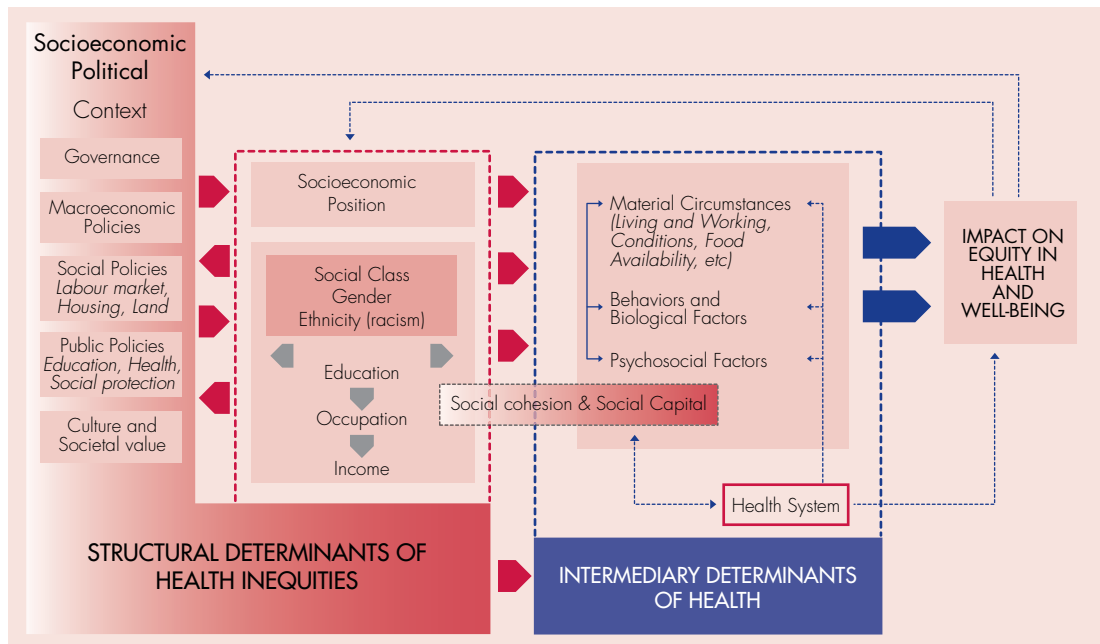
A comprehensive framework that explains the links between health and the 'social determinants' of health was recently developed by the WHO Commission on Social Determinants of Health (see Figure 1.3). This framework identifies that many of the factors influencing our ability to be healthy are outside the direct control of individuals. Government policies relating to income protection and social support influence how we are able to raise our children and what opportunities we can provide them. At a more direct level, our educational standards will affect our abilities to find and understand health-related information.

22 Australian Institute of Health and Welfare (2008), *Australia's Health 2008* (Australian Institute of Health and Welfare: Canberra).

23 General practitioner (7 July 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Perth.

24 Public Health Association of Australia (2008), Submission 429 to the National Health and Hospitals Reform Commission.

Figure 1.3: There are many 'social determinants' that influence the health and wellbeing of our communities



Source: World Health Organization Commission on Social Determinants of Health (2007), A conceptual framework for action on the social determinants of health: Discussion paper, at: http://www.who.int/social_determinants/resources/csdh_framework_action_05_07.pdf

The Commission on Social Determinants of Health used this framework to identify that there were three broad, complementary strategies that could be used to reduce health inequities²⁵, namely:

- introducing targeted programs for disadvantaged populations;
- closing health gaps between worse-off and better-off groups; and
- addressing the social health gradient across the whole population.

From our perspective, we have debated long and hard about the approach we should take to proposing reform directions that involve groups and government agencies outside the health care system.

Cross-sectoral action is an essential ingredient to tackling the problem of health inequity

Clearly, cross-sectoral action is an essential ingredient to tackling the problem of health inequity. We have been pleased to see the establishment by the Commonwealth Government of the Australian Social Inclusion Board. This Board has been challenged with achieving better outcomes for the most disadvantaged in our community.²⁶ Priorities identified by the Commonwealth Government for early action by the Board include:

- addressing the incidence and needs of jobless families with children;
- delivering effective support to children at greatest risk of long-term disadvantage;
- focusing on particular locations, neighbourhoods and communities to ensure programs and services are getting to the right places;
- addressing the incidence of homelessness;
- providing employment for people living with a disability or mental illness; and
- closing the gap for Aboriginal and Torres Strait Islander peoples.

²⁵ World Health Organization Commission on Social Determinants of Health (2007), A conceptual framework for action on the social determinants of health: Discussion paper, at: http://www.who.int/social_determinants/resources/csdh_framework_action_05_07.pdf

²⁶ Information on the Australian Social Inclusion Board, at: http://www.socialinclusion.gov.au/aus_inclusion_board/

Many of these issues are crucial to tackling health inequities and go to the cause of why Australia, and indeed most countries, has a social health gradient.

Other groups can also have an important role in stimulating cross-sectoral action. Our proposal for the establishment of a national prevention and health promotion agency (see Section 1.6) is based strongly on the need for such an agency to engage collaboratively with many groups who sit 'outside' the current health system.

We further note the galvanising effect in some countries of major reports on the relationship between social policies and health equity. The ground-breaking Black Report on inequalities in health was the catalyst for major change, not only in the United Kingdom, but it spurred national inquiries and action in many other countries including the Netherlands, Spain and Sweden.²⁷ Similarly, in the United States, the Agency for Healthcare Research and Quality produces an annual National Healthcare Disparities Report²⁸ that measures quality and access among various racial, ethnic and income groups, as well as other priority populations such as children, older adults, rural residents and people with disabilities. The publication of such reports helps 'keep us honest' about whether we are doing enough to tackle some of the systemic issues that lead to health inequities.

A precursor for action on health inequity is that the issue becomes visible.

Reform direction 1.3

We propose the preparation of a regular report that tracks our progress as a nation in tackling health inequity.

1.4 Promoting health in our local communities

A strong feature of the consultation feedback we received was how to combine the best elements of a 'national' health system with 'local' engagement and innovation.

We believe it is important to match national action on social determinants and health inequity with local participation and action to tackle problems that influence the health of our local communities. There is a wealth of ideas and a passionate enthusiasm among many local communities about how they can make their communities healthier places to live.

Across the country, many local councils develop population health plans, working collaboratively with local community health services and their communities. Many other groups are also strongly engaged in creating healthier local communities (see Figure 1.4).

■ There is a wealth of ideas and a passionate enthusiasm among many local communities about how they can make their communities healthier places to live

27 World Health Organization Commission on Social Determinants of Health (2007), A conceptual framework for action on the social determinants of health: Discussion paper, at: http://www.who.int/social_determinants/resources/csdh_framework_action_05_07.pdf

28 Agency for Healthcare Research and Quality (2008), National healthcare disparities report 2007, at: <http://www.ahrq.gov/qual/qdr07.htm>

Figure 1.4: Local communities are 'doing' health promotion 'for themselves'

We read and heard of many examples of local action to promote healthy communities. Some of these stories follow.

Sustainable farm families

In western Victoria, the Sustainable Farm Families project was started by the Western District Health Service in 2003. With the motto 'No point in a better bottom line if you're not there to enjoy it', the project takes an early intervention approach to working with families who may be facing tough financial circumstances. Over 1000 farmers and 100 rural health professionals are involved in a 'settings based' approach to health promotion. This project recognises that the health of farming families and communities is a resource that needs to be proactively nourished and supported, moving beyond the simple provision of curative health services.

Afghani women's swim team

In Hobart, the Migrant Resource Centre has organised an Afghani Muslim women's swim team. The women gather regularly for swimming lessons, with a Farsi speaking interpreter in a 'women only' session at a local pool. These sessions promote the importance of exercise, but also help the women bond and form new friends while they are learning to adjust to living in a new country.

Food security, nutrition, physical activity and social inclusion

In inner Melbourne, the Inner South Community Health Service defines health promotion as 'the process of enabling people to increase control over the determinants of their health, thereby improving it'. The health service runs several activities that are linked to promoting social inclusion, food security and nutrition, and encouraging physical activity. These include: community gardens projects to increase access to nutritious food and create opportunities for social connection and physical activity; a fortnightly gathering and lunch for the Aboriginal and Torres Strait Islander community, our Rainbow Place, which is led by community elders; and a community winter breakfast program that aims to bring community members together over a healthy breakfast.

Sources: Sustaining Farm Families project: Victorian Healthcare Association (2008), Submission 190 to the National Health and Hospitals Reform Commission.

Afghani women's swim team: Community member (29 May 2008), National Health and Hospitals Reform Commission consultation meeting with consumers in Hobart. See also: <http://www.mrchobart.org.au/index.shtml>

Inner South Community Health Service: Health promotion plan 2006–2009, <http://www.ischs.org.au/Whoware/CommunityHealth/Ourhealthpromotionplan/tabid/113/Default.aspx>

Local community engagement in building healthier communities requires information about local health issues and priorities. One approach canvassed at the 2020 Summit in April 2008 was the development of a 'wellness footprint'.²⁹ This was described as being similar to a 'carbon footprint', but it would measure a range of factors that contribute to healthy communities covering issues such as urban planning and schools.

In fact, we learned during our national consultations that a similar concept, called Community Indicators Victoria, has been operational since July 2007.³⁰ The Community Indicators Victoria website presents a broad array of information on the health of local communities (available at the level of local government areas) against five major domains:

29 Australian Government (2008), Australia 2020 Summit – Final Report, at: http://www.australia2020.gov.au/final_report/index.cfm

30 Community Indicators Victoria, at: <http://www.communityindicators.net.au/>

- Healthy, safe and inclusive communities;
- Dynamic, resilient local economies;
- Sustainable built and natural environments;
- Culturally rich and vibrant communities; and
- Democratic and engaged communities.

Everyone is able to look up how their community (or any Victorian community) measures up against about 80 indicators (see Figure 1.5) within these five domains. Maps can be created to show how your community is tracking relative to other Victorian communities on indicators such as: child health assessments, school retention rates, unemployment, household waste recycling, public transport patronage, and household affordability. The Community Indicators Victoria website provides a tool that local communities can use to 'get local conversations started' in building healthy communities.

Figure 1.5: Victorians can access information about the health of their communities

Community wellbeing indicators reported on the Community Indicators Victoria website are grouped against five domains. These domains are further split into several elements which have about 80 indicators listed under the elements. (The actual indicators are not listed here due to space limitations.)

1. Healthy, safe and inclusive communities

- a. Personal health and wellbeing*
- b. Community connectedness*
- c. Early childhood*
- d. Personal and community safety*
- e. Lifelong learning*
- f. Service availability*

2. Dynamic, resilient local economies

- a. Economic activity*
- b. Employment*
- c. Income and wealth*
- d. Skills*
- e. Work-life balance*

3. Sustainable built and natural environments

- a. Open space*
- b. Housing*
- c. Transport accessibility*
- d. Sustainable energy use*
- e. Air quality*
- f. Water*
- g. Biodiversity*
- h. Waste management*

4. Culturally rich and vibrant communities

- a. Arts and cultural activities*
- b. Leisure and recreation*
- c. Cultural diversity*

5. Democratic and engaged communities

- a. Citizen engagement*

The Community Indicators Victoria website allows reports and websites to be generated for each of the indicators for every local government area in Victoria. Detailed information is available on how the indicators are defined and collected. Case studies are also provided on how local communities are using the community indicators in planning for healthy communities

Source: Community Indicators Victoria, at: <http://www.communityindicators.net.au/>

We support the development of accessible information on the health of local communities. This information should take a broad view of the factors contributing to healthy communities, including the 'wellness footprint' of communities and issues such as urban planning, public transport, community connectedness and a sustainable environment.

1.5 Promoting health in our workplaces

Communities can take many shapes. In our discussion above, we were mainly focusing on communities united by geography. Each of us participates in many communities – whether they are schools, sporting clubs, church groups or any other of the spheres of our lives. For some of us, our workplace is another such community.

Businesses and employer groups have become increasingly engaged in the public debate about health reform. This makes absolute sense given the close relationship between a healthy workforce and economic productivity. As we heard in one of our submissions:

Because health is so fundamental to a nation's social and economic prosperity, the Business Council of Australia supports the view that health is everybody's business, including Australia's businesses. For too long health policy decisions have been seen as a matter for governments and the health sector. But as we face new possibilities and difficult choices about the allocation of scarce resources, we all need to take responsibility for understanding the challenges and participating in the debate.³¹

At the level of individual businesses, the traditional focus of workplace health on occupational health and safety issues is expanding to include new programs targeting wellness, health promotion, risk screening and self-management for workers with chronic diseases.

Currently there are about 35 corporate wellness providers in Australia who provide services to about 500,000 employees, equal to five per cent of the total workforce.³² Private health insurers are also increasingly providing similar services to their members, including wellness, risk assessment and support for people with chronic disease. There is some overlap between these programs and populations, although privately insured people include those outside the workforce as well as employed people. However, the general point is that wellness and health improvement programs are being offered outside traditional health service providers. And, of course, many people also participate in other non-sponsored activities to keep them healthy, such as sporting activities or gym memberships.

- Investment by businesses and private health insurers in health management and wellness programs reflects a commercial assessment that such programs generate a positive return on investment
- Investment by businesses and private health insurers in health management and wellness programs reflects a commercial assessment that such programs generate a positive return on investment. In its submission³³, the Health and Productivity Institute of Australia provided examples of, and evidence on, the cost-effectiveness of such programs to employers, including:

31 Business Council of Australia (2008), Submission 319 to the National Health and Hospitals Reform Commission.

32 J Lang (2008), Workshop Paper – Prevention and Wellness, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

33 The Health and Productivity Institute of Australia (2008), Submission 334 to the National Health and Hospitals Reform Commission.

- A recent international review of workplace wellness programs found that the average cost benefit ratio for such programs was about 1:6. Every dollar invested in workplace wellness programs generated a return of six dollars.
- In Australia, a health and wellbeing program offered to ANZ employees improved the rate of work time lost from employee poor health and injury by 23 per cent over two years.
- Members of one Australian private health insurance company had lower claims (\$50 annually) against their health insurer if they completed a health risk assessment questionnaire and even lower claims (\$500 annually) if they also participated in health coaching that was relevant to their identified risks and health problems.

While businesses are already investing in workplace health programs, we also received advice about strategies to encourage further growth of such programs.³⁴ These included:

- the introduction of government financial support for such programs;
- amending various tax provisions to promote greater uptake of workplace health programs;
- changing private health insurance rules to promote health screening; and
- encouraging the development of a national wellbeing index with workplace health programs being one of the groups that would collect data on the wellbeing of the working population.

We note that some governments are already investing in workplace health programs. Tasmania has allocated funding of \$3.3 million to fund workplace health programs for its public servants³⁵, while the Victorian Government announced a five year, \$600 million investment to fund screening for preventable diseases for 2.6 million workers.³⁶ We are also aware that there are several wellbeing indices being developed or already in use; for example, since 2001, Australian Unity, in association with Deakin University, has collected and reported information on a personal wellbeing index.³⁷

Reform direction 1.5

We support the delivery of wellness and health promotion programs by employers and private health insurers. Any existing regulatory barriers to increasing the uptake of such programs should be reviewed.

34 The Health and Productivity Institute of Australia (2008), Submission 334 to the National Health and Hospitals Reform Commission.

35 J Lang (2008), Workshop Paper – Prevention and Wellness, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

36 Victorian Government (2008), World first plan to help workers fight chronic disease, Media release, 18 March 2008.

37 Australian Unity (2008), What makes us happy: Australia's first and foremost guide to wellbeing, at: http://acqol.deakin.edu.au/index_wellbeing/Survey_18.2.pdf

1.6 Encouraging national leadership on health promotion and prevention

Our examination of strategies to support health promotion and prevention at the national level has been influenced by a range of material including:

- the outcomes of the National Prevention Summit³⁸;
- the work of the National Preventative Health Taskforce³⁹;
- a series of discussion papers that we commissioned on various strategies to expand the role of prevention and health promotion⁴⁰; and
- the views that we received through our submissions and consultation meetings.⁴¹

There was strong support from many sources for national leadership on health promotion and prevention. For example:

*We need a new agenda to elevate prevention to a national priority and to fund it appropriately. This national prevention agenda needs to be accompanied by developing good working relationships between a range of existing and new players, including the public, who are the ultimate beneficiaries of investment in health.*⁴²

*Social change management strategies will need to be employed to shift the society from an illness model to a wellness model. Stop bragging about having the best health system in the world. It's time to start bragging about Australia having the best wellness system in the world.*⁴³

National leadership on health promotion and prevention can occur in different ways. Some groups suggest that there should be dedicated funding for prevention, with targets for the share of the health budget being spent on prevention.⁴⁴ The absence of an overarching national public health strategy has been cited as one of the barriers to greater investment.⁴⁵ National leadership should also facilitate sharing resources and information about what works across the whole country.

We believe that there are three important elements or ingredients to building health promotion and prevention capacity at a national level, namely:

- committing to 10-year health goals;
- establishing a national health promotion and prevention agency; and
- financing prevention on a level playing field.

Each of these elements is now discussed.

38 Information on the National Prevention Summit, at: <http://www.vichealth.vic.gov.au/Content.aspx?topicID=574>

39 The National Preventative Health Taskforce, at: <http://www.preventativehealth.org.au/>

40 These discussion papers are available at: <http://www.nhhrc.org.au>

41 Submissions and consultation reports are available at: <http://www.nhhrc.org.au>

42 Australian Institute of Health Policy Studies and VicHealth (2008), A vision for prevention in Australia: Discussion paper, at: http://healthpolicystudies.org.au/component/option,com_docman/task,cat_view/gid,88/Itemid,145/

43 T Findlay (2008), Submission 360 to the National Health and Hospitals Reform Commission.

44 B Oldenburg and T Harper (2008), 'Investing in the future: prevention a priority at last', *Medical Journal of Australia*, 189(5): 267–268.

45 L Russell, G Rubin and S Leeder (2008), 'Preventive health reform: what does it mean for public health?', *Medical Journal of Australia*, 188(12): 715–719.

1.6.1 Committing to ten-year health goals

Flowing from the 1981 Alma Ata Declaration, there is a long history in Australia⁴⁶ and many countries of using national health goals and targets to drive a greater focus on health promotion and prevention.

In the 1980s the work of the Australian Better Health Commission resulted in the development of a series of 20 goals and 65 targets for health promotion and disease prevention, organised by population groups, major causes of illness and death, and risk factors. It identified that the first set of priorities should relate to five areas: control of high blood pressure, improved nutrition, prevention of injury, the health of older people, and prevention of cancer (particularly lung, skin, breast and cervical cancer). The original 1988 goals were refocused following a 1993 review to emphasise four major priorities:

- Preventing morbidity and mortality;
- Addressing healthy lifestyles and risk factors;
- Ensuring health literacy and life skills; and
- Promoting healthy environments.

Over time, this approach evolved into the existing National Health Priority Areas which have a strong focus on particular diseases or health problems (such as cancer, diabetes, cardiovascular health and mental health).

The benefits of a national health goals approach have been described as providing:

*... a rallying point for public health. Having goals and targets as a device was possibly more important than what they covered.*⁴⁷

The United States is now developing its fourth set of decade-long goals for public health – Healthy People 2020 – to be released in 2010 (see Figure 1.6).

46 Discussion of the Australian experience with goals and targets is based on the following article: S Leeder (2007), 'Influencing public health policy and practice: the role of the public health academic', Association of Pacific Rim Universities World Institute Workshop, at: <http://www.ahpi.health.usyd.edu.au/pdfs/srl07/apru260507.pdf>

47 S Leeder (2007), 'Influencing public health policy and practice: the role of the public health academic', Association of Pacific Rim Universities World Institute Workshop, at: <http://www.ahpi.health.usyd.edu.au/pdfs/srl07/apru260507.pdf>

Figure 1.6: Public health goals have shaped United States health policy for 30 years

In the United States, the Healthy People goals approach sets rolling ten-year national objectives for promoting health and preventing disease. This approach commenced in 1979 and work is currently underway to develop the fourth set of ten-year goals, known as Healthy People 2020, scheduled for release in 2010.

The development of these goals is highly collaborative and informed by scientific evidence. The United States Department of Health and Human Services states:

The Healthy People process is inclusive; its strength is directly tied to collaboration. The development process strives to maximise transparency, public input and stakeholder dialogue to ensure that Healthy People 2020 is relevant to diverse public health needs and seizes opportunities to achieve its goals. Since its inception, Healthy People has become a broad-based, public engagement initiative with thousands of citizens helping to shape it at every step along the way.

Under Healthy People, the status of the nation's health against the goals is measured at the beginning of the decade with regular progress monitoring over the decade to identify whether the goals are going to be achieved.

Healthy People 2010 involves a cascading hierarchy of goals and targets. The two overarching goals are to increase the quality and years of healthy life, and to eliminate health disparities.

These two goals are supported by 467 objectives in 28 focus areas. There is also a smaller set of health priorities reflecting ten major public health concerns in the United States. The ten Leading Health Indicators are intended to readily convey the importance of health promotion and disease prevention to everyone. The current set of Leading Health Indicators are:

- *Physical activity – promote regular physical activity*
- *Overweight and obesity – promote healthier weight and good nutrition*
- *Tobacco use – prevent and reduce tobacco use*
- *Substance abuse – prevent and reduce substance abuse*
- *Responsible sexual behaviour – promote responsible sexual behaviour*
- *Mental health – promote mental health and wellbeing*
- *Injury and violence – promote safety and reduce violence*
- *Environmental quality – promote healthy environments*
- *Immunisation – prevent infectious disease through immunisation*
- *Access to health care – increase access to quality health care*

There is a strong focus on the Healthy People goals being used by all sections of the community. For example, toolkits and guides are available to help community groups, schools and workplaces use the Healthy Goals in their health promotion and prevention activities.

While the goals have evolved over time, there is good evidence that many of the goals set under the Healthy People approach have been met, resulting in a healthier population.

Source: United States Department of Health and Human Services, Healthy Goals website, at: <http://www.healthypeople.gov/Default.htm>

We believe that there is strong merit in establishing a renewed focus on health goals.

Reform direction 1.6

We propose that governments commit to establishing a rolling series of ten-year goals for health promotion and prevention, to be known as Healthy Australia Goals, commencing with Healthy Australia 2020 Goals. The goals should be developed to ensure broad community ownership and commitment, with regular reporting by governments on progress towards achieving better health outcomes under the ten-year goals.

We do not see the Healthy Australia Goals being ‘delivered from above’, like Moses bearing stone tablets with the Ten Commandments. There should be broad community consultation and engagement in setting the priorities for what we as a community want to achieve in better health. Many groups, including the Australian Health Care Reform Alliance, have called for greater citizen and consumer engagement in developing a common vision for our health system and a healthy population.⁴⁸ Of course, the specifics of the Healthy Australia Goals must also be informed by evidence from clinical and epidemiological studies about risk factors for poor health and effective strategies to achieve better health outcomes.

We also want to ensure that the Healthy Australia Goals don’t sit, gathering dust, on people’s bookshelves. One way to avoid this is to make sure that we develop a manageable number of goals – quality over quantity – so that we have the best possible chance of achieving the most important priorities we agree and set for a healthier community. Importantly, the Healthy Australia Goals should be a ‘living’ document. Although we have described them as 10-year goals, we envisage biennial reports to the community on progress to keep focus and commitment and to celebrate achievements or alert lack of progress. It would also be sensible to review and update the goals as new priorities may emerge or, even better, if we meet some of the goals before the ten-year timeframe has elapsed.

We were struck in reading the submissions how much our draft principles resonated with many groups and how much these principles provided an organising framework for identifying areas for improvement. We believe that Healthy Australia Goals would provide a similarly powerful framework to catalyse action on health improvement.

In the same way that we advocate a community-wide process for developing the Healthy Australia Goals, there should also be community-wide responsibility for achieving the goals. We want to emphasise that everyone can contribute to Australia becoming a healthier society. Governments have a role to play, but so do businesses, workplaces, private health insurers, community groups, non-government organisations, health services, families and individuals.

We envisage, for example, that workplaces and community groups might choose to use a subset of the national Healthy Australia Goals, identify action they can take at the local level, and measure their progress and improvement in reaching better health. Accessible information on the health of local communities, such as the wellness footprint concept and the Community Indicators Victoria data, would provide the backbone of information to support local participation in national goals on health promotion and prevention. Reporting on progress towards better health through the Healthy Australia Goals could thus occur at many levels including national, state, workplace and local communities.

■ There should be broad community consultation and engagement in setting the priorities for what we as a community want to achieve in better health

48 Australian Health Care Reform Alliance (2008), Submission 446 to the National Health and Hospitals Reform Commission.

1.6.2 Establishing a national health promotion and prevention agency

The second element of national leadership relates to the proposed establishment of a national health promotion and prevention agency.

We are conscious that, although there is wide consensus on the need for a greater focus on prevention in our health system, the mechanisms to translate this sometimes easy rhetoric into hard reality are either lacking or underdeveloped.

The National Preventative Health Taskforce has argued that:

The recent history of public health in Australia shows that preventative efforts have been most effective when effective supports have been put in place ... An essential component to enable effective action is to ensure leadership and coordination through the establishment of a National Prevention Agency.⁴⁹

Participants, at both the 2020 Summit and the National Prevention Summit in April 2008 strongly supported the concept of a national prevention agency

- Proposals for a national prevention or public health agency have been around since at least the mid 1970s. More recently, participants at both the 2020 Summit and the National Prevention Summit in April 2008 strongly supported the concept of a national prevention agency. The idea is not new – it is overdue.

We commissioned several experts to assess the models for how a national health promotion and prevention agency could be set up.⁵⁰ This included:

- examining models from other countries, Australian states and other sectors to identify the different approaches, and advantages and disadvantages of these approaches;
- identifying options for the financing and governance of a national health promotion and prevention agency; and
- outlining the range of potential functions and key objectives under which such an agency might operate.

Based on this work and our consultations, we have formed some preliminary views on the desirable features of how a new national health promotion and prevention agency might be established and operate. We believe that:

- The agency should be independent (outside government) and preferably established by statute.
- It should have reasonable funding certainty (say, on five year cycles), rather than be subject to annual appropriation processes.
- To promote broad take-up and participation in the health promotion and prevention agenda, the agency's board should be diverse (including, for example, representatives from the community, business sector and governments).
- Its scope should be cross-portfolio and across all sectors (not limited to health) reporting to the Prime Minister and the parliament.
- Its functions should include: building the evidence base for the value of health promotion and prevention; leadership, development and management of the proposed ten-year goals; undertaking social marketing and educational campaigns; and leading cross-sectoral action on health promotion and prevention.

49 National Preventive Health Taskforce (2008), Australia: the healthiest country by 2020, A discussion paper.

50 R Moodie, T Harper and B Oldenburg (2008), A national agency for promoting health and preventing illness, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

We want to emphasise that national leadership on prevention and health promotion through the proposed new agency must involve a strong focus on cross-sectoral action, rather than being limited to action within the health portfolio only. Our commissioned discussion paper described this requirement as follows:

Much of the new national organisation's primary work would be about forging productive relationships, both with and between other key parties ... Its networking activities would span governments at all levels, national agencies, professional associations, non-government organisations, the private sector, the philanthropic sector and academia. This would ensure that the transformative aspect of its work is spread from boardrooms to factory floors, from hospitals to homeless shelters.⁵¹

Reform direction 1.7

We propose the establishment of an independent national health promotion and prevention agency. This agency would be responsible for national leadership on the ten-year health goals, as well as building the evidence base, capacity and infrastructure that is required so that prevention becomes the platform of healthy communities and is integrated into all aspects of our health care system.

1.6.3 Financing prevention on a level playing field

The financing of prevention (or more accurately the absence of identified funding streams for prevention) is often raised by groups that want to see a stronger emphasis on prevention in our health system. For example:

The current level of investment in preventative approaches is like trying to treat a clinical outcome with half an aspirin.⁵²

The National Prevention Summit's platform for advancing prevention proposed that sustainable financing mechanisms for prevention needed to be established.⁵³ The summit identified some specific actions to create more sustainable financing of prevention including:

- scaling up of prevention programs that have been demonstrated to be efficient, effective and equitable;
- tasking the Council of Australian Governments with establishing a new financial framework for prevention and health promotion;
- building on experience with the use of tax-based strategies to establish health promotion foundations;
- developing transparent funding models to support prevention through new and existing financing mechanisms (such as the Medicare Benefits Schedule, hospital funding, private health insurance, taxes on unhealthy foods or alcohol);
- encouraging private sector engagement in prevention and health promotion including using price signals or tax incentives to support the provision of healthy products and funding for prevention research; and
- ensuring that government funding of health services does not introduce disincentives for health promotion and prevention.

51 R Moodie, T Harper and B Oldenburg (2008), A national agency for promoting health and preventing illness, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

52 Government official (19 June 2008), National Health and Hospitals Reform Commission consultation meeting with government agencies in Brisbane.

53 Australian Institute of Health Policy Studies and VicHealth (2008), A platform for advancing the health and wellbeing of all Australians, at: http://healthpolicystudies.org.au/component/option,com_docman/task,cat_view/gid,88/Itemid,145/

To further stimulate debate on how best to finance prevention and health promotion, we commissioned two discussion papers that tackled aspects of the financing of prevention, namely:

- an analysis of the evidence on the effectiveness of using financial incentives to encourage greater personal responsibility for health⁵⁴; and
- a paper on options to systematically fund prevention through a prevention benefits schedule.⁵⁵

On the issue of financial incentives, the paper identified that financial incentives can be effective in increasing the uptake of preventive health programs. They work best when they are targeted to relatively simple one-off interventions (such as immunisation) and if they are used to reward positive behaviour, rather than applied as a financial penalty. We note that the issue of financial incentives was raised quite frequently during our consultation meetings, including:

There are no tax incentives or rebates for taking actions to keep you well. So there was a suggestion from a local Tasmanian that why couldn't we have tax rebates for families for their purchases of fresh fruit and vegetables and I guess that could be explored more.⁵⁶

The second paper examined the complex issues associated with the potential establishment of a prevention benefits schedule, using the analogy of the existing assessment and funding arrangements that apply for medical and pharmaceutical services in Australia. The authors recommended that clinical prevention activities (involving interactions between a health professional and an individual patient) could be funded under existing programs such as the Medicare Benefits Schedule and the Pharmaceutical Benefits Schedule. Further, they recommended that the assessment and funding of health promotion activities (involving populations) occur through separate, new arrangements.

We welcome feedback on the ideas and proposals in both these papers, noting that they represent quite ground-breaking concepts in the context of the existing Australian health system (although both have been used in other countries).

Moreover, we note that we have already proposed earlier that one of the key functions of a new national health promotion and prevention agency would be to build the evidence base. Among other areas, this evidence base could include further Australian studies on the impact of using financial incentives to encourage healthy behaviour.

At this time, we would also suggest that the proposed national health promotion and prevention agency could take the lead in collating (and sharing with relevant groups) evidence about the efficacy and cost-effectiveness of health promotion and prevention interventions. That is, our preliminary view is that the assessment of population-based health promotion and prevention interventions would be best served through a dedicated, expert agency focused solely on health promotion and prevention, in preference to being rolled into the same processes as apply for medical and pharmaceutical services. (However, we argue later in Chapter 12 that clinical prevention interventions (targeted at individuals) should be considered together with medical and pharmaceutical services under new umbrella arrangements involving the establishment of a National Health Intervention Assessment Agency.)

54 A Scott and S Schurer (2008), Financial incentives, personal responsibility and prevention, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

55 A Harris and D Mortimer (2008), A preventative priorities advisory committee and prevention benefits schedule for Australia, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

56 Nurse (28 May 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Hobart.

We propose that the national health promotion and prevention agency would also collate and disseminate information about the efficacy and cost effectiveness of health promotion and prevention interventions.

1.7 Encouraging people to take greater responsibility for improving their own health

We turn now to the issue of individuals and how they can be supported to take greater responsibility for their own health and that of their families. Good health is clearly a personal, as well as a collective, responsibility.

Our principle on shared responsibility tackled the sometimes vexed issue of the balance between individual and community responsibility for improving health as follows:

All Australians share responsibility for our health and the success of the health and aged care system. Within the context of our physical and social circumstances, life opportunities and the broad economic and cultural environment, we make decisions about our life-style and personal risk behaviours which impact our health risks and outcomes ... The health and aged care system can only work effectively if everyone participates to the best of their ability and circumstances, according to these shared responsibilities, recognising and valuing the important roles of consumers/patients, their families and carers, advocates and community groups and staff. The health system has a particularly important role in helping people of all ages and abilities become more self reliant, health literate and better able to manage their own health care needs. This includes helping people to make informed decisions through access to health information that supports informed consent and participation; by providing support and opportunities to make healthy choices; and by providing assistance for managing complex health needs.

Our submissions and consultation meetings highlighted the diversity of views on what was needed to allow people to take greater responsibility for their own health. They also identified that people have different capacities to take personal responsibility, with many factors (including socio-economic circumstances, educational levels and intellectual capacity) affecting the extent to which people can make meaningful choices about their health behaviours.

Figure 1.7 presents some of the 'community voices' on what it means to be healthy and what is needed to help individuals and families work towards better health.

■ Good health is clearly a personal, as well as a collective, responsibility

Figure 1.7: People have many views about health and staying healthy

The following are some of the views of people attending our consultation meetings:

On the issue of health and wellness:

I think without a doubt health is really linked with happiness and appreciation of life. So if there's anything that I could suggest for being healthier it's certainly got to do with mental health and probably got to do with expectations. So if we're teaching our kids about what life really is when they're young and what to expect, then they're more likely to be satisfied and happy and healthy. (Community consultation, Sydney, 5 June 2008)

Let's adopt a wellness model – let's pay incentives to keep people well and put greater funding into partnership working rather than paying for illness. This could include private health insurance rebates for wellness. (Health professional, Melbourne, 25 June 2008)

The term wellness has within an implicit emphasis on those who are healthy. It should also include those with chronic illness, not just those who are able bodied. Prevention should focus on quality of life for all. (Community consultation, Melbourne, 25 June 2008)

Being healthy is not just about having private health insurance or gym memberships, it is about social inclusion and connectedness as well as a work/life balance, to have time to contribute to society and the time to exercise and eat well. Group exercise classes such as Pilates and Tai Chi are a positive way to interact and stay fit at the same time. These should be offered at affordable rates for people of all ages. (Community consultation, Canberra, 23 July 2008)

Spiritual life and sense of purpose is important. A balance in body, mind and spirit is needed through a society where people behave well and have an ethical basis for communication and interaction. (Community consultation, Hobart, 29 May 2008)

On strategies to improve health and wellness:

Patients should be taking more responsibility for their health; there's certainly a good way to promote a healthy Australia and I believe that should be part of the key focus of the work – saying it's not to the doctors and nurses to fix you up, the patients should be encouraged to take more responsibility. (General practitioner, Alice Springs, 12 June 2008)

I'd just like to see healthier food with less additives, less preservatives, that's produced for the healthiness, not for the size and not for the colour. (Health professional, Shepparton, 27 June 2008)

I know one community where four potatoes costs \$1.5, a pie costs \$1.50 – what are you going to buy? (Health professional, Geraldton, 8 July 2008)

I'm very concerned about the education of the young people, particularly to educate them away from drugs and alcohol because I think that we need to as a community give them all their education and support that we can. (Community consultation, Dubbo, 2 June 2008)

Land use planning should contribute into the health system, particularly creating workable safe communities, where people are encouraged to walk and not to depend on cars. So the more people start walking, it will create a healthier community – particularly if they are obese, there will be other problems like diabetes, heart attack. Therefore the health system actually has to put pressure onto the planning system to create safer and healthier communities whereby people can be encouraged to walk, and also the public transport system and the land use planning should be integrated. (Community consultation, Shepparton, 26 June 2008)

Good health is a personal, as well as a collective, responsibility. Research by the Australian Institute of Health and Welfare shows that 32 per cent of the burden of disease in Australia is due to seven risk factors which can be reduced or prevented by lifestyle and personal behaviour – factors such as smoking, obesity, physical inactivity, excess alcohol consumption and poor nutrition. The National Preventative Health Taskforce has also highlighted the interrelationship between individual responsibility for better health and the role of other groups (including governments, employers and health services) in supporting people to make healthier choices. In its discussion paper⁵⁷ the Taskforce argues that:

Ultimately, it is communities, families and individuals who must change behaviours if we are to become a healthier nation.

It also observes that:

The solutions are not only about individual choice and personal responsibility but also about the role of governments, business and industry, and non-government organisations.

But for many people, healthy choices are not easy choices. People have different capacities to take personal responsibility, with many factors (including socio-economic circumstances, educational levels and intellectual capacity) affecting the extent to which people can make meaningful choices about their health behaviours.

We have designated 'taking responsibility' as one of our four major pathways to reform. Taking responsibility involves individual and collective action to build good health and wellbeing by all parts of society – people, families, health professionals, communities, employers and governments.

■ People have different capacities to take personal responsibility, with many factors affecting the extent to which people can make meaningful choices about their health behaviours

Reform direction 1.9

We support strategies that help people take greater personal responsibility for improving their health through policies that 'make healthy choices easy choices'. This includes individual and collective action to improve health by people, families, communities, health professionals, employers and governments.

We anticipate that the National Preventative Health Taskforce will be undertaking further work on strategies that help people to make healthier choices in areas including obesity, tobacco and alcohol.

We turn now to health literacy as one of the major levers that can be used to help people take greater responsibility for their own health.

1.8 Strengthening health literacy

Health literacy is defined by the Australian Bureau of Statistics as 'the knowledge and skills required to understand and use information relating to health issues such as drugs and alcohol, disease prevention and treatment, safety and accident prevention, first aid, emergencies, and staying healthy'.⁵⁸

If people are to take greater personal responsibility for their health, it is vital that they have a reasonable level of health literacy. This is especially important as people live longer with multiple health problems and chronic diseases. As the Health Care Consumers' Association of the ACT observed:

57 National Preventive Health Taskforce (2008), Australia: the healthiest country by 2020, A Discussion paper, at: <http://www.preventativehealth.org.au/internet/preventativehealth/publishing.nsf/Content/discussion-technical-1>

58 Australian Bureau of Statistics (2008), Australian literacy and life skills survey: Summary results, at: [http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4228.02006%20\(Reissue\)?OpenDocument](http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4228.02006%20(Reissue)?OpenDocument)

Self-management is what most people with long term conditions do – they manage their daily lives and cope with the effects of their condition as best they can, for the most part without any intervention from professionals.⁵⁹

The evidence is clear-cut that lower health literacy is associated with poorer health outcomes

■ Moreover, the evidence is clear-cut that lower health literacy is associated with poorer health outcomes. Among other things, lower health literacy leads to lower rates of screening for preventable health conditions, poorer experience in managing the health of children, and difficulty in following discharge instructions.⁶⁰

The most recent available data on levels of health literacy among the Australian population should raise serious alarm bells. The 2006 Australian Literacy and Life Skills Survey⁶¹ of people aged 15–74 years examined health literacy, together with the following four domains of general literacy:

- Prose literacy: the ability to understand and use information from various kinds of narrative texts, including texts from newspapers, magazines and brochures.
- Document literacy: the knowledge and skills required to locate and use information contained in various formats including job applications, payroll forms, transportation schedules, maps, tables and charts.
- Numeracy: the knowledge and skills required to effectively manage and respond to the mathematical demands of diverse situations.
- Problem solving: goal-directed thinking and action in situations for which no routine solution is available.

In our complex health system, these general literacy domains are likely to be essential to understanding and navigating health services, over and above the specific domain of health literacy.

For each of the five domains of literacy (including health literacy), people were grouped into one of five 'skill levels', corresponding to their proficiency. People at Level 5 are classed as having the best literacy, while people at Levels 1 and 2 are assessed as having such a low level of proficiency that they would be unable 'to meet the complex demands of everyday life and work in the emerging knowledge-based economy'. About half the population lack basic proficiency in the literacy domains of prose, documents or numeracy (see Figure 1.8). Three out of every five adults lack basic proficiency in health literacy – they do not have the skills to equip them to manage their health and health problems.

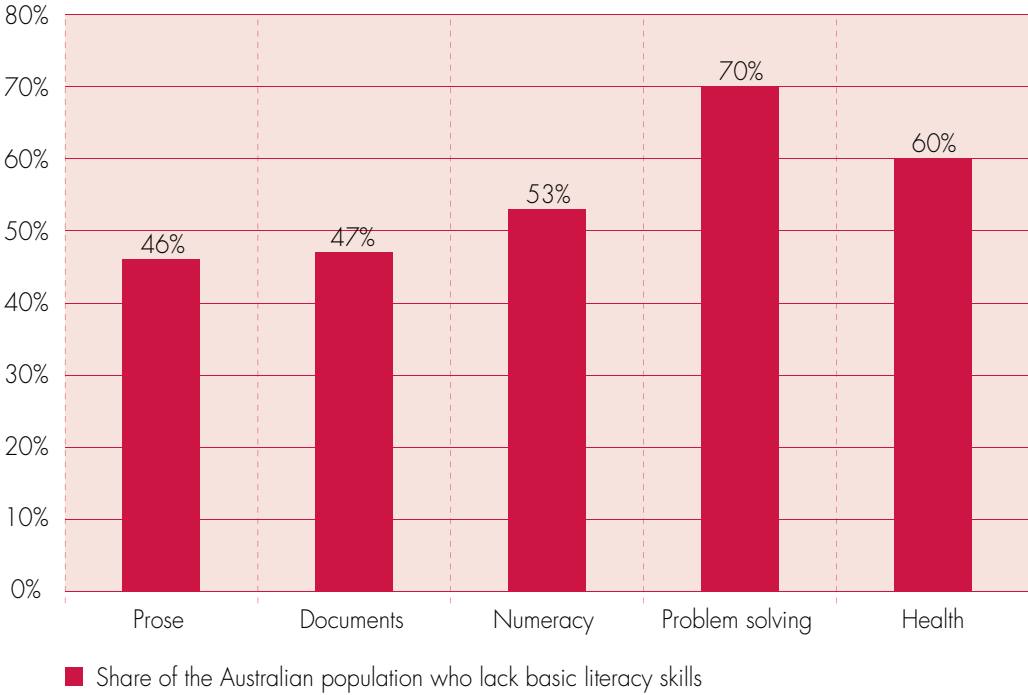
In considering how to tackle this major challenge of low health literacy, we believe that one major approach must involve equipping children and young people with better skills to understand their health and how to use the health care system. As we discuss later in Chapter 3, we believe that a healthy start to life is a vital investment in working towards a healthier population. Investment in the health of children and young people (and their families) should include a focus on health promotion to encourage good nutrition and healthy lifestyles. We further believe that this approach needs to be extended to promote better health literacy.

59 Health Care Consumers' Association of ACT (2008), Submission 89 to the National Health and Hospitals Reform Commission.

60 Agency for Healthcare Research and Quality (2004), Literacy and health outcomes: Evidence report/Technology Assessment No. 87, at: <http://www.ahrq.gov/downloads/pub/evidence/pdf/literacy/literacy.pdf>

61 The analysis in this section is based on: Australian Bureau of Statistics (2008), Australian literacy and life skills survey: Summary results, at: [http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4228.02006%20\(Reissue\)?OpenDocument](http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4228.02006%20(Reissue)?OpenDocument)

Figure 1.8: Many Australians lack basic general literacy and health literacy skills



Source: Australian Bureau of Statistics (2008), Australian literacy and life skills survey: Summary results, at: [http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4228.02006%20\(Reissue\)?OpenDocument](http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4228.02006%20(Reissue)?OpenDocument)

Note: This is based on the proportion of the population who are classified as having only Level 1 or Level 2 literacy skills and do not meet the minimum standards required for everyday life and work.

Reform direction 1.10

We propose that health literacy is included as a core element of the National Curriculum and that it is incorporated in national skills assessment. This should apply across primary and secondary school.

An expanded focus on health literacy in our schools was supported in a number of our submissions. CHOICE argued for a similar approach to be adopted for health literacy as has occurred with financial literacy.⁶² In 2006, the Commonwealth Government provided \$21 million to establish the Financial Literacy Foundation to undertake research and develop programs to raise the level of financial literacy. The Understanding Money website allows people to take a ‘financial health check’ and develop budgets.⁶³ Another element of the foundation’s program is working with schools so that financial literacy is included in the curriculum from Kindergarten to Year 10 from 2008. It is difficult to argue that our physical and mental health should not be at least as important as our financial health, even in a time of international financial instability.

62 CHOICE (2008), Submission 63 to the National Health and Hospitals Reform Commission.

63 Understanding Money, at: <http://www.understandingmoney.gov.au/>

There is a need for life-long learning to support people in making informed choices about their health

■ While early education and skills development on health literacy is vital, we also recognise that there is a need for life-long learning to support people in making informed choices about their health. Information overload may be a truism, but it also reflects how many of us feel when confronted with the difficult task of finding the 'right' information to help us make decisions about our health and use of health services. Through our submissions and consultations, we learned of many valuable information sources and tools that can help people access and use high quality health information including:

- The National Breast and Ovarian Cancer Centre⁶⁴ provides an online risk calculator that 'translates the evidence about risk factors for breast cancer into a meaningful tool for individuals'. Women answer a series of questions to better understand their personal risk of breast cancer and lifestyle choices that they can make to reduce their risk.
- Lab Tests Online Australasia⁶⁵ provides peer-reviewed information that is targeted to consumers about the purpose of hundreds of pathology tests including what tests are used to diagnose particular conditions. For example, consumers can find detailed information about cholesterol testing, including how the test is done, what the findings mean and treatment and lifestyle change options.
- The Media Doctor Australia website⁶⁶ has been developed by a team at the University of Newcastle to improve the accuracy of medical news reporting. The site assesses current news items about medical treatments, presenting examples of good and bad coverage, using a robust rating scale with the aim of improving 'journalistic practices in reporting new medications and treatment in Australia'.

Many non-government organisations also offer high-quality online information related to particular diseases, such as heart disease, diabetes or cancer. The Commonwealth and state governments also provide access to reliable health information, often on specifically tailored consumer sites, and sometimes facilitate access to people whose first language is not English.

It would be naïve to assume that the vast array of potentially valuable information about health on the web could be organised and navigated through a single site. There are so many diverse needs for often highly specific information and so many groups able to contribute to providing, filtering and interpreting health-related information. Health information is everybody's business, in the same way that health is everybody's business.

We recognise that there are many channels by which people continue to learn and acquire information on health throughout the course of their lives. These include online resources, friends and family, the media, their GP and other health care professionals, community groups, private health insurers, and governments. Each of these has a role to play in ensuring that people have access to the best possible information to make healthy choices.

Reform direction 1.11

We encourage all relevant groups (including health services, health professionals, non-government organisations, media, private health insurers and governments) to provide access to evidence-based, consumer-friendly information that supports people in making healthy choices and in better understanding and making decisions about their use of health services.

64 National Breast and Ovarian Cancer Centre (2008), Submission 122 to the National Health and Hospitals Reform Commission. The online risk calculator is at: <http://www.nbocc.org.au/risk>

65 National Coalition of Public Pathology (2008), Submission 123 to the National Health and Hospitals Reform Commission. The online pathology test information site, customised for Australia, is at: <http://labtestsonline.org.au/>

66 The Media Doctor Australia, at: <http://www.mediodoctor.org.au/>