Health Promotion and Illness Prevention

Policy Position Statement

Key messages

1. Health promotion and illness prevention saves lives and money and delivers the best public return on investment in health.
2. Australian investment in health promotion and illness prevention has progressively declined and lags comparator countries.
3. Our future investment should reflect the best available evidence on how to tackle the underlying causes of ill-health and inequity.
4. This will require investment in multi-sector programs that engage public, private and non-government organisations within and beyond the health sector.
5. Investment should be sustained, at a scale and proportionate to the level of need.

Key positions

1. Appropriate funding, implementation, monitoring and evaluation of the Australian government's (draft) National Preventive Health Strategy is required.
2. Overarching, strategic government leadership for health promotion and illness prevention beyond a focus on specific topics or particular diseases is essential.
3. A target of 5% of health expenditure by all Australian governments should be directed to health promotion and illness prevention.
4. Health promotion and illness prevention workforce planning, training, professional development and registration (through the International Union for Health Promotion and Education National Accreditation Organisation) is required.

Audience

Federal, State and Territory Governments, policy makers, program managers, AHPA and PHAA members and the media.

Responsibility

AHPA and PHAA Boards

Date adopted

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AHPA and PHAA affirm the following principles

1. "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[1] Health is "a resource for everyday life, not the objective of living... a positive concept emphasizing social and personal resources, as well as physical capacities".[2]
2. The determinants of health and wellbeing and inequities in health include socio-economic, cultural, commercial, political, ecological, working and environmental conditions.[3,4] Early childhood development, social and community networks, psychosocial factors, access to quality health care programs and services and biomedical factors also impact on the health of individuals and populations. Individuals' health practices are directly and indirectly affected by social and economic contexts, which can both cause and compound poorer health outcomes.[5]
3. Addressing the interconnected determinants of health requires a multi-sector and whole-of-system response involving public, non-government organisations, universities and research institutes and the private sector. Partnerships based upon co-design and co-benefit are required.
4. Strategies that focus on the whole population as well as groups at risk/vulnerable to poor health are required. Supporting and empowering those whose life circumstances lead to social disadvantage (e.g. economic insecurity, lower levels of education, experiences of stigma, racism and other forms of discrimination, intergenerational poverty) is critical.
5. Effective health promotion and illness prevention requires multiple complementary evidence-based strategies. These include health promoting policies (such as strengthened legislation, regulatory, and fiscal measures), the creation of health promoting environments, community engagement and action, support to empower people to increase awareness and control over their health and ensuring person-centred health.[2,6]
6. Investment in health promotion and illness prevention needs to be sufficient, consistent and coordinated.
7. Strong leadership and governance by governments at all levels, private and non-government organisations, communities and the public are essential. The health sector needs to take a system enabler role and work collaboratively alongside other sectors.
8. A trained, skilled and supported workforce is required.
9. Evidence, research, evaluation, quality data and monitoring are crucial enablers of the system.

AHPA and PHAA note the following evidence

Many health problems are preventable

10. Overall Australians have generally good health.[5] Yet serious problems exist within our society. Currently almost half of Australians have at least 1 of 10 selected chronic conditions including arthritis, asthma, back pain, cancer, cardiovascular disease, chronic obstructive pulmonary disease, diabetes, chronic kidney disease and mental health conditions and osteoporosis).[7] These conditions contributed to 89% of deaths in 2018, 61% of the total disease burden and 51% of hospitalisations in 2017-18.[5]
11. Many of the health problems affecting the everyday lives of individuals and their families are associated with a common set of contributing physical and social factors. Much current and future projected burden of disease is preventable through effective health promotion and illness prevention policy and practice.[6]
12. Good health is not evenly distributed across the population. Some demographic groups experience disproportionate burden of disease leading to differences in health, wellbeing and longevity. These groups include the following communities: Aboriginal and Torres Strait Islander people, culturally and linguistically diverse communities, LGBTQIA+ groups, people with mental illness, people of low socioeconomic status, people with a disability, and rural, regional and remote communities. Chronic condition rates in Australia also follow an equity gradient, and this gradient is becoming steeper (i.e. more inequitable) over time.[8]
13. Poorer health outcomes are particularly apparent in the Aboriginal and Torres Strait Islander community. While the death rates for young Aboriginal and Torres Strait Islander children has declined (1998 - 2018) significantly there is still a gap and the gap in life expectancy has had only a small reduction. Participation in high quality childhood education is critical. Enrolments in preschool education are increasing but school attendance and reading and numeracy gaps persist. More positively, participation in post-secondary education is almost double the proportion of 2002[9]. Chronic conditions such as ear disease, poor mental health and rheumatic heart disease persist. A higher proportion of Aboriginal and Torres Strait Islander households live in conditions that do not support good health.[10]
14. The health of people and of populations cannot be separated from the health of the planet, and economic growth alone does not guarantee improvement in a population's health.[11] Environmental conditions, including those caused by climate change, and notably the increased occurrence of natural disasters, are key drivers of public health outcomes and intergenerational inequity.[4,12]
15. Political decisions have a significant impact on population health outcomes. Government policies impact on economic and social inequities and shape unhealthy living and working environments. They often fail to address inequities of age, gender, race, ethnicity, disability, sexuality, education, and occupation. Health promoting political choices are urgently called for in the face of the many complex, existing and emerging challenges to health and wellbeing in countries and globally, including rapid urbanisation, climate change, pandemic threats and the proliferation of unhealthy commodities.[13]

Evidence-based approaches to promoting health and preventing illness

16. Decades of experience and evidence clearly demonstrates that health promotion and illness prevention are achieved most effectively through a whole-of-systems approach. Initiatives which involve a multi-sectoral and multi-faceted approach generally produce the greatest benefit and are most cost-effective.[14,15] It is essential to ensure comprehensive and coordinated strategies are sustained at sufficient levels to produce improvements over the long term. The places where Australians live, learn, love, work, play and age should be environments which support health. Built, social, natural and economic environments should all be the focus of health promotion action.
17. Individuals and communities, especially those more at risk, need support to be healthy. The COVID 19 pandemic has reinforced the importance of a focus on the whole population and those at higher risk. Proportionate universalism involves the implementation of universal interventions that are implemented with a scale and an intensity that is proportionate to the level of need.[16]

18. Evidence-based and innovative programs and services developed benefit when developed in partnership with communities and individuals with lived experience. Co-design builds skills and knowledge, supports health literacy and can positively influence attitudes and behaviours. It can strengthen communities and enhance positive social norms. Health communication strategies that enable dialogue and development of shared meanings are more likely to be effective, compared with unidirectional transmission of information. Local government, non-government agencies and community groups are important partners in implementing these strategies.[17,18]
19. Nanny state' arguments, often by opponents of government action and with vested interests, undermine efforts to promote health and prevent illness, particularly those based on legislation and regulation.[19]

Health promotion and illness prevention are effective

20. Effective health promotion and illness prevention interventions have been shown to improve health outcomes in both the short and long term.[20] Evidence to support this has emerged across multiple areas of health promotion and illness prevention practice, including in the areas of smoking cessation, cardiovascular disease prevention, dental caries, periodontal disease, child injury, road safety, sudden infant death syndrome and HIV.[14,21]
21. Investment in public health interventions is highly cost-saving [22] and cost-effective[23]. The evidence comes from controlled trials and well-designed, rigorous observational studies. Some health promotion and illness prevention activities have been found to be cost-saving, but most generate flow-on benefits – such as reduced burden on health care – which provide positive returns for public investment.[15,24,25,26,27]
22. Such interventions contribute to national economic and social productivity by increasing the number of years that Australians remain in good health.[20,28,29] Better health, wellbeing and equity will enhance Australia's social and economic progress and can contribute to reduced absenteeism and presenteeism.[23]

Investment and enablers

23. Australia has a strong – yet intermittent – history of action to promote health and prevent illness.[30] However in recent times Australia is slipping behind its OECD (Organisation for Economic Co-operation and Development) counterparts, with investment now much lower than the OECD average.[24,31] Investment is one critical enabler. Although it is difficult to reliably compare spending levels, it is clear that Australia spends considerably less on prevention and public health than Canada, the United Kingdom and New Zealand. In 2017 out of 31 OECD countries providing data Australia was ranked 16th for per capita expenditure on prevention and public health, 19th for expenditure as a percentage of gross domestic product (GDP), and 20th for expenditure as a percent of current health expenditure.[24]
24. A range of enablers are necessary to mobilise a health promotion and illness prevention system.[32,33] Leadership and governance are key enabler to address the determinants of health through strategic and coordinated whole-of-government responses. Health In All Polices is a recognised approach to addressing the determinants of health and is being implemented globally to drive multi-sectoral action, including to address the UN Sustainable Development Goals.[34] Other mechanisms include ensuring health promotion and illness prevention representation on whole-of-government committees, cabinet committees and on health portfolio executive committees.
25. A well trained and resourced health promotion and illness prevention workforce is also essential. Specialist health promotion practitioners work in agencies such as health promotion teams, hospitals and community health services, as well as in non-government agencies and local government. The health promotion and illness prevention workforce also include managers, researchers and evaluators working on health promotion issues within practitioner teams. In addition academia and clinical health professionals include health promotion and illness prevention as part of their work. Building and enabling this workforce requires workforce planning, supportive systems and infrastructure, standards, accreditation and ongoing training. Importantly, investment in undergraduate and postgraduate education courses ensure supply. Like other health professionals, registration of specialist health promotion practitioners in Australia, via the International Union for Health Promotion and Education, supports the quality and credibility of the workforce.[35]
26. Evidence, research, evaluation, quality data and monitoring are essential tools for ensuring support for an effective portfolio of health promotion and illness prevention programs and policies and require a strategic, comprehensive and ongoing approach including workforce capacity building.[36,37]

AHPA and PHAA seek the following actions

27. AHPA and PHAA note and strongly support the National Preventive Health Strategy (draft) and urge the Australian Government to adopt the Strategy and commit investment for its implementation, monitoring and evaluation.[38,39]
28. As a priority, the Australian Government progresses the National Preventive Health Strategy Leadership, and Governance strategies, including the establishment of an independent governance mechanism. The independent governance mechanism should include members with recognised broad based health promotion expertise.
29. All of Australia's governments commit to a target of at least 5% of annual health expenditure being directed to health promotion and illness prevention initiatives. Funding should be ongoing and stable over the long term, avoiding changing short-term programs.
30. The Australian Government adopt a whole-of-government multisectoral approach such as Health in All Policies and establish the necessary governance structures, mechanisms and processes to enable cross government collaboration to support the application of a health lens across public policy. All Australian state and territory governments should adopt similar whole-of-government multisectoral approaches to support the delivery of healthy public policy.[32,34]
31. Governments engage and support non-government sectors to recognise and maximise their potential to support good health and ensure their policies and services support the health of their staff and the broader community.
32. The Australian Government should commit 10% of the Medical Research Future Fund (MRFF) to health promotion and illness prevention population-level research, evaluation, knowledge translation, workforce capacity building, and research into the wider determinants of health and health inequalities.
33. There should be a comprehensive long-term strategy to measure and report on health promotion and illness prevention indicators, including regular Australian Health Surveys.[40]
34. Governments should examine models for organisational structures to evaluate the cost-effectiveness of health promotion and illness prevention interventions e.g. the National Institute of Health and Care Excellence model.[24] Governments and agencies should also include program evaluations into public health initiatives where appropriate.
35. Key decision-makers (policy actors) and practitioners actively engage with, and utilise, the high-quality evidence published in the Health Promotion Journal of Australia and the Australian and New Zealand Journal of Public Health to formulate and revise national health and social policies, programs and services.[41]
36. The health promotion and illness prevention workforce should be identified, recognised and registered (through the International Union for Health Promotion and Education National Accreditation Organisation) as an integral part of the health system with associated workforce support strategies.
37. Support AHPA and PHAA as peak bodies for the sector for their joint conferences and workforce professional development activities.

AHPA and PHAA resolve to

38. Advocate for the above steps to be taken based on the principles in this position statement.
39. Work with our membership to support workforce planning and professional development.
40. Undertake ongoing campaigns to address the negative impact of industry lobbying on the community's beliefs about the prevention of illness.
41. Encourage and support the registration of Health Promotion Practitioners through the International Union for Health Promotion and Education National Accreditation Organisation.

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Prepared with advice from the expert review panel

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