Response ID ANON-WK6N-8HEM-R

Submitted to **Consultation Paper for the National Preventive Health Strategy**
Submitted on **2020-09-28 14:30:04**

Development of the National Preventive Health Strategy

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Vision and Aims of the Strategy

4 Are the vision and aims appropriate for the next 10 years? Why or why not?

Vision and aims :
The Australian Health Promotion Association (AHPA) feels the vision and aims are broadly appropriate within the time frame though believe the reference to risk factors could be replaced with determinants of health (which in turn impact on risk factors). We believe the vision would be greatly enhanced by inclusion of a reference to building and strengthening the prevention system (as set out in the Mobilising a prevention system section).

In relation to the aims we make these comments:

Australians have the best start in life.
The life course perspective includes pre-conception and perinatal care, the first 12 months of life and intergenerational cycle. At a global level, the United Nations Sustainable Development Goals (SDG) recognise the interrelated nature of health and wellbeing including gender equity, education, and health across the life course (see United Nations. Sustainable Development Goals. https://www.un.org/sustainabledevelopment/). There is clear evidence to suggest a poor start in life sets a trajectory for poor health across the life course, and a good start in life sets a trajectory for good health across the life course. Early life is a product of the social gradient in health underpinned by the 'causes of the causes'; social, economic, cultural, commercial, political, working, and environmental conditions. These socioeconomic circumstances of people's lives act together to cause and compound (or improve) health outcomes for individuals, community's and population health. This includes factors such as psychological factors (e.g. resilience), access to quality health care programs and services and early childhood development. For example, evidence indicates investing in the early years of life and education would save more lives than would the current investment in medical advances. Children living in poverty grow up at greater risk of diabetes, heart disease and obesity and contribute to the burden of disease for government health care systems (see Binns, C., Howat, P., Barnett, L., Smith, J. and Jancey, J. (2017). Health promotion futures. Health Promotion Journal of Australia; 28: 175-177). The Strategy should reflect whole of government approaches which address 'upstream' policies to provide all Australian's with the opportunity for good early start in life through systemic changes to organisational practices aligned with healthy public policy to enable easy healthy choices (see Smith, J., Crawford, G. and Signall, L. (2016). The case of national health promotion policy in Australia: where to from here? Health Promotion Journal of Australia; 27: 61-65). The Strategy's aims should clearly identify early life stages to ensure targeted early interventions at critical and sensitive periods across the life-course.

Australians live as long as possible in good health.
Promoting good health and preventing illness requires consideration beyond risk factors and chronic disease (see Smith, J. and Herriot, M. (2017). Positioning health promotion as a policy priority in Australia. Health Promotion Journal of Australia; 28: 5-7). There is a plethora of evidence indicating health is significantly affected by factors outside the health sector (housing, transport, the environment, education and employment) and impacts on people's ability to make healthy choices. To illustrate this, the health sector deals with the victims of traffic collisions but the best opportunities for preventing such collisions are situated in the transport sector, urban planning, and education sectors. Essentially, health is a product of social, economic, cultural and political determinants. Therefore, good health should be considered in the broader context of, for example, climate change, injury prevention, mental health, drug use, sexual health, health for hidden populations and access and equity. The Strategy should be more than a chronic disease policy and not reflect a narrow focus on 'healthy lifestyles', 'behaviours' and approaches driven by addressing 'risk factors'. This approach fails to recognise the complexity of the causes of ill-health and relies on people themselves to assume responsibility for their poor health and stigmatises individuals or communities. The Strategy should reflect an increased emphasis and action on the wide range of contextual factors which impact health outcomes. Improving the conditions in which Australian's grow, live, work and age can enhance health opportunities for everyone. This includes, for example, easy access to fresh affordable produce, good health literacy, good housing, access to health services, clean, safe places to walk, cycle, and play and universal quality, compulsory, free education. The Strategy's vision and aims should clearly identify the underlying social, economic, political, cultural and environmental determinants of health to ensure action addresses the context of people's lives.

Australians with more needs have greater gains.
All Australians, regardless of background, should be able to lead healthy and productive lives. To the Australian population's detriment, there has been too much focus on 'lifestyle' approaches to disease prevention. These old-fashioned approaches, such as health education 'messages', based on behavioural risk factor reduction, have limited efficacy and impact and do not reach the populations most at risk. For example, lower socioeconomic groups and culturally and

linguistically diverse populations and Indigenous populations. This third aim recognises existing inequities but we would encourage a more explicit focus on equity and underserved populations including Aboriginal and Torres Strait Islander health (see Smith, J., Griffiths, K., Judd, J., Crawford, G., D'Antoine, H., Fisher, M., Bainbridge, R. and Harris, P. (2018). Ten years on from the World Health Organisations Commission of Social determinants of Health: Progress or procrastination. Health Promotion Journal of Australia; 29: 3-7). The need to renew and extend efforts to close the gap on Aboriginal and Torres Strait Islander health is paramount. These efforts need to be led by Aboriginal and Torres Strait Islander people with strong support from all those committed to health promotion and public health and informed by the social determinants approach. This can be achieved by building a sustainable and secure Aboriginal and Torres Strait Islander health promotion workforce (see CS DH. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization: 2008. https://www.who.int/social_determinants/final_report/csdh_finalreport_2008.pdf). The Strategy's vision and aims clearly identify access and equity to all Australians to lead healthy and productive lives. The reference to 'personal circumstances' has a hint of individualising the problem and would be better omitted.

Investment in prevention is increased.
A commitment to funding and political will is fundamental to any successful strategic plan. Australia has a strong history of action to promote health and prevent illness. However, in recent times Australia is slipping behind fellow member countries of the Organisation for Economic Co-operation and Development (OECD). Although it is difficult to reliably compare spending levels, it is clear Australia spends considerably less on prevention and public health than Canada, the United Kingdom and New Zealand. By most measures, these countries are healthier and their overall health costs (per capita) are lower than Australia's. In 2017, 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 out of 31 OECD countries providing data.

Studies of the cost-effectiveness of health promotion and illness prevention interventions provide a strong case for increasing spending to improve the health of Australians. Investment is well below the level required to minimise the long-term costs associated with chronic conditions and the increasing negative impacts preventable health problems will create in the future. To support implementation of initiatives, an investment in health promotion workforce including training and career structure, is needed. The Strategy should reflect a commitment to a 5% health expenditure target for health promotion and illness prevention initiatives and an investment in the health promotion workforce. Since public health programs typically require sustained effort over time to achieve their full effect, funding should be ongoing and stable over the long term, avoiding changing short-term programs (see Smith, J., Herriot, M., Williams, C., Judd, J., Griffiths, K. and Bainbridge, R. (2019). Health promotion: A political imperative. Health Promotion Journal of Australia; 30: 133-136). The Strategy's vision and aims should identify funding and ensure political commitment to monies for real change and better health outcomes.

Recognition of both illness and injury prevention is warranted.

Goals of the Strategy

5 Are these the right goals to achieve the vision and aims of the Strategy. Why or why not? Is anything missing?

Goals :
AHPA feels the goals achieve the vision and aims broadly but think there are some key ideas missing in the Strategy. The Strategy does not refer to climate change - despite this posing the "greatest health threat of the 21st century. Climate change poses significant immediate, medium term and longer term risks to the health of Australians and must be a central focus of the Strategy. Climate change affects health in many ways and is increasing the global burden of disease. The Strategy goals should highlight climate change as a priority to improve environments for healthy living.

As identified in relation to the Aims, a goal on strengthening the prevention system would be welcome. Other comments are as follows:

Different sectors, including across governments at all levels, will work together to address complex prevention challenges.
AHPA strongly supports this goal. Given the social determinants of health impact on the health and wellbeing of individuals and communities, and these determinants sit largely outside of the health sector, action to understand and address these determinants, and the resultant inequities, is essential and must involve multi-sector strategies. The health of the community overall and the marked social gradient in health is a result of the social determinants of health or 'causes of the causes' which include socio- economic, cultural, commercial, political, working and environmental conditions, as well as social and community networks (see CS DH. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization: 2008. https://www.who.int/social_determinants/final_ report/csdh_finalreport_2008.pdf). These factors act together to strengthen or undermine the health of individuals and communities (see Australian Institute of Health and Welfare. Australia's health 2018. Australia's health series no.16 AUS 221. AIHW. 2018). Individuals' health practices are also affected by social and economic circumstances, which can both cause and compound poorer health outcomes. Action across all levels of government is essential and across sectors other than health. Public, private and non-government organisations, as well as civil society, are essential partners in across sector approaches. Importantly, this action must incorporate policy responses to complex or 'wicked' problems, in addition to collaborative projects and programs. Problems such as the persistent marketing of proven unhealthy commodities, enduring inequalities and environmental degradation, will invariably require strengthened legislative, regulatory, and fiscal measures involving both health and other sectors.

Health In All Policies (HiAP, see: https://www.who.int/healthpromotion/frameworkforcountryaction/en/) takes a 'mutual gain' approach avoiding health imposing its demands on other sectors. It is a recognised methodology to addressing the determinants of health and is being implemented globally to drive multi-sectoral action, including to address the UN Sustainable Development Goals. Other mechanisms include ensuring health promotion and illness prevention representation on whole of government committees, cabinet committees and on health portfolio executive committees. COVID has shown how health can work effectively with a range of sectors for health and wellbeing protection. This approach does require resourcing including a skilled workforce and funding for initiatives.

Prevention will be embedded in the health system
The health system is an important player in a systems approach to promoting good health and preventing illness. Whilst the main focus for AHPA is the health of the population and groups at risk, we support a goal that actively promotes the wider responsibilities of the health care system in health improvement. Access to, and the quality of (e.g. youth friendly, culturally appropriate) health care services are important determinants of health and wellbeing. We note initiatives overseas (Ireland, UK) for the "making every contact count" approach which recognises that the daily interactions of health professionals with patients, families and carers provide multiple opportunities to support individuals with their health and social issues and offer illness prevention advice (see

http://www.makingeverycontactcount.com). This is particularly the case for those who are more vulnerable and may have reduced access to health information.

Further, as key opinion leaders in the community, health services and health professionals can be strong advocates for policies and strategies to promote good health and prevent illness and injury (for example health professionals helped set standards for safer hot water temperatures to prevent burns). And, as a major employer, health services take responsibility for improving the health and wellbeing of their own workforce, have the opportunity to create healthy workplaces and can implement healthy procurement services. In many jurisdictions such as Ireland, Wales and NZ, health authorities are requiring the inclusion of health and wellbeing objectives in health service plans, and leading efforts to embed prevention, early detection and models of self-care for people living with chronic conditions into all aspects of clinical care and programs. In Scotland, legislation to implement health and social care integration brings together NHS and local council care services under one partnership arrangement for each area. With a greater emphasis on joining up services and focussing on anticipatory and preventive care, integration aims to improve care and support for people who use services, their carers and their families. They will be jointly responsible for the health and care needs of patients, to ensure that those who use services get the right care and support whatever their needs, at any point in their care journey (see for example https://www2.gov.scot/Topics/Health/Policy/Health-Social-Care-Integration)

Aboriginal Community Controlled Health Services are fundamental in supporting the health and wellbeing of Aboriginal communities and operate consistent with this goal. They have a focus on prevention, early intervention and comprehensive care reducing barriers to access and unintentional racism and progressively improving individual health outcomes for Aboriginal people. They also play a significant role in training the medical workforce and employing Aboriginal people. Most recently, Aboriginal Community Controlled Health Organisations (ACCHOs) have demonstrated their capacity to deliver scientifically valid, evidence■based and culturally translated COVID■19 prevention messages (See Finlay and Wenitong https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7361256/). They must be in scope as part of this goal.

Primary health care providers also play a role in promoting health and preventing illness and reaching a large part of the population. Their work is relevant to the aims and goals and, for example, they are an important piece of the puzzle in reducing smoking through support for quitting along with services such as the Quitline

Environments will support health and healthy living

Effective health promotion and illness prevention are underpinned by partnerships and involve multiple complementary strategies all of which are important and interrelated. This includes policies, community action, partnerships between funders and providers, support for individuals to make healthier choices easier and the creation of health promoting environments. 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. The place based approaches supported through several states under the National Partnership Agreement on Preventive Health, and similar programs, illustrate the opportunities to influence these environments with a focus on different age groups (e.g. healthy ageing), health issues (e.g. encouraging physical activity or mentally healthy communities), different settings (e.g. child care services) etc. Importantly the intensity or 'dose' of effort needs to be sufficient to make a difference. 'Weak prevention', with insufficient intensity of effort and no coherent approach, should have no part in this national Strategy. All health agencies should be health promoting workplaces and all policy levers should be enabled to encourage this. For example, health department grants should be tied to a commitment to ensuring a health promoting organisation. Governments should engage and support non- government sectors to better understand their potential to support good health and ensure their policies and services support the health of their staff and the broader community. AHPA would be pleased to see inclusion of these directions in the final strategy.

Communities across Australia will be engaged in prevention

The place-based focus of Goal 4 appears to have some overlap with the settings focus of Goal 3. Goal 4 could more strongly recognise the importance of:

• strong community empowerment and ownership of any health-related initiatives to enhance sustainable solutions
• an active partnership with communities in the identification and development of strategies that promote health building on community assets, capacity and willingness
• the need for cultural expertise and sensitivity in dealing with diverse communities including Aboriginal and Torres Strait Islander Peoples, marginalised groups, multicultural communities etc – the groups where health status is often poorer.
• Having a focus on empowering those whose circumstances (e.g. economic insecurity, lower levels of education, stigma and discrimination, intergenerational poverty) make them more vulnerable to poor health. Initiatives need to be responsive to and reflect local needs and contexts.

Individuals will be enabled to make the best possible decisions about their health

AHPA supports this goal which is consistent with the World Health Organization's 1986 Ottawa Charter for Health Promotion key action area Developing personal skills. However, there are several key risks to this approach:

• A very real risk of increasing inequities through universal strategies that are not supplemented by enhanced support for those at greater risk ('progressive universalism')
• There is strong evidence that social, economic and environmental factors are significant determinants of behaviours and health status (structural perspectives or structural factors) and that addressing individual responsibility, without due consideration of the structural factors, can be viewed as a naive approach.
• A focus on individual approaches can be part of an ethos of 'victim blaming' - blaming victims allows for avoidance of dealing with the social and environmental impacts on health and lifestyle behaviours, which often affect those who are most vulnerable.
• It risks becoming a focus of 'personal responsibility' rather than focussing on the change to a system and influence of the environment which the Strategy appears to be trying to achieve.

Individuals and communities, especially those more at risk, need support to be healthy. They need timely, clear and accurate advice and information about health and its broader determinants, healthy behaviours, self and family care, health systems and services and how and where to get help. Evidence-based and innovative programs and services developed in partnership with communities and individuals with lived experience can assist in increasing individuals' skills, attitudes and knowledge, support health literacy, influence attitudes and behaviours, build personal skills, strengthen communities, change social norms and address health risks. Health communication strategies that enable dialogue and development of shared meanings are more likely to effective, compared with unidirectional transmission of information. Many health promotion practitioners work with individuals and higher need groups to help them make the best possible decisions about their health. They also work tirelessly to ensure that policies and environments support good health for all. They work in broad range of sectors including health, education, welfare, environment, transport, law enforcement, town planning, housing and politics and are based in Government departments and agencies, universities, non-Government organisations, community-based organisations and groups, private companies and industries. This workforce is an

essential component of this, and indeed all goals.

Prevention efforts will be adapted to emerging issues and new science
AHPA supports the development and implementation of a contemporary, evidence-informed and well-resourced public health system for Australia to build capacity to effectively respond to ongoing, emerging and remerging infectious diseases, non-communicable diseases and their influencing factors. Continual consultation and engagement with relevant key agencies will provide timely advice on emerging trends.

In our recent letter to the Chief Medical Officer of Australia in response to the Localised Health Response plan AHPA supported the following proposed actions to be undertaken by relevant jurisdictions:
• Strengthen a formal surge plan for the public health response workforce.
• Review the ongoing structure of the public health units.
• Progress the national interoperable notifiable disease surveillance system project and prioritise appropriate interfaces.
• Establish a national training program for surge workforce.
• Better support the Communicable Disease Network of Australia, including shared costs.
• Prioritise enhancing the public health physician workforce capacity.
• Consider options for developing a formal public health workforce training program.

Climate change
Climate change affects health directly (via increased intensity and frequency of extreme weather) and indirectly (via worsening air quality, food security and water quality, spread of vector-borne, zoonotic, and infectious diseases, and declining mental health). These conditions contribute to an increased risk of infectious disease, cardiovascular disease, respiratory disease, asthma, allergies, mental illness, psychosocial impacts, violence, poor nutrition, injury, poisoning and death. The 2017, 2018 and 2019 Countdown reports from international medical journal The Lancet have documented the worsening health effects of climate change in Australia and across the world.[2] The 2019 report makes clear that as CO2 emissions continue to rise, adverse health effects “will most certainly worsen without immediate intervention”. The profound nature and scale of the impacts from climate change mean that climate action is the best opportunity we have this decade to promote human health and well-being. As an organisation that cares deeply about the health and wellbeing of the community, we would like to ensure the National Preventive Health Strategy focuses on tackling the most significant risk to positive health and wellbeing - climate change.

Mobilising a Prevention System

6 Are these the right actions to mobilise a prevention system?

Enablers :
It is pleasing to see the proposed focus on strengthening structures and systems for prevention. This is consistent with contemporary evidence from Australia and globally. Whilst we believe that these enablers are generally the right mix to mobilise an effective prevention system for Australia, we would like to reiterate a need for explicit targets and actions for each area. AHPA would like to highlight that any proposed benefits of the proposed Strategy will be realised only with clarity about what constitutes preventive health activity, who is responsible for carrying out the preventive agenda, how it is integrated and funded within the health care system and beyond, and how its outcomes will be measured and evaluated. The enablers are largely consistent with calls made in our previous submissions to government and in our policy documents and these have been used again to frame our comments here. We refer you to the Health Promotion and Illness Prevention Position Statement endorsed by the Australian Health Promotion Association (AHPA) and the Public Health Association of Australia (PHAA) (see: https://healthpromotion.org.au/images/Health_Promotion_and_Illness_Prevention_Policy_Statement_.pdf). The Position Statement was informed by a Background Paper which provides useful evidence to support systems based action for illness prevention and health promotion (see: https://healthpromotion.org.au/images/Health_Promotion_and_Illness_Prevention_Background_Paper_draft.pdf).

Comments on workforce
As noted workforce is critical. A workforce able to meet the challenges of a rapidly changing health landscape requires resilient systems, strong leadership, sustained investment and wide-ranging partnerships. As expected at this time there is little detail as to the way in which the illness prevention and health promotion workforce will be considered in the Strategy. As noted in the consultation paper, the capacity and capability of the illness prevention and health promotion workforce, both current and emerging, will be integral to achieving success. We would like to expand on these points.

To achieve a coordinated prevention system and improved population health, planning needs to occur to ensure a workforce for the future is trained, skilled and supported to meet the increasing demands. A sufficiently sized and skilled workforce is required to achieve illness prevention and health promotion targets and ultimately, positive health outcomes for the community. Any new efforts in the Strategy around workforce should not re-invent the wheel but capitalise on the capabilities, strengths and expertise of the existing specialist infrastructure and capacity for the illness prevention and health promotion workforce and only then develop strategies to build overall capacity for primary, secondary and tertiary prevention within and outside the health sector.

It is important to recognise that there is an Australia-wide infrastructure of health promotion and public health teams with expertise in this field that are part of state and territory health systems. This expertise, including those who deliver programs in communities, should be acknowledged. The Strategy will need to work with state and territory governments, which fund and/or manage the bulk of public health, health promotion and community health programs, and who have appropriate skills and experience. National efforts to expand prevention efforts should work with these teams.

Despite a stated need for workforce capacity building, barriers exist to practitioners initiating and maintaining a career in illness prevention and health promotion. Several workforce reviews have been completed nationally, though none recently (see for example: Ridoutt LPV, Lee K. Final report aboriginal health worker profession review. Sydney: Department of Health and Families; 2009; University of Sydney. Mapping the preventative health workforce ■ overview report. Sydney, NSW: University of Sydney Business School; 2014; Gadiel D, Ridoutt L, Lin V, Shilton T, Wise M, Bagnulo J. Audit of the preventive health workforce in Australia: Final report of project findings. Sydney: Human Capital Alliance; 2012.). Key findings from these reviews suggest difficulties in defining workforce boundaries; recognition of the need for greater collaboration within and across sectors; the impact of limited funding; the need for improved workforce development and training and defined and dedicated career pathways. The literature also highlights the challenges of quantifying the public health, illness prevention and health promotion workforce, particularly with no mandated requirement for registration of practitioners and fairly recent inroads towards self■regulation (see: Jones■Roberts A, Phillips J, Tinsley K. Creating a sustainable health promotion workforce in Australia: a health promoting approach to

professionalisation. Health Promot J Austr. 2014; 25: 150– 2.). Findings tend to suggest that the illness prevention and health promotion workforce is highly multidisciplinary with porous boundaries into other sectors. The heterogeneity of the areas of work undertaken across the prevention spectrum presents a range of inherent challenges, including adequately monitoring sector needs, and measurement of individual and collective impact of programs on health outcomes. National individual registration of health promotion practitioners and accreditation for university courses is relatively recent, and historically, inconsistent application and use of core competencies for practice both with job roles and university courses have been reported.

Findings often suggest a number of categories in which the illness prevention and health promotion workforce is divided: leaders/champions, the direct workforce (researchers, practitioners and policy makers) and the indirect workforce (whose roles indirectly impact on illness prevention and health promotion outcomes but who may not identify with the workforce per se). Critically there a core of practitioners who report that they identify as illness prevention or health promotion specialists (those who had specific qualifications or registration in or whose whole role focuses on these areas). However, due to classification difficulties and the significant influence of the non■core or indirect components of the workforce, size is difficult to accurately enumerate. Having an agreed definition of the illness prevention and health promotion workforce is critical. Commissioning new research to quantify and describe the characteristics of the current and future illness prevention and health promotion workforce will be critical to effective implementation of the Strategy to assist with workforce planning and capacity building. AHPA have specific expertise in this area and request inclusion in any work in this area.

Findings from some workforce reviews have highlighted that a large proportion of the workforce indicate a focus on working with priority populations including Aboriginal and Torres Strait Islander people and in regional and remote areas. This provides a timely reminder for a need for effective interventions for specific groups, such as Aboriginal and Torres Strait Islander people and individuals in remote or regional areas to improve health equity. Some of these issues cannot be addressed easily without systemic consideration of workforce planning and resourcing. The establishment of stronger partnerships with the non■core components of the workforce to address gaps in service, particularly in areas lacking stable, experienced staffing may ameliorate some of these issues. Any strategies must include action to increase the number of Aboriginal and Torres Strait Islanders in the health sector workforce in general and the health promotion workforce in particular. Supporting Indigenous people to have access to quality education will increase future employment opportunities within the health and other sectors and is essential for enhancing the focus on illness prevention and health promotion and to ‘Close the Gap’ (see: Wilkins A, Lobo RC, Griffin DM, Woods HA. Evaluation of health promotion training for the Western Australian Aboriginal maternal and child health sector. Health Promot J Austr. 2015; 26: 57–63; Rose MR, Jackson Pulver L. Aboriginal Health Workers: professional qualifications to match their health promotion roles. Health Promot J Austr. 2004; 15: 240– 284).

There are relatively few examples of transition to practice programs for new graduates or for those moving from other professions to practice in illness prevention and health promotion. Transition programs and graduate■specific positions feature heavily across other areas of health in Australia and globally, acknowledging benefits to both new graduates and organisations, including reducing staff turnover and promoting leadership. Support programs that develop required competencies, usually in the form of rigorous orientation and/or mentoring, have been shown to improve confidence and leadership, increase retention and provide an avenue to support and strengthen the workforce. Accordingly, there is a need to ensure graduates, and others new to illness prevention and health promotion are well supported in their transition into practice. One example of a program to build capacity and transition graduates from university programs into practice is the Western Australian Health Promotion Scholarships program (see response to question 8).

There is an illness prevention and health promotion specialist workforce and it is important to build its capacity. In most cases, this workforce provides the skills and experience within established infrastructure at the community level to implement any Strategy recommendations. The Health Promotion specialist workforce has evolved in practice in Australia since the 1970s and has developed alongside and in response to the international health promotion and broader new public health movement. Health promotion practitioners are employed by health departments, other government departments and local government, or health services or non-government organisations located in the community. There is also a significant network of self-employed consultants in Australia. They work as designated project managers, policy officers, advocates, education officers, community engagement practitioners, project officers, project consultants, evaluation and research officers and communication officers to name a few. All work with populations with the ultimate aim of improving health and reducing health inequities. Illness prevention and health promotion practitioners require a tertiary degree or equivalent, in health promotion or a relevant health or social science such as psychology, public health, nursing, medicine, communication, nutrition, sociology, epidemiology, social work, or education. This multidisciplinary base is one of the specialty workforce’s great strengths. Building this workforce requires workforce planning, supportive systems and infrastructure, standards, accreditation and ongoing training (see: http://apps.who.int/iris/bitstream/10665/93635/1/9789241506502_eng.pdf). AHPA has undertaken many years of work to explore systems to formally recognise the profession of health promotion. Formal definitions for health promotion exist along with a defined set of core competencies for health promotion practitioners. Registration of specialist health promotion practitioners in Australia, via the International Union for Health Promotion and Education (available at www.healthpromotion.org.au/our-profession/practitioner-registration) supports the quality and credibility of the workforce. Additionally, courses of study at the tertiary level can apply to become accredited, standardising expectations of health promotion graduates. Registration of Health Promotion practitioners in Australia provides an opportunity for funding organisations to ensure the illness prevention and health promotion workforce is competent to effectively implement strategies.

The health promotion and illness prevention workforce including specialist health promotion practitioners should be identified, recognised and registered as an integral part of the health system workforce. Associated workforce planning strategies should be developed (see: Smith JA, Gleeson S, White I, et al. Health promotion: essential to a national preventative health strategy. Health Promot J Austr. 2009; 20: 5– 6; Smith JA, Crawford G, Signal L. The case of national health promotion policy in Australia: where to now? Health Promot J Austr. 2016; 27: 61– 5).

To ensure a skilled illness prevention and health promotion workforce AHPA recommends that the Strategy supports:
• an internationally registered health promotion and prevention workforce through AHPA;
• the establishment of graduate programs and pathways;
• supported professional development and capacity building opportunities; and
• measurement of the size and scope of the public health, illness prevention and health promotion workforce.

AHPA is well placed to provide workforce capacity building, support for accreditation of practitioners and courses and guidance on the development of competencies for practice. Mentoring, national communities of practice, scholarships, leadership and governance training, health promotion fundamentals, evaluation and a thinker in residence form part of our suite of actions to support a robust workforce.

Information and literacy skills

The specialist illness prevention and health promotion workforce has considerable experience in co-design, participatory methods, community engagement and communications, particularly in working with priority populations. It must consider individual and environmental health literacy capacity and needs and must include a focus on basic literacy. Mobilising the community health promotion sector and a greater investment in community based health services including those for migrant groups would contribute to the stigma and discrimination experienced by many who feel unduly targeted by certain health messages, but also serve to ensure that communications account for the heterogeneity of target groups and differing communications wants and needs.
Better measures for health literacy are required and more frequent national data capture is needed. It goes beyond health information. Information on the factors that often cause stress in people's lives and create structural health inequities are important considerations. This means applying a health lens to information about housing, education, welfare, transport and employment. There is a need to support the role of the workforce, but specifically a culturally competent workforce that builds the capacity of affected groups to take on roles as peer educators and champions. Those from affected groups and priority populations should feature heavily in the design of any materials. Consistent with evidence-informed and ethical practice, materials should be based on theory and sufficiently tested and should support but not replace other strategies. Resourcing implications must be considered in relation to any strategies that may create greater demand for health services as a consequence of increased health literacy efforts.

As per the framework from the Australian Commission on Safety and Quality in Health Care (see: https://www.safetyandquality.gov.au/sites/default/files/migrated/Health-Literacy-Taking-action-to-improve-safety-and-quality.pdf), health literacy action must consider both individual health literacy and the health literacy environment:
• Individual health literacy is the skills, knowledge, motivation and capacity of a person to access, understand, appraise and apply information to make effective decisions about health and health care and take appropriate action. Consideration of an individual's multiple and intersecting identities, communities and cultures is critical (for example consideration of gender, sexuality, religion, ethnicity etc).
• The health literacy environment is the infrastructure, policies, processes, materials, people and relationships that make up the health system and have an impact on the way in which people access, understand, appraise and apply health-related information and services.

Culturally appropriate resources, information and services go beyond translation. Effective and consistent guidelines should be established for the development and evaluation of resources, policies and materials that build health literacy and are culturally competent (used in its broadest sense to account for intersecting cultures).

Health system action
Reorienting the health system towards illness prevention and health promotion requires more than embedding prevention in primary care or hospitals. A settings based has utility, and there are a number of excellent examples globally of the Health Promoting Hospitals and Health Services movement (which are worth of consideration) (https://www.who.int/healthy_settings/types/hospitals/en/). However it is likely that it is through implementation of Healthy Cities (see: https://www.who.int/healthpromotion/healthy-cities/en/), action on the Sustainable Development Goals, consideration of HiAP and action on the upstream causes of poor health and health inequities where real change will be achieved. Changes to the build environment, the regulatory environment, social policy and action on climate change are key. Consequently, given that the greatest impacts on health will be achieved through action outside the health sector, we would caution ascribing significant focus here at the expense of cross-sectoral action.

Too often, we have seen well-meaning strategies to get those in the health sector, particularly in clinical and health care roles, to do more prevention work with the ultimate outcome of pouring more money into tertiary care and little achieved by way of prevention outcomes. We note the many changes to structures supporting primary care in recent years and stability is important. We would suggest that any work in this space include careful consideration of the Primary Health Networks (PHNs) in relation to their ability to effectively support illness prevention and health promotion. As suggested by Russell and Dawda (2019) "Their focus is on healthcare, clinical services and general practice serving people who are unwell rather than a more expansive view of primary health care that includes the social determinants of health and preventive activities to deliver health and wellbeing." They also suggest that in relation to Aboriginal and Torres Strait Islander health, PHNs may not be fit for purpose, as they have been resistant to meaningful engagement with ACCHOs. There is a further suggestion that the funding model lacks acknowledgement of the importance of self-determination and cultural safety, critical to the operation of Aboriginal and Torres Strait Islander health organisations (https://apo.org.au/sites/default/files/resource-files/2019-02/apo-nid220956.pdf).

It has highlighted a critical need for reinvestment in community based health programs and services. Primary health care providers play an important role in supporting individuals to be healthy and to prevent, detect and intervene early in illnesses. There are many groups within Australia's public health workforce that have elements of primary prevention in their work, including, for example, Early Childhood Workers, Community Health Nurses, Allied Health Workers and GPs. These health professionals have important aspects of prevention in their work but this is not their core function. GPs expertise for example, is diagnosis of illness and treatment. They provide secondary prevention in the form of screening and brief interventions. However, their often reported heavy workloads assessing and managing patients, along with their current training and payment structure, limits their role in primary prevention. The main primary prevention workforce is outside of the GPs surgery and a focus beyond general practice to include the wide range of primary health care providers, including health promotion practitioners, is encouraged.

Action on illness prevention and health promotion must be made essential in the healthcare system. This includes increasing expenditure on illness prevention and health promotion programs and creating a long term plan for investment. We note that many of the enablers are supported by a range of research including from Wutzke and colleagues (2017) who provide a roadmap for effective action on chronic diseases: refocusing the health system to prevention over cure, raising the profile of public health with health decision-makers, funding policy- and practice-relevant research, improving communication about prevention, learning from both global best-practice and domestic successes and failures, increasing the focus on primary prevention, and developing a long-term prevention strategy with an explicit funding commitment (see: 10.1186/s12961-017-0231-7). Identifying and implementing cost effective illness prevention and health promotion investments at scale can improve the efficiency of the Australian health care system, reducing expenditure related to health care for chronic diseases (see: https://www.pc.gov.au/research/ongoing/report-on-government-services/2015/health/primary-and-community-health). Specifically, the Strategy should encourage those in the health system to focus a greater proportion of their efforts to tackling the social determinants of health rather than developing or administering costly medical interventions to prevent or treat chronic illness.

Partnerships
Collaborative approaches to addressing health needs can facilitate improvements. Consequently, health needs to be 'everybody's business'. It makes sense to enlist the commitment and hold to account all sectors of government to act collaboratively. The health sector cannot be expected to lead on this alone. Government must be a champion for the health of its people. Decades of experience and evidence clearly demonstrates that illness prevention and health

promotion are achieved most effectively through a whole-of-systems approach. Initiatives which involve a multi-sectoral and are multi-faceted generally produce the greatest benefit and are most cost-effective and involve public, private and non-government organisations within the health sector and with links to sectors other than health. The interconnectedness between the determinants of health (including commercial, political, environmental and social) requires strong and effective action by governments and societies.

Governments at all levels should commit to addressing the social determinants of health through strategic and coordinated whole-of-government responses. An integrated and intentional policy response across portfolio boundaries can enable the government to address the determinants of health in a systematic way.

More than lip-service must be paid to collaborative and partnership approaches within and outside the health sector. Bringing the appropriate groups to the table, including those from the community is critical. Establishment of citizen platforms for engagement with illness prevention and health promotion would be a good investment. This includes citizen community and consumer feedback groups to hold practitioners, policymakers and researchers to account over the distribution of funding and decision-making. Support for the establishment of research-policy-practice-community partnerships and funding to support a strong civil society would be valuable along with support for community coalitions to take action on issues of local concern using models such as Parent's Voice or local drug action groups.

Leadership and governance

It is time that funding and governance is ring-fenced for prevention. We need strong, independent institutions and financing and decision-making mechanism. Overarching national leadership in illness prevention and health promotion has waxed and waned in Australia over recent decades. When such overarching leadership has existed, it has proved to be vulnerable to political shifts and funding uncertainty. Protecting illness prevention and health promotion strategies and initiatives against the vagaries of political cycles is essential to harness future social and economic benefits. The absence of an independent national illness prevention and health promotion agency in Australia has severely slowed progress in addressing chronic diseases; reduced the status of illness prevention and health promotion efforts and success; and limited approaches to illness prevention and health promotion.

We recommend the establishment of an illness prevention and health promotion leadership structure/mechanism to establish strategic directions, prioritise actions and allocate resources. AHPA strongly supports the establishment of an adequately funded national illness prevention and health promotion agency to provide support structure for illness prevention and health promotion policies and infrastructure (education, research, capacity building, coordination etc) and fund and guide the implementation of the Strategy. This agency or mechanism should have clear responsibilities to promote health, reduce health inequity and to keep illness prevention and health promotion high on the political agenda. Illness prevention and health promotion requires visibility and status at the highest level of health governance within each Australia government.

At the least, this function needs to be supported within the Department of Health. Better still, such an entity could use a Centres for Disease Control (Prevention and Health Promotion) model with ring-fenced, long-term investment and sufficient research and evaluation support. Many comparable international bodies have been refocused or grown to not only focus on communicable disease control, but on prevention of non-communicable and preventable chronic diseases. For example, Public Health England, Public Health Wales and Healthy Ireland have integrated approaches to health promotion, health protection and community care. In Australia there is Wellbeing SA and Health and Wellbeing Qld. Two states also have long standing Health Promotion Foundations which is another model for consideration (VicHealth and Healthway). These foundations are part of an international Network with models in Malaysia, Singapore, Thailand, Korea, Tonga and Taiwan. It has been suggested that health promotion funds or foundations provide strategic investment, sustainable finance and governance for preventing non-communicable diseases and reducing health inequalities. The recent COVID-19 crisis has also demonstrated a need for a Chief Health Officer in each jurisdiction who has responsibility for public health and illness prevention and health promotion and who will not become enmeshed in debates on hospital beds.

We are interested to know more about the quantum of funds to be allocated to support such work, noting that a range of scholars and practitioners have previously identified deficits in the implementation process associated with many health policies. AHPA urges a greater budgetary allocation to address illness prevention and health promotion challenges. As mentioned earlier, 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. Countries such as New Zealand, Canada and Finland allocate 6% of their health budget to public health activities. Unsurprisingly, by most measures, these countries are healthier and their overall health costs (per capita) are lower than that of Australia's (https://onlinelibrary.wiley.com/doi/full/10.1002/hpja.165).

Studies of the cost-effectiveness of illness prevention and health promotion interventions provide a strong case for increasing spending to improve the health of Australians. Investment is well below the level required to minimise the long-term costs associated with chronic conditions and the increasing negative impacts that preventable health problems will create in the future. The recent WA Sustainable Health Review has committed to an increase to 5% over the next 10 years (see here: https://ww2.health.wa.gov.au/-/media/Files/Corporate/general-documents/Sustainable-Health-Review/Final-report/enduring-strategies-and-recommendations.pdf). Shiell and Jackson have also undertaken recent modelling regarding how much Australia invests in prevention and suggest that there is a strong case for increased spending on prevention (https://onlinelibrary.wiley.com/doi/full/10.1002/hpja.165). Australia's governments should jointly commit to a target of 5% of health expenditure being directed to illness prevention and health promotion initiatives. Since public health programs typically require sustained effort over time to achieve their full effect, funding should be ongoing and stable over the long term, avoiding changing short-term programs.

Preparedness

We believe that preparedness is critical for Australia's public health. We would caution consideration as to how preparedness is considered and applied in the Strategy to prevent resource shifting or mission drift. We suggest that specific government plans for public health preparedness and associated actions and resourcing be identified and developed through national cabinet and referenced and supported here. The focus in this Strategy should be on impact (such as housing precariousness, poor mental health, food security, increases in alcohol and other drug use, barriers to employment and social security). We believe a focus on applying a health equity lens to our responses to large –scale emergencies is appropriate. This should go beyond COVID-19. Climate change, Aboriginal and Torres Strait Islander Health, homelessness etc are all examples of large-scale health issues that preparedness measures and a health equity lens must be applied to.

Research and evaluation

As per our previous correspondence we suggest that while disease prevalence, waiting lists and hospital separations are routinely counted and benchmarked–

the outcome and impact of illness prevention and health promotion programs is not routinely evaluated outside of the agency implementing an intervention. These evaluations are not always shared and are not used in the development of future interventions. This has consequences for understanding what works and why and where pilot programs have shown utility, implementing these at scale. Continuing to develop the evidence base for illness prevention and health promotion is critical.

AHPA would like to emphasise that our flagship peer-reviewed publication, the Health Promotion Journal of Australia (HPJA) provides an important source of evidence to guide a range of actions which will eventuate from the Strategy. AHPA is enthusiastic to explore options in commissioning a special issue of the HPJA on 'Prevention in Australia: ensuring no one is left behind', focusing on health equity and hidden and priority populations in collaboration with the Australian Government and other peak bodies with an interest in illness prevention and health promotion, if that is of interest. See more information about the HPJA here: https://onlinelibrary.wiley.com/journal/22011617 including a specially commissioned issue on prevention by The Australian Prevention Partnership Centre here: https://onlinelibrary.wiley.com/toc/22011617/2018/29/S1 with comments from many senior public health figures including Prof Paul M Kelly, Acting CMO for Australia: https://onlinelibrary.wiley.com/doi/10.1002/hpja.63.

AHPA trusts that the Strategy will recognise and take action on the paucity of research funding for illness prevention and health promotion and recommends the establishment of a parallel National Prevention Research Strategy. Although the evidence base on what works to improve the determinants of health and health inequity is growing, it needs further strengthening. There is growing recognition that individual interventions and programs take place within a complex system which must be considered in evaluation and research frameworks. Most health research funding is aimed at and favours biomedical issues rather than conditions which influence health. There has been an overreliance on randomised control trials as gold standard evidence which are costly and often difficult to implement in community based illness prevention and health promotion work. Further they are inappropriate to measure the effectiveness of interventions designed to influence social determinants of health. Evidence needs to be judged on fitness for purpose or in other words - does the evidence convincingly answer the question asked? Similarly targets for health outcomes particularly if they are behaviourally based in a community setting need to move beyond established hierarchies of evidence to more qualitative and contextual questions linked to systems that control, mould or direct individual and collective health behaviours. Estimates of progress towards health outcomes must be aligned along proxy or intermediate targets that inform progress towards the target.

Cost-effectiveness of interventions should be explored alongside the social impact of interventions and research. Research should have a strong focus on translation to policy and practice and should, at all times be designed in partnership with the community. The health system needs to fund training to support research and evaluation of health promotion initiatives at local, state and national levels to build a more robust evidence base to inform the development of health promotion programs and policies. There needs to be much more collaborative research and evaluation by academics and practitioners across disciplines. Such collaborations are important in connecting research, policy and practice, which is vital for cost effective illness prevention and health promotion.

We recommend committing 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. Governments should examine models for organisational structures to evaluate the cost-effectiveness of health promotion and illness prevention interventions such as the National Institute of Health and Care Excellence (www.nice.org.uk). Public health initiative commissioning governments and agencies should include program evaluations into public health initiatives where appropriate.

AHPA would also note its work developing a community health ethics model to support organisations without access to formal ethical oversight to engage in ethical approval processes for program implementation and evaluation. This work is also seeking to improve critical and ethical practice for the illness prevention and health promotion workforce of individuals. Such action could be further supported through the work of the Strategy.

Monitoring and Surveillance
Monitoring and surveillance is critical. It is more than data on risk factors and diseases, it is developing better indicators to measure progress against action on the determinants of health. This includes developing indicators to effectively capture health literacy, stigma and discrimination and overall measures of wellbeing. Research, evaluation and monitoring are essential tools for ensuring support of an effective portfolio of health promotion and illness prevention programs and policies and require a strategic, comprehensive and ongoing approach including workforce capacity building. We would support the development of a comprehensive long-term strategy to measure and report on health promotion and illness prevention indicators, including regular Australian Health Surveys.

Boosting Action in Focus Areas

7 Where should efforts be prioritised for the focus areas?

Boosting Actions:
AHPA is concerned that the broad statements in the Consultation Paper and the system-wide goals are contradicted by the narrow focus on biomedical and behavioural focus areas. These focus areas have received attention from federal and state governments for many years, and do not represent a new approach. The Federal Department of Health's website states the National Strategic Framework for Chronic Conditions, the National Obesity Strategy and the National Tobacco Strategy are being developed. Presumably, these strategies include components on illness prevention and health promotion and raises questions about the relationship between these documents.

AHPA strongly believes the Strategy should focus on the determinants of health rather than take a specific chronic disease prevention approach focusing on lifestyle behaviours and risk factors. This narrow focus fails to recognise the complexity of the causes and the compounding factors of poor health and assumes people have control to take responsibility for their own health. People should be empowered to take an active role in decisions to improve their health however there are many factors outside their control. There is a plethora of evidence to suggest health is significantly affected by factors outside the health sector. For example, housing, transport, the environment, education and employment. These broad contextualised environmental factors impact on people's ability to make healthy and healthier choices. The Strategy should resist calls to focus on risk factor, behavioural change and healthy lifestyles approaches made redundant by a lack of substantive empirical evidence. Population level changes require multiple interventions at individual, community, environmental and policy levels to improve poor health and promote good health. An alternative to disease-based focus areas is an approach based on people and places, populations, and the planet. This approach works across sectors (education, transport) throughout the life course (such as early childhood, youth, aged care) with a focus on the determinants of health (housing, education) and fosters the opportunity for whole of government response to emergent issues.

Other options for focus areas could include: working across sectors; action across the continuum and life course; action on the determinants and a responsive approach to addressing areas that emerge. Or indeed a focus on populations, planet, policies, places/environments and people.

Recognising there may be an imperative for a focus on these health areas, inclusion of strategies related to access to support change is encouraged e.g. in relation to physical activity
• Collaboration in health promotion and urban planning to increase access to parks and exercise infrastructure in communities, particularly lower socioeconomic areas.
• Public school sports programs from primary to high school, that is inclusive and values participation, not success.
• Creating safer spaces to increase physical activity: Infrastructure including streetlights, paths, housing proximity to parks and shopping centres.
• Public transport: decreasing fares for people on Centrelink or from lower socioeconomic areas to increase physical activity while walking to and from train stations/bus stops.
• Safer train stations with bike racks, lighting and security.
• Discounted gym memberships for people on senior concession or Centrelink.
• Remote and regional Australia: Increase access to sporting programs, health promotion physical activity programs, gym/sporting infrastructure.

Continuing Strong Foundations

8 How do we enhance current prevention action?

Continuing Strong Foundations:
The Strategy should recognise the public health context in which it is being implemented. The Strategy should build on previous illness prevention and health promotion strategies at the local, national and international level recognising the successes and failures of historical public health, illness prevention and health promotion policy. For example, there must be recognition that in a number of jurisdictions, there have been significant funding cuts to the public health workface which means that some level of re-investment is required along with building good will within a workforce that has been starved of resources. It should also make explicit reference to other relevant national strategies as well as global frameworks for health and wellbeing including the Lancet Commission on Climate and Health (see: https://www.thelancet.com/climate-and-health) and the Sustainable Development Goals (see: https://sdgs.org.au/). There are many lessons to be learned for example from the successful development and implementation of the national drug strategy and national HIV strategy which have achieved bi-partisan support over several decades. It is also important to recognise the intersecting challenges across a range of health issues that should not be considered in silo for example the relationship between mental health and sexual health and alcohol and other drugs, or the relationship between injury, alcohol and other drugs and mental health, or the physical health issues (including poor nutrition, oral health, overweight and obesity for those with mental health issue or those who are homeless).

AHPA supports the Strategy's intention to be responsive and adaptable but believe this should come with sufficient resourcing and monitoring. To see the impact of prevention takes time and the Strategy risks too many changes will not see a sustained positive impact to the health of the community. We agree the Strategy should build on previous successful and evidence-based prevention and health promotion strategies at the local, national and international level. For example, a strong partnership with central agencies has been shown to be beneficial to joined up policy delivery in South Australia through the application of the HiAP approach. Staff exchanges, 90-day change projects, high level leadership and support for across sector collaboration, networking opportunities and building skills for collaboration are all important enablers (see https://www.sahealth.sa.gov.au/wps/wcm/connect/b3625480407ed2b790e7f3deb8488407/SAH001-Working+Together+Joined-Up+Policy+Guide-FA-Digital.pdf?MOD=AJP
Several other successful programmatic examples based on systems and a social determinant approach include OPAL, Healthy Together Victoria and Healthy Active by Design.

It is important to note that the rollback of previous national funding led to cessation of extensive programs underway in a number of jurisdictions for illness prevention and health promotion with staff leaving and other supports folding including related programs. To build this capacity again will be challenging. There are considerable learnings from these programs and these should inform this Strategy. Two years is not sufficient to make a difference as it takes at least six months to set up such programs. Four years is required at a minimum. The workforce in many states has been significantly weakened and a period of renewal and investment in training and career structure will be needed. It is not certain that previous initiatives could easily resume and setting up an advisory process to inform how this will roll out is essential including key people from these former programs.

The Western Australian Health Promotion Scholarships Program provides an example of long■term investment in building capacity with potential for scale up and replication in other jurisdictions. The Program provides those new to illness prevention and health promotion practice a unique opportunity to be mentored by an experienced practitioner and develop their competencies which is increasingly important as the sector has now implemented practitioner registration. Further, it provides a means to transition new career practitioners to highly skilled and experienced practitioners with long■term careers in illness prevention and health promotion practice. The role of funding agencies in collaboration with professional associations in maintaining and investing in structures and systems to develop a well■trained and funded illness prevention and health promotion workforce can make a critical contribution to ethical, evidence■informed and effective practice. The scholarship program (the Program) commenced in 1993 through a collaboration between AHPA (WA Branch) and Healthway (the Western Australian Health Promotion Foundation). Initially, for university graduates, it expanded to include Aboriginal people interested in a career in health promotion in 2000. Four competitive scholarships are offered each year for recipients to conduct health promotion projects as part of a paid work placement (6 months full■time or equivalent part■time). Recipients develop and improve health promotion competencies under the supervision of an experienced health promotion practitioner who provides project management, health promotion mentoring and workplace navigation. Project activities and professional development are mapped to established health promotion core competency frameworks (initially those from AHPA and later the International Union for Health Promotion and Education, see: http://www.iuhpe.org/images/JC-Accreditation/Core_Competencies_Standards_linkE.pdf). The annual budget (currently less than $200,000 a year) includes funds for the recipients' wages, a small professional development budget, career mentoring and travel allowance (for rural or remote areas). More than one-third of recipients are Aboriginal and a large number of scholarship recipients have been placed in regional and rural locations, expanding the capacity of our illness prevention and health promotion workforce into areas of greatest need (see: https://onlinelibrary-wiley-com.dbgw.lis.curtin.edu.au/doi/10.1002/hpja.32)

Additional feedback/comments

9 Any additional feedback/comments?

Additional feedback:

Action on climate change and health

AHPA would urge explicit consideration of climate change in the Strategy. Addressing the health impacts of climate change through mitigation and adaptation strategies is one of the World Health Organization's top priorities - aimed at preventing the deaths of around 12.6 million people who die each year as a result of living or working in an unhealthy environment. The goal of the National Preventive Health Strategy should be to tackle the systems that undermine positive health and wellbeing. These include environmental, commercial and political determinants of health. As with junk food, pharmaceuticals, tobacco, and alcohol, it is critical that the role of vested interests in relation to climate change is identified as undermining efforts to prevent illness and promote health and wellbeing. This must be addressed as part of the National Preventive Health Strategy. These recommendations are consistent with international frameworks Australia is a signatory to, including the Sustainable Development Goals (see https://sustainabledevelopment.un.org/memberstates/australia), in which Good Health and Wellbeing and Climate Action are both recognised as key goals; and the International Covenant on Economic, Social and Cultural Rights in which everyone in Australia has the right to the highest attainable standards for physical and mental health. (The 'right to health' as outlined in the International Covenant on Economic, Social and Cultural Rights, to which Australia is a party, refers to "the right to the enjoyment of the highest attainable standard of physical and mental health." See: https://www.ag.gov.au/RightsAndProtections/HumanRights/Human-rights-scrutiny/PublicSectorGuidanceSheets/Pages/ Righttohealth.aspx It also includes (as outlined in the World Health Organization Constitution which Australia has ratified) "a system of health protection that gives everyone an equal opportunity to enjoy the highest attainable level of health." See: http://www.who.int/mediacentre/factsheets/fs323/en/). While any initiatives at the sub-national level are important, this is occurring in the absence of an overarching policy directive at the federal level. Leadership and action at the national level from the Commonwealth Government is vital. A National Preventive Health Strategy that is fit for purpose in the 21st century must address climate change - or it will fail in its objectives.

Consultation

As AHPA represents a workforce that is integral in implementing this Strategy we would like to be included in the Expert Steering Committee prior to the release of the Strategy. We also acknowledge that the term 'preventive health' now seems widespread but we would prefer health promotion and illness (and injury) prevention as they provide greater clarity.

AHPA believes the time allocated for consultation on the Consultation Paper has been insufficient to receive meaningful and well consider responses from the sector. We recommend the online consultation of the draft Strategy be open for a longer period of time to allow genuine consultation with the sector and for member-based Associations such as AHPA to undertake meaningful engagement with our members to provide a comprehensive response. AHPA has a membership of over 800 and this is a critical voice to capture for the development this Strategy.