Australian Health Promotion Association
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Australian Health Promotion Association

Submission to the Chief Medical Officer in relation to the *Role and Functions of an Australian Centre for Disease Control (Prevention-Promotion-Protection): Discussion Paper December 2022*

Contact for submission:
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The Australian Health Promotion Association

The Australian Health Promotion Association Ltd (AHPA®) is the peak body for health promotion in Australia. AHPA advocates for the development of healthy living, working and recreational environments for all people. It also supports the participation of communities and groups in decisions that affect their health. Incorporated in 1990, AHPA is the only professional association specifically for people interested or involved in the practice, policy, research and study of health promotion. Our member-driven national Association represents over 1000 members and subscribers. The Association is governed by a Board at the national level with operational branches representing all states and territories.

Membership of AHPA is diverse, and includes designated health promotion practitioners, researchers and students, as well as others involved in promoting physical, mental, social, cultural and environmental health, whose primary profession or area of study may be something different, but whose responsibilities include promoting health. Members represent a broad range of sectors including health, education, welfare, environment, transport, law enforcement, town planning, housing, and politics. They are drawn from government departments and agencies, universities, non-government organisations, community-based organisations and groups, private companies, and students.

Our activities include: national registration of health promotion practitioners for the International Union for Health Promotion and Education (IUHPE) in Australia; national health promotion university learning and teaching network; early career support; national and local conferences and events; a tri-yearly Population Health Congress (with partners: Public Health Association of Australia, Australasian Epidemiological Association and Australasian Faculty of Public Health Medicine); a website providing professional and membership information; a national listserv providing members with sector news, employment, advocacy and events information; stakeholder and member communication across a range of platforms; advocacy action; strong partnership working with a range of organisations; awards; traineeships; mentoring; scholarships and bursaries; and the Health Promotion Journal of Australia, which has a strong focus on health equity and participation by First Nations people.

Our Vision

A healthy, equitable Australia.

Our Purpose

Leadership, advocacy and workforce development for health promotion practice, research, evaluation and policy.

Our Principles

- Ethical practice - Supporting culturally informed, participatory, respectful, and safe practice.
- Health equity - Addressing the sociocultural, economic, political, commercial and ecological determinants of health in order to build health equity.
- Innovative and evidence informed approaches - Promoting and supporting evidence informed research, policy and practice.
- Collaboration - Working in partnership with other organisations to improve health and wellbeing.

Our Strategy

1. Promote the health promotion profession and our members
2. Advocate for health promotion
3. Build the professional capacity of AHPA members
4. Support career pathways in health promotion
5. Promote equity, diversity and inclusion
6. Provide responsible and sustainable governance and management

Detailed actions to achieve the strategy can be found in our Strategic Plan document.

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Health Promotion

Health promotion not only embraces actions directed at strengthening the skills and capabilities of individuals but also actions directed towards changing social, environmental, political and economic determinants or conditions that influence health and wellbeing, in order to improve individual, community and population and health. AHPA draws the basis of its health promotion action and its definitions from the World Health Organization's Ottawa Charter for Health Promotion (1986) and subsequent global charters and declarations: *"Health promotion is the process of enabling people to increase control over the determinants of health and thereby improve their health".*

AHPA strongly encourages the use of this definition to underpin descriptions of health promotion. Further, we respectfully ask that health promotion is used in full wherever mentioned rather than other terms such as health protection and promotion, and disease prevention for example. Health Promotion is both a discipline and profession and consequently contemporary perspectives and nomenclature are important. We encourage the use of descriptions from the Global Charter for the Public's Health in defining the functions and scope of health promotion and the other related functions of health protection and illness/disease prevention and public health more broadly.

Background

Australia is one of the healthiest countries in the world largely because of effective public health, including action to create and support the social and environmental conditions that enable Australians to enjoy a healthy and happy life. We are now more aware than ever of just how complex the circumstances are by which human health is influenced – policies and actions shaped by the unfair distribution of wealth, power and resources, both locally and internationally. We are also more cognisant of the range of skills and practices required to enhance individual and community capacity and act to address those forces that lead to health inequities - the unfair and avoidable differences in health status seen within and between countries. Health promotion's role has never been so significant.

Winslow (1920) defined public health as 'the science and the art of preventing disease, prolonging life and promoting physical health and efficiency through organized community efforts' (p. 30). Almost one hundred years later, the World Federation of Public Health Associations, supported by the World Health Organization (WHO), launched the Global Charter for the Public's Health, which highlighted the role of protection, prevention, and promotion, ('services') and governance, advocacy, capacity, and information ('functions') of in public health. The Charter called for resilient public health systems, in recognition of the fragmented nature of public health governance, funding, and leadership. The COVID-19 pandemic has amplified growing inequalities and the need for strong public health systems and structures, with sufficient investment to build the capacity of the public health workforce.

From: The Global Charter for the Public's Health

For more than 30 years, the Association has supported the health promotion service of public health (along with protection and prevention) and its related functions (governance, advocacy, capacity and information). AHPA welcomes the establishment of a national public health agency. We understand that the initial purpose of the entity is to improve pandemic preparedness and response, lead the federal response to future disease outbreaks, and work to prevent both non-communicable and communicable diseases. AHPA has advocated for a national, arms-length institution for public health for a number of years, including in its joint submission with the Public Health Association of Australia on the abolition of the National Prevention Health Agency.

We are delighted to provide the following input and insights into the purpose, scope, and functions of the entity to help shape an organisation fit for the future of public health.

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Functions of the CDC

1. What decision-making responsibilities, if any, should the CDC have?

Response: An Australian Centre for Disease Control (CDC) (or preferably for protection, promotion and prevention to recognise a more positive view on health, and/or Australian Public Health Agency) should come with ring-fenced, long-term investment and sufficient research and evaluation support to ensure accountability, sustainability and the greatest impact on the health of Australians. A national hub and spoke model is recommended, with consideration for and no duplication of the work undertaken by state and territory governments. The CDC should have decision making powers to ensure effective monitoring and response to public health emergencies as well as ongoing health promotion, health protection, and prevention activities. The CDC should have the ability to draw on evidence and provide information to community and also governments through national coordination to inform local decision-making.

We are supportive of the inclusion of the National Preventive Health Agency, however, would like to understand further the role and function of this within the CDC.

2. What functions should be in and out of scope of the CDC?

Response: The International Association of National Public Health Institutes suggests that the key functions of public health systems include investigating and controlling outbreaks; undertaking disease surveillance, detection and monitoring; laboratory science; research; analysis of health information to develop policy; health promotion and education; and workforce capacity building. The Association broadly agrees with this scope.

It was pleasing to see health promotion in scope as part of Table 1: Draft CDC functions in scope, however we have concerns about the understanding of what health promotion is, as the focus is 'guide and communicate', yet health promotion is much broader than communication. As outlined on page 3 of our submission, AHPA endorses the World Health Organization's (1986) definition of health promotion: *the process of enabling people to increase control over the determinants of health and thereby improve their health.* Health Promotion practitioners can effectively roll out evidence informed, tailored programs at scale. Health promotion as part of coordinated public health action, saves lives and money and delivers the best public return on investment for health.

Health promotion should be included as part of the initial focus of the CDC.

More information:

• What is health promotion? https://www.healthpromotion.org.au/our-profession/what-is-healthpromotion

• WHO's Ottawa Charter (1986) https://www.healthpromotion.org.au/images/ottawa_charter_hp.pdf

• Health Promotion Journal of Australia article The lazy language of 'lifestyles'

In addition to health promotion, the Association supports the following items outlined in Appendix B to be included in scope:

- Health workforce education and development
- Prevention
- Disease control
- Disease surveillance, evaluation, and data analysis

- Emergency preparedness and response
- Collaborating with research institutions and labs
- Expert advisory and guidance
- Design and implement national public health programs
- Provide preventive health and other specific research grants
- Biosafety and radiation protection (not my area of expertise to know)

There is a role in the CDC implementing a One Health framework, however in addition to this, there should be consideration for a broader ecological perspective and focus on planetary health.

Applying a health equity lens to all work including 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.

3. What governance arrangements should be implemented to ensure public confidence in the CDC?

Response: The CDC should play a central independent role at the federal level but work closely and collaborate with state and territory governments to allow for consistency across the nation and reduce duplication. A hub and spoke model with a central function, and local state and territory arms that are integrated into existing local jurisdictions systems is an option. This approach was outlined in a previous submission by AHPA and PHAA on the Australian National Preventive Health Agency (Abolition) Bill 2014. The organisational model for the CDC should be well planned with input from key stakeholders and government officials to ensure it is robust and fit for purpose and the future.

In Australia, some states have existing bodies with a focus on health promotion, health protection and community care (e.g. Wellbeing SA and Health and Wellbeing Qld). Two states also have long standing Health Promotion Foundations which is another model for consideration (ie. VicHealth, and Healthway). These foundations are part of an international network with counterparts in Malaysia, Singapore, Thailand, Korea, Tonga and Taiwan. Health promotion funds or foundations provide strategic investment, sustainable finance, and governance for preventing non-communicable diseases and reducing health inequalities. It would be important for the CDC to work closely with these existing bodies.

AHPA supports calls by partner organisations such as PHAA in its submission for this consultation that the CDC be organisationally structured as a statutory body with a CEO reporting to a Board and the relevant Ministerial department/s. In additional AHPA calls for selections for Board and CEO to be made with input from key federal and state/territory leaders in consultation with key public health and emergency experts. These positions should be filled by a range of health experts and some positions with financial and risk management expertise. The idea of collaborating centres (similar to the WHO model) would be worthy of further consideration (see submission from PHAA).

We recommend the workforce of the CDC be appropriately trained and include several specialist positions including health promotion. Where possible, health promotion roles should be filled by International Union for Health Promotion and Education (IUHPE) Registered Health Promotion Practitioners, as these practitioners meet the internationally recognised core competencies of health promotion. AHPA is the National Accreditation Organisation for IUHPE in Australia and can provide support to Government on workforce training for the core competencies.

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To ensure accountability, regular monitoring and reporting of CDC activities and budgetary expense should be made publicly available with the opportunity for review and feedback by sector stakeholders (see response to question 27).

More information:

• Health promotion practitioner registration, https://www.healthpromotion.org.au/our-profession/practitioner-registration

Why do we need a CDC?

A coordinated and national approach to public health

4. How can the CDC best support national coordination of the Australian public health sector?

How can the CDC ensure effective collaboration and exchange of information with relevant stakeholders, including engagement with the private sector?

Response: The CDC can support national coordination by:

- Fulfilling an independent advocacy function for Australia
- Working in partnership with national associations and peak health bodies including AHPA, to ensure activities are better connected, effective and efficient
- Providing strong leadership that responds to the Government's priorities and policies, including developing and monitoring key targets, in partnership with jurisdictions
- Working across Government portfolios, not just the health sector, to align to the social determinants of health principles and approaches
- Using a Health In All Policies (HiAP) approach. HiAP 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-19 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.
- Leading and coordinating key research and evaluation priorities that support all jurisdictions to deliver effective and evidence-based programs and policies.
- Judicious engagement with the private sector. Corporate influence and commercial interests are key contributors to poor health and should be removed from policy making processes where possible.

5. What lessons could be learned from Australia's pandemic response?

Response: The pandemic created an environment in Australia where there was rapid change in implementation, resourcing and redeployment of the public health workforce. This immediate action and response to the pandemic needs to be applied across all 'routine' activities.

In many jurisdictions, the existing health promotion and public health workforce were used to support these emergencies. Their involvement was beneficial as it drew on their broad and transferable skill set.

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However, we also observed that moving staff to surge roles had the knock-on effect of other health priorities getting put on hold, particularly in community facing roles which will have an inevitable impact on improving these outcomes (for example community mental health, tobacco control or nutrition programs). By redeploying the same workforce, it also has the unintended consequence of taking the workforce away from and out of their communities where relationships/trust has been established. For example, many members of the health promotion workforce who sit in community health and health services in Victoria were redeployed during COVID-19 which will likely have had a detrimental impact on health promotion work progress / quality / capacity, and the attractiveness of working in health promotion in these organisations. Anecdotally, members have informed AHPA that work individuals were redeployed to do did not take advantage of existing transferrable skills and capacities – work was often unskilled, mind numbing and, at times, risky (e.g. concierge, checking medical staff wore their PPE correctly). Many of our members have significant qualifications and skills that could be better utilised during such emergencies.

There are significant lessons to be learned from Australian responses to other public health issues such as HIV. Key to Australia's success was the combined action of affected communities, those with lived experience and clinicians working in partnership with government, public health and research. This long-established partnership response moved from a crisis response to a constant and continuously adapting response. Such partnerships that are engaged, politically active, adaptive and resourced to work across multiple social, structural, behavioural and health-service levels can be beneficial.

The health promotion profession plays a vital role in pandemics, including:
• Expertise in community facing roles implementing 'on the ground' programs alongside communities using community engagement processes.
• Understanding how to work with affected communities and privilege meaningful involvement by those with lived experience
• Planning and evaluation skills.
• Strong research and communication skills.
• Ensuring that considerations of health equity and social justice principles remain at the forefront of pandemic responses
• Innovative thinking and advocating skills
• Supporting development for national public health communication and other pragmatic measures that reach people most in need.

There is a critical need for pandemic surge workforce relating to mental health and wellbeing, community engagement and health/risk communication.
A workforce mentoring program appears to be an effective way of providing the surge workforce with support. See: https://www.phaa.net.au/documents/item/5257

If there were a CDC in place during COVID-19, the CDC could have overseen the development of national digital products, such as the COVID-19 app, to support Australians and jurisdictions could have diverted its resources into developing partnerships within their State to support and lead the development of appropriate messages and initiatives that motivated harder to reach communities. It is also important to note that some countries that did have a CDC function in place were criticised for being too slow to respond to the pandemic. It's imperative that if Australia set-ups a CDC it needs to be nimble to respond to communities and ensuring a mixture of public health experts are employed to ensure it is effective in its delivery e.g., community development officers, health promotion officers, data experts, etc.

See:

- Mobilisation, politics, investment and constant adaptation: lessons from the Australian health-promotion response to HIV, available here: https://www.publish.csiro.au/he/pdf/HE13078

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- COVID-19: Vulnerability and the power of privilege in a pandemic, available here: https://onlinelibrary.wiley.com/doi/full/10.1002/hpja.333
- Positive outcomes associated with the COVID-19 pandemic in Australia. available here: https://onlinelibrary.wiley.com/doi/10.1002/hpja.494

A data revolution

6. What are the barriers to achieving timely, consistent and accurate national data?

7. What existing data sources are important for informing the work of the CDC, and how could existing data bodies (national, state and territory) be utilised and/or influenced by the CDC?

8. What governance needs to be in place to ensure the appropriate collection, management and security of data?

9. How do we ensure the CDC has the technical capability to analyse this data and develop timely guidance?

Response: There are challenges with data linkage across federal and state/territory jurisdictions. A focus on improving the system and structures to ensure timely sharing of data is vital. How data is captured and analysed should also be reviewed to allow for accurate, clear communication of data.

The CDC discussion paper suggests –

To set up the Australian CDC we will consult and work with:

- state and territory governments
- health and aged care stakeholders
- the community.

It needs to be clarified what is meant working with 'community'. This needs to be data negotiated with, prioritised by, and collected via key community stakeholders addressing key social determinants of health.

Recent COVID-19 related data and messaging has caused considerable confusion over the last few years – and lessons should be learnt in relation to what constitutes effective health communication strategy (not just for communicable diseases – but also broader), see:

- https://onlinelibrary.wiley.com/doi/10.1002/hpja.644
- https://www.afr.com/policy/health-and-education/poor-covid-19-data-reporting-points-to-need-for-an-australian-cdc-20220922-p5bk5n

Prominent International public health/health promotion organisations offer data that could be utilised by CDC i.e.,

- WHO - https://www.who.int/data (https://www.who.int/data/gho/publications/world-health-statistics)
- UN data - https://data.un.org/

It is imperative that the CDC focuses on targets and resourcing related to social determinants of health and embrace health equity with targeted population health strategies which reach and resource vulnerable communities and populations most in need.

A national data plan would be welcomed by AHPA, however this should be developed in consultation with experts working in data and others who would be using the information. This is key given notable

security/data recent data breaches within large corporate organisations in Australia. Data sovereignty considerations are critical (see: https://www.sbs.com.au/language/nitv-radio/en/podcast-episode/lowitja-institute-launches-indigenous-data-sovereignty-evaluation-toolkit/nwrfbaed3).

The current potential ''traditional' focus on medicalised public health indicators and data are often at the expense of broader targets related to determinants of health inequities. These are needed to closely explore, examine, effectively resource, and implement strategies that prioritise a focus on social determinants of health, merely targeting specific diseases and treatments has not served us that well to date – alongside heavily medicalised (epidemiological) data sources. It is also the case that current data sources, assumptions and ways of collecting data serve option to reify existing differences rather than making any meaningful improvements.

There are various organisations that look to effective governance structures for health/healthcare data, see:

- https://healthcaregovernance.org.au/
- https://ahha.asn.au/governance

However, it needs to be noted that many similar organisations focus on clinical healthcare and priorities. CDC data governance should mirror broader social determinant/health equity strategy.

10. How can the CDC ensure collaboration with affected populations to ensure access to, and the capability to use, locally relevant data and information, particularly as it relates to First Nations people?

Response: AHPA believes strongly in meaningful involvement of those with lived experience, led by people with lived experience. The CDC should aim to move participation up the spectrum of engagement (see for example https://iap2.org.au/resources/spectrum/ and https://www.mhc.wa.gov.au/media/2532/170876-menheac-engagement-framework-web.pdf) towards co-production, empowerment and self-determination. It may be that independent structures are needed or very different ways of working so as not to reproduce colonising practices. The time and trust that it takes to establish such systems must be recognised and built-into development lead times. Consumer/Community reference groups are an absolute minimum. Capacity building activities to ensure community voices are front and centre are critical, for example: provision of training to support community to participate in governance activities, leadership, governance and advocacy. The use of Outreach Officers, Community Navigators, Community Engagement Practitioners and the inclusion of a peer-workforce would be valuable as part of an engagement and participation unit. Sufficient budget is required to enable the group to undertake social listening activities online and out in the community on a regular basis. Online, rolling consultation opportunities (e.g., digital deliberative dialogue spaces) would be valuable as well as tools such as Granicus/EngagementHQ/Bang the Table (https://granicus.com/solution/govdelivery/engagementhq/).

See: https://www.sbs.com.au/language/nitv-radio/en/podcast-episode/lowitja-institute-launches-indigenous-data-sovereignty-evaluation-toolkit/nwrfbaed3

National, consistent and comprehensive guidelines and communications

11. How can the CDC establish itself as a leading and trusted national body that provides guidance to governments based on the best available evidence, and participates in generating that evidence?

Response: The provision of consistent, evidence-informed advice could improve communications between governments, health departments and the public. A CDC could provide Australian governments with evidence-informed guidance to support informed decision making and ensure health promotion

interventions are evidence-based. Establishing an Australian CDC independent of government would assist in building trust in it as an institution. For the Australian public, a CDC would be a credible, apolitical information source to address misinformation, improve health literacy and enable the public to make informed, evidence-based choices related to the social determinants of health. AHPA's work to develop health promotion a system to support registration of health promotion practitioners can support the work of the CDC to provide comprehensive health promotion responses.

12. To what extent should the CDC lead health promotion, communication and outreach activities?

Response: The CDC would be well placed to lead and coordinate health promotion activities, including but not limited to health communication and outreach, at a national, state and local level, providing the appropriate governance and organisational structures are in place. To achieve this, the CDC needs a governance structure that works with governments and existing health promotion agencies, peak bodies and associations, whilst remaining independent of government influence. To enhance its ability to build the public's trust as an apolitical evidence-based source of health promotion resources, the CDC would need the certainty of long-term funding (10+ years). Sufficient and sustained investment is needed.

A key issue is ensuring that people are aware of health promotion as a specialist profession (with many different career pathways). Recognition of health promotion as a unique discipline and profession is required. The CDC could play a role in the reestablishment in a national program such as the previous PHERP model and advocacy for Commonwealth supported places for postgraduate programs and accelerated pathways to practice. Scaling up the health promotion components of jurisdictional or national public health traineeship programs are warranted–see specific health promotion traineeship examples, such as the Healthway funded AHPA Health Promotion Scholarship program- Twenty years of capacity building and partnership: A case study of a health promotion scholarship program. Finally, providing greater resourcing for health promotion action (such as the previous functions of the National Partnership Agreement on Preventive Health (NPAPH) is worthy of reconsideration. This was a watershed for health promotion and prevention with significant national investment to 'on the ground' activity. Such investment would support the objectives of the National Preventive Health Strategy. As has been noted by Sonia Wutzke and colleagues–

> *"The NPAPH, as a national initiative for achieving improvements to the prevention of chronic disease, was a welcome investment. Disinvestment in the NPAPH, as well as other promising reforms of the time, led to a loss of credibility in outcomes focussed funding collaborations as well as missed opportunities for the future health and wellbeing of the Australian population. Australia needs a recommitment at all levels of government to investment and action in prevention and a restoration of funding in prevention commensurate with the size of the health burden."*

See: Australia's National Partnership Agreement on Preventive Health: Critical reflections from States and Territories available here: https://onlinelibrary.wiley.com/doi/full/10.1002/hpja.9.

13. Are there stakeholders outside of health structures that can be included in the formulation of advice?

Response: If the CDC is to provide advice and guidance on the social determinants of health and health equity, then it will be necessary to engage with a broad range of stakeholders from government, non-government, professional health associations, community and private sectors which influence health and wellbeing. Transparent, collaborative processes to engage and strengthen partnerships with and between these sectors will assist with shared decision-making. A range of stakeholder collaboration and consultation

mechanisms could be implemented, such as expert advisory bodies and public forums. Using a Health in All Policies approach would be valuable.

National Medical Stockpile

14. What has your experience, if any, been of accessing supplies from the National Medical Stockpile (either before or during COVID-19), and can you identify any areas on which the CDC could expand or improve?

Response: AHPA does not have experience accessing the National Medical Stockpile. It is critical that supply distribution is done equitably to prioritise those with the greatest need, with a focus on mitigating any supply chain issues, planning for disruption and ensuring we also meet our commitments to countries in our region.

World-class workforce

15. How could a CDC work to ensure that our public health workforce is prepared for future emergencies, both in Australia and abroad?

Response: AHPA supports mapping the public health workforce to identify gaps and regulatory barriers, and to inform and strengthen future planning. In addition to increasing workforce capability and establishing a register of public health workers to be called on in a crisis, AHPA believes that core health promotion competencies should be mapped against the skills and capacities needed in emergency responses. This will create a clear understanding of how existing health promotion workforce skills and capabilities can best be utilised in future emergencies and thus extend the known potential workforce capacity for such events.

16. How could the CDC support and retain the public health workforce in reducing the burden of non-communicable disease?

Response: The public health workforce could be supported and retained through consultation and close collaboration with peak bodies that have a focus on workforce development like AHPA and with universities that offer public health-related qualifications to scope opportunities to understand aligned competencies and embed additional capabilities. A package of short-term training opportunities should include consideration of establishment of public health traineeships / fellowships that include health promotion competencies relevant to emergency response. The development of emergency management resources seems appropriate. Consultation with peak bodies like AHPA should be a key step in the process of development. AHPA endorses the importance of culturally appropriate training to ensure an equitable and culturally safe and appropriate response to emergencies.

In relation to the health promotion workforce:

Over the past three decades, the health promotion workforce has grown substantially due to an increase in the number of health promotion training programs and organisations globally. However, Australia has seen significant ebbs and flows during this time, reflecting periods of government investment and disinvestment making it challenging to maintain a strong professional identity. See article: https://onlinelibrary.wiley.com/doi/full/10.1071/HE15055

In Australia, in most health organisations that employ public health staff there is a lack of a formal structure to enable career progression – it is usually a very flat structure, with few opportunities to take a step up e.g. graduate roles, senior roles, leadership roles. Many lone health promotion practitioners sit within

systems and organisations with little understanding of or supports for health promotion practice. Furthermore, there are many graduates and few employment opportunities.

Long-term, sustainable funding is critical. It is also important to understand the availability, distribution, capacity and skills of the workforce. Critically, reflecting on their attendance at the 2017 Labor Party's National Health Policy Summit, Smith and Herriot wrote of the discussions on workforce, that -

> *"Workforce was identified as a critical enabler of an effective health system. However, scant attention was paid to the health workforce required to tackle health inequities and increase action in health promotion and prevention. While we raised concerns about the health promotion workforce, this received little recognition during the Summit. Comments were made that there is currently poor data on self-regulated and unregulated health professions in Australia. This was also noted previously in a national audit of the preventive health workforce.[6] It will be important for AHPA to ensure good data collection on the health promotion workforce as it embarks on the National Accreditation Organisation health promotion practitioner regulation. The profession needs to be more articulate about what the health promotion workforce offers (the recent Virtual Issue of the Health Promotion Journal of Australia, 'Health Promotion Workforce', makes a timely contribution in this regard). This involves explaining that health promotion practitioners have core competencies well suited to tackling health inequities and whole-of-government challenges."*

See: Positioning health promotion as a policy priority in Australia, available here: https://onlinelibrary.wiley.com/doi/10.1071/HEv28n1_ED2

An important emerging trend is the global uptake of IUHPE registration for health promotion practitioners and accreditation of health promotion courses. This is a significant step forward to ensure quality of practice, visibility and viability of health promotion as a public health profession and a unique discipline.

- The IUHPE Core Competencies and Professional Standards for Health Promotion are internationally recognised and have been in place for several years now. Supporting the promotion and use of these competencies is recommended.
- Currently there are 115 IUHPE Registered Health Promotion Practitioners in Australia. More on the international system can be found here: https://www.iuhpe.org/index.php/en/the-accreditation-system
- Quality learning and teaching is vital for equipping the health promotion workforce to address complex public health challenges, available here: https://onlinelibrary.wiley.com/doi/10.1002/hpja.666

More information on practitioner registration:

- https://www.healthpromotion.org.au/our-profession/practitioner-registration
- Creating a sustainable health promotion workforce in Australia: a health promoting approach to professionalisation https://onlinelibrary.wiley.com/doi/10.1071/HE13076

Rapid response to health threats

17. What role could the CDC play in greater national and international collaboration on One Health issues, including threat detection?

Response: There is opportunity for Australia to work closely with other countries to share resources, monitor and report on One Health issues and other focus areas as outlined previously. This may allow for a rapid, collective response to public health and health promotion and limiting the negative outcomes of emerging threats.

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18. What are the gaps in Australia's preparedness and response capabilities?

Response: 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 and experts 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.

These actions potentially fit within the CDC model.

19. How can the CDC position Australia, mindful of global, regional and local expertise, to be better prepared for future pandemics, health emergencies, and other public health threats?

Response: As outlined previously, a health equity lens should be applied to a public health emergency response, and a continued focus on addressing the social determinants of health.

It is also critical for the CDC to be well prepared with an appropriately trained workforce. 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 health promotion and public health targets and ultimately, positive health outcomes for the Australian community. Any new efforts should not re-invent the wheel, but capitalise on the capabilities, strengths and expertise of the existing specialist infrastructure and capacity of the health promotion workforce and only then develop strategies to build overall capacity for prevention within and outside the health sector.

International partnerships

20. What role should the CDC undertake in international engagement and support internationally, regionally or domestically?

Response: AHPA does not have feedback on this item at this time.

Leadership on preventive health

21. How can the CDC foster a holistic approach across public health, including the domains of health protection, and promotion and disease prevention and control?

Response: The CDC practices should be underpinned by the principles and values of health promotion. One model we recommend is the Red Lotus Critical Health Promotion Model (see:

https://onlinelibrary.wiley.com/doi/full/10.1002/hpja.642). This model encourages the use of a holistic health paradigm rather than a biomedical-behavioural health paradigm, acknowledging that health is a complex construct with multiple components, for which the importance to communities can differ and within individuals can change over time. Important components of health include the physical, mental, spiritual, social and cultural aspects of wellbeing, which can encompass health protection, disease prevention and control in addition to health promotion. The CDC must also acknowledge that health is impacted by many factors, from the planetary and built environment through to the social determinants that can impact health, such as socioeconomic status and education. Thus, to foster a holistic approach across public health, it is essential that the CDC is transdisciplinary and uses community-engaged processes working with (not on) communities. The CDC workforce needs to be as diverse as our communities within Australia to effectively engage and support them, so strategies to maximise recruitment of a diverse workforce is essential. Ensuring that the CDC has effective collaboration strategies to engage with peak health and social policy bodies is important, to support the professional development and registration of public health professionals that have the competencies to support health holistically within individuals, communities and populations. Likewise, the CDC should engage with universities across Australia with health promotion and public health courses, to ensure that the next generation of workers are competent in holistically understanding and supporting health.

22. What role could the CDC have in implementing the goals of the National Preventive Health Strategy?'

Response: The CDC should take a lead role in implementing the goals of the National Preventive Health Strategy 2021-2030 by driving, activating and supporting organisations working in public health. It is essential when implementing the goals of the strategy that sustainability is a priority – the CDC should not just run projects for a given period but facilitate new, evidence-informed, models that build capacity within existing communities and systems, so that they can deliver programs ongoing in sustainable models. The CDC should take a lead advocacy role to drive future investment in public health, which will require building a strong evidence base for prevention strategies, extensive community and program implementation, stakeholder support and ensuring translational frameworks are created to support embedding evidence-informed principles into new preventive health models.

23. Should the CDC have a role in assessing the efficacy of preventive health measures?

Response: Evidence on efficacy to support/reject prevention measures is essential to ensure that resources are provided for the strategies that are most effective and sustainable at scale. The CDC should take a leading role in ensuring that preventive health measures are rigorously evaluated not just at the efficacy level but also at wide-scale effectiveness level. This would require evaluation at all levels: from formative stages, to process, impact and outcome using quantitative and qualitative methods to comprehensively explore efficacy. Use of implementation science frameworks and health economic analyses will be necessary to ensure that research progresses from initial efficacy pilot studies through to effectiveness-implementation hybrid trials at scale, on to practice and policy change. It would also be important for the CDC to provide training and support in research and evaluation to public health organisations so that they are competent to assess efficacy of their programs.

24. How could the CDC work in partnership with at-risk populations and associated health sectors, including First Nations people, people with a disability and older Australians, to ensure their voices are included in policy development?

Response: Reducing health inequities is critical. It is important not only to develop partnerships but also provide significant opportunities for at-risk and unmet need populations to lead the discussion and

implementation of policies. The engagement needs to be genuine and ongoing. As outlined in AHPA and PHAA's Health Promotion and Illness Prevention Policy Position Statement 2021, 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 have 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 (see Australian Government. Overcoming Indigenous disadvantage: key indicators 2020. Productivity Commission. https://www.pc.gov.au/research/ongoing/overcoming-indigenous-disadvantage/2020). 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 (see Department of Prime Minister and Cabinet. Closing the Gap Prime Minister's Report 2018. Canberra: Commonwealth of Australia 2018).

We encourage an 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.

Aboriginal Community Controlled Health Services are fundamental in supporting the health and wellbeing of Aboriginal communities. 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).

25. How can the CDC best deliver timely, appropriate, and evidence-based health information to culturally diverse and/or at-risk populations?

Response: Building and maintaining relationships with key community members and groups who are engaged and empowered to provide suitable, culturally sensitive information is critical. Individuals and communities, 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 a 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.

As outlined in AHPA and PHAA's Health Promotion and Illness Prevention Policy Position Statement 2021, 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 (see PHIDU Inequality graphs: time series [Internet]. 2020 [cited 1 June 2021]. Torrens University Adelaide: 2020). 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.

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 (see O'Hara B, Grunseit A, Phongsavan P, Bellew W, Briggs M, Bauman A. Impact of the Swap It, Don't Stop It Australian National Mass Media Campaign on Promoting Small Changes to Lifestyle Behaviors 2016; and Werder O. Toward a humanistic model in health communication. Global Health Promotion. 2016).

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 CDC. 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 with comments from many senior public health figures including Prof Paul M Kelly, CMO for Australia.

26. How should the CDC engage across sectors outside its immediate remit (including portfolios with policy responsibility for wider determinants of health, culture, and disability)?

Response: 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 act on issues of local concern using models such as Parent's Voice or local drug action groups.

As outlined in AHPA and PHAA's Health Promotion and Illness Prevention Policy Position Statement 2021, 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. 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.

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 CDC should have more than a chronic disease approach 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 CDC 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 CDC'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.

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). 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.

Research prioritisation

27. Should the CDC have a role in advising on (or directly administering) funding or prioritisation of public health and medical research?

Response: Yes, with a focus on public health research. Public Health research (and practice) is critically underfunded in Australia. This is despite the returns on investment that public health and its protection, promotion and prevention functions delivers. For example, in describing global megatrends for CSIRO, Naughtin and colleagues (2022) suggest that:

> *health protection and promotion interventions return an average of $14.30 in benefits for every $1 invested. Health protection (e.g. vaccinations) and legislative interventions (e.g. taxing sugar-sweetened beverages) were associated with a higher return on investment than mass health promotion. However, health protection and promotion makes up a minor share of healthcare expenditure in Australia and this has declined from 2.1% in 2008–09 to 1.5% in 2018–19. COVID-19 provides a unique window of opportunity to accelerate progress on the socio-economic determinants of health, with previously unforeseen policy actions in housing, social support and education rapidly implemented in response to the pandemic. Given that the benefits of preventative health typically unfold over longer timespans, future investments will require broad-based support.*

See also:

- Friel S, Baum F, Goldfeld S, Townsend B, Büsst C, Keane L (2021) How Australia improved health equity through action on the social determinants of health The Medical Journal of Australia, 214(8 Supplementary): S7-S11

- Masters R, Anwar E, Collins B, Cookson R, Capewell S (2017) Return on investment of public health interventions: a systematic review. Journal of Epidemiology and Community Health, 71(8): 827-834.

We are aware that public health receives very little through any of the major granting bodies in Australia (NHMRC, MRFF etc) where the majority goes to basic science and clinical researchers.

If the CDC does not directly administer funding, at the very least it should have a serious role in advising on what constitutes public health research and advocating to ensure that this is funded, particularly in line with investments made towards the National Preventive Health Strategy and complementary strategies

that address the institution's protection, promotion and prevention functions. Much of what is currently funded under the banner of public health does not align with the definitions and functions of public health, particularly the health promotion and illness/disease prevention functions. Advocacy and partnership building to strengthen academic institution research and evaluation towards public health is an important role.

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 trusts that the CDC will recognise and act on the paucity of research funding for illness prevention and health promotion and recommends the establishment of a 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, always 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 a significantly higher proportion of the 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

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illness prevention and health promotion workforce of individuals. Such action could be further supported through the work of the CDC.

The CDC Project

28. How could the success of a CDC be measured and evaluated?

Response: 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 protection, health promotion and illness prevention indicators, including regular Australian Health Surveys. Regular and transparent review timepoints should be developed along with a monitoring and evaluation framework on progress that should be released publicly. Recognising that the impacts of public health measures can take some time and that establishment of new institutions will take time to bear fruit, broader progress and impact of the CDC should be measured at three to five years after initiation. Process could be measured yearly. Mixed methods should be used to capture a wide range of impacts including social and economic returns on investment. The community should have a voice in designing evaluation measures that. Knowledge translation should be central to evaluation. Several quick wins should be identified and reported on to encourage early decision-maker and community engagement and support. Learning from previous mistakes is important. Most institutions for public health have not been given sufficient time to demonstrate their worth. Some external evaluation may be warranted but AHPA cautions the use of consultants here and recommends the establishment of an evaluation branch or relationship with an academic research institution charged with some of this function. In Canada, the Office of Audit and Evaluation conducts evaluations that provide neutral evidence to support government accountability and decision-making on policy, expenditure management, and program improvements within the Public Health Agency of Canada. Planning for evaluation is vital. In the Canadian model this includes evaluation of the agency function as well as of the individual areas/programs/strategies that it delivers. A focus on both implementation and outcomes is important.

Implementation questions will be critical per Proctor and colleagues (2011). Engagement with the evaluators of the agencies in other countries may be beneficial to understand what works, and why and in what context and for whom.

We welcome further opportunities to contribute to the ongoing dialogue and vital national efforts to establish a national institution for the public's health and enhance capacity across its core functions - health protection, health promotion and illness/disease prevention.

Please do not hesitate to contact us with further questions.

Yours sincerely

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