Healthy Lifestyles

2002 - 2007

A STRATEGIC FRAMEWORK FOR PRIMARY PREVENTION OF DIABETES AND CARDIOVASCULAR DISEASE IN WESTERN AUSTRALIA 2002 - 2007

GOVERNMENT OF WESTERN AUSTRALIA
Department of Health

Healthy Lifestyles

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Government of Western Australia
Department of Health

This publication has been produced by
the Population Health Division of the
Department of Health, Western Australia
in association with Marg Miller Health
Consulting and Simpson Norris International.

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SUGGESTED CITATION

Department of Health, Western Australia (2002) *Healthy Lifestyles. A Strategic Framework for the Primary Prevention of Diabetes and Cardiovascular Disease in Western Australia 2002-2007*. Western Australian Government, Perth: Western Australia.

This document will also be available on the
Department of Health,
Western Australia Home page:
www.health.wa.gov.au

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ABBREVIATIONS

ACCHO: Aboriginal Community Controlled Health Organisation (s)
CDPTF: Chronic Diseases Prevention Task Force (see Objective 4, Action 6)
DoH: Department of Health, Western Australia (previously Heath Department of WA)
DGP: Division(s) of General Practice
HDWA: Health Department of Western Australia (now Department of Health)
HCC: Health Consumers' Council
NCD: Non-communicable diseases eg diabetes, cardiovascular disease, cancer, chronic obstructive pulmonary disease, obesity
Non-government sector: Non-government health sector such as Heart Foundation, Diabetes Australia
NPHP: National Public Health Partnership
PHD: Public Health Division of the Department of Health (now Population Health Division)
PHD statewide programs: Public Health Division statewide programs eg Nutrition, Quit
PHU: Public Health Units
UWA : University of Western Australia
WADS: Western Australian Diabetes Strategy
WHO: World Health Organisation

S: Short term, one to two years
M: Medium term, three to five years
L: Long term, six to ten years

FOREWORD

Cardiovascular disease is Australia's largest health problem. It kills more people and its health and economic burden exceeds that of any other disease. It accounts for 12 per cent of health system costs, 22 per cent of disease burden, 33 per cent of premature death and almost nine per cent of years of healthy life lost through disease, impairment and disability[1].

Diabetes is the seventh leading direct cause of death in Australia but it can lead to a variety of other serious conditions and complications such as heart disease, stroke, blindness, kidney failure and neurological problems. Its direct cost to the health system is 2.2 per cent of all health costs. It accounts for almost five per cent of healthy life lost through disease, impairment and disability[2] and shortens life expectancy by up to 15 years.

The burden of diabetes and cardiovascular diseases for Aboriginal and Torres Strait Islander people is much greater than for the general Australian population. Reporting of diabetes in the 1995 National Health Survey was seven to eight times higher amongst Aboriginal and Torres Strait Islander people aged 25 to 54 years, and almost three times higher amongst those 55 years or more[3,4]. Hospital discharges in WA for Aboriginal and Torres Strait Islander people compared to non-Aboriginal people are nine times higher for diabetes and three times higher for myocardial infarction[5]. Rates of death in WA due to diabetes are 13 times higher for female and six times higher for male Aboriginal and Torres Strait Islander people than for non-Aboriginal people[5]. Rates of death due to ischaemic heart disease are twice as high amongst Aboriginal and Torres Strait Islander people[5].

Much of the death, disability and illness caused by cardiovascular disease and diabetes is preventable. Smoking, being physically inactive, eating a diet high in saturated fat and/or being overweight are all preventable risk factors for cardiovascular disease and type 2 diabetes. Poor nutrition in foetal and early life is also considered to predispose a person to developing type 2 diabetes[6].

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[1] AIHW Australia's Health 2000. The seventh biennial report of the AIHW. AIHW Cat. No. 19, Australian Institute of Health and Welfare, Canberra, 2000, p56-60

[2] AIHW Australia's Health 2000. The seventh biennial report of the AIHW. AIHW Cat. No. 19, Australian Institute of Health and Welfare, Canberra, 2000, p84-89

[3] ABS. 1995 National Health Survey. ABS Cat. 4806.0 Australian Bureau of Statistics, Canberra, 1999

[4] ABS. 1994 National Aboriginal and Torres Strait Islander Survey. ABS Cat. 4704.0 Australian Bureau of Statistics, Canberra, 1999

[5] WA 2000 report against the National Performance Indicators for Aboriginal and Torres Strait Islander Health. Health Department of WA, 2000

[6] Hales CN and Barker DJP. Type 2 (non-insulin dependent) diabetes mellitus: the thrifty phenotype hypothesis. Diabetologia, 35:595-601, 1992

The prevalence of overweight and obesity in adults aged 25 years and over is 60 per cent[9]. Around 20 per cent of non-Aboriginal[3,9] and 25 to 30 per cent of Aboriginal and Torres Strait Islander people[4] are obese. Half of all Australian adults are insufficiently physically active to maintain good health and approximately one in six (16%) undertakes no physical activity at all[7]. Approximately 23 per cent smoke[8]. Smoking rates for Aboriginal and Torres Strait Islanders living in non-remote areas are double those of non-Aboriginal people[3,4].

The proportion of overweight and obese Australians is increasing rapidly[8,9] and is thought to be one of the main reasons contributing to the trebling between 1981 and 2000 of the number of adults in Australia with diabetes[9]. In contrast, rates of fatal and non-fatal heart attacks have decreased significantly over the last 30 years, with a steady decline of almost four per cent per year in the last ten years[1]. The decline is partly attributed to reduced rates of smoking and reduced dietary intake of saturated fat, despite increased body weight and little change in physical activity levels[1].

The health, economic and social costs of cardiovascular disease and diabetes, and the potential to change rates of disease by modification of preventable risk factors are compelling reasons to invest in primary prevention. The burden of disease attributable to preventable risk factors such as smoking, physical inactivity, obesity and poor nutrition is substantial. At the national level, tobacco smoking causes almost ten per cent of total disease burden, physical inactivity seven per cent, obesity four per cent and inadequate fruit and vegetable intake three per cent[10].

Rates of cardiovascular disease and diabetes and the prevalence of risk factors in the Western Australian population are not substantially different from national figures, although intra-state variations have been observed [11]. Substantial reductions in disease burden would be expected from investment in primary prevention to modify the key lifestyle risk factors of Western Australians.

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[7] Dunstan D et al, Diabetes and Associated Disorders in Australia 2000. The Accelerating Epidemic. AusDiab Australian Diabetes, Obesity and Lifestyle Report. Executive Summary. International Diabetes Institute, Melbourne 2001

[8] AIHW Australia's Health 2000. The seventh biennial report of the AIHW. AIHW Cat. No. 19, Australian Institute of Health and Welfare, Canberra, 2000, p166

[9] Dunstan D et al, Diabetes and Associated Disorders in Australia 2000. The Accelerating Epidemic. AusDiab Australian Diabetes, Obesity and Lifestyle Report. Executive Summary. International Diabetes Institute, Melbourne 2001

[10] Mather C, Vos T and Stevenson C. The Burden of Disease and Injury in Australia. Australian Institute of Health and Welfare, Canberra 2001

This Healthy Lifestyles strategic framework provides a primary prevention, population approach to reducing or eliminating lifestyle and environmental risk factors. Primary prevention programs are those addressing risk factors for people in the community who have no obvious symptoms of disease. A population approach is based on the knowledge that by far the greatest number of disease cases arises from that majority of the population who are not seen as "at risk"; and that small changes in this group can produce much greater community benefit than large changes in a small number of high risk individuals[12,13]. A population focus will provide a supportive social and physical environment to make healthier choices easier choices for individuals.

A population focus does not exclude consideration of the needs of different populations or provision of intensive interventions for high risk groups. Aboriginal and Torres Strait Islander people have a particularly high risk of cardiovascular diseases and diabetes. The Healthy Lifestyles framework incorporates the risk factor prevention needs of Aboriginal and Torres Strait Islander people, but also acknowledges that different strategies and approaches will be required to address their special needs, particularly in the area of determinants of health.

[11] Review of Primary Prevention of Type 2 Diabetes in Western Australia prepared for the HDWA by Health Promotion Evaluation Unit, Department of Public Health, University of WA
[12] Rose G Sick individuals and sick populations. Inter J Epidemiol. 14:32-38, 1985
[13] Syme S L Individual vs. Community Interventions in Public Health Practice: Some thoughts about a new approach. Health Promotion Matters (2): 2-9, 1997

PURPOSE OF THE STRATEGIC FRAMEWORK

Healthy Lifestyles: A Strategic Framework for Primary Prevention of Diabetes and Cardiovascular Disease aims to facilitate a more coordinated and strategic approach to the development and implementation of strategies and interventions to prevent type 2 diabetes and cardiovascular disease in this state. The Healthy Lifestyles strategic framework provides:

- Linkages with existing state and national prevention plans.
- The capacity to overlay state, regional and service area plans and prevention activities.
- The basis for funding primary prevention services by the DoH.
- A clear vision, goals and strategic objectives for those engaged in achieving improved healthy lifestyles for Western Australians.

POLICY CONTEXT

The Healthy Lifestyles strategic framework has been developed taking into consideration policies and plans at international, national, state and regional levels.

At the international level, the World Health Organisation (WHO)[14] has endorsed a global non-communicable diseases (NCD) strategy and recommended that this be adopted by member states. The strategy addresses the four most common non-communicable diseases: cardiovascular disease, diabetes, cancer and chronic obstructive pulmonary disease. These diseases are linked by common preventable risk factors related to lifestyle, namely tobacco use, unhealthy diet and physical inactivity. The WHO strategy recommends that action to prevent these diseases should focus on controlling associated lifestyle risk factors in an integrated manner. Guidelines for countries to implement a comprehensive strategy are outlined in the WHO strategy. These include broad goals to:

- Generate an information base for action.
- Establish a national program for NCD prevention.
- Address issues outside the health sector that influence NCD control.
- Ensure health sector reforms are responsive to the NCD challenge.

[14] WHO Global Strategy for the Prevention and Control of non-communicable diseases. Report by Director General, 53rd World Health Assembly, A53/14, 22 March 2000
www.who.int/wha-1998/IntWhaEb/intro.html

The WHO guidelines have been used at the national level in Australia to prepare a National Public Health Partnership (NPHP) discussion paper proposing a strategic framework for the prevention of chronic (non-communicable) diseases[15].

Diabetes and cardiovascular disease are two of six National Health Priority Areas. A number of national disease, risk factor and target group strategies exist that are relevant to these areas[16]. The intention of the NPHP chronic diseases prevention framework is to co-ordinate action across key preventive strategies and to integrate public health strategies with other major initiatives, particularly primary health care reforms and Aboriginal and rural health initiatives. Specialised programs would continue, but joint and collaborative approaches would be developed where integration was appropriate, such as in workforce training, monitoring and surveillance and local program delivery.

In a number of Australian states, health departments have developed strategic plans or outcome-based approaches to address diabetes or cardiovascular disease. The Northern Territory has provided leadership with a strategy[17] that links prevention of the major chronic diseases at primary, secondary and tertiary prevention levels.

In Western Australia, a Western Australian Diabetes Strategy (WADS) was launched in July 1999. The WADS addresses prevention, primary care and specialised care of type 1 and type 2 diabetes. This Healthy Lifestyles framework provides a statewide plan for primary prevention of major chronic diseases including type 2 diabetes. Its implementation is intended as an integral part of the WADS. Pilot Integrated Diabetes Care Programs in a number of regions in Western Australia have the potential to implement the Healthy Lifestyles framework as part of an integrated approach to achieving the objectives of WADS.

Another Western Australian initiative that emphasises the importance of primary prevention in achieving healthy individuals and communities is the 2000 HDWA report, New Vision for Community Health Services for the Future[18]. As with the

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[15] National Strategies Coordination Working Group. Preventing Chronic Disease. A Strategic Framework. Draft Discussion Paper May 2000. National Public Health Partnership 2000.
[16] Relevant national strategies include: National Tobacco Strategy, Active Australia (national physical activity and health strategy), Acting on Australia's Weight: a strategic plan for the prevention of overweight and obesity, Eat Well Australia (national nutrition and obesity strategy), National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan National Alcohol Action Plan, National Diabetes Strategy, National Mental Health Strategy, National Cancer Control Initiative, National Aboriginal Health Strategy, Rural Health Strategy, Women's and Men's Health Strategies, SNAP Risk Factor Framework for General Practice and National Initiative for the Early Years.
[17] Territory Health Services. Northern Territory Preventable Chronic Diseases Strategy-Overview and Framework. September 1999.
[18] Marshall J and Craft K. New Vision for Community Health Services for the Future report. Perth. Western Australian Health Department 2000.

WHO NCD strategy, the New Vision report advocates for early intervention, health promotion and community development to foster appropriate programs, the development of a skilled workforce, collaboration between stakeholders and effective strategic management.

Other major Western Australian health policies and plans that have some bearing on the implementation of this Healthy Lifestyles strategic framework include the Western Australian Aboriginal Health Strategy, Regional Aboriginal Health Plans, and the Norhealth, South West and Perth Metropolitan 2020 Health Plans. Statewide strategic plans and programs of the Public Health Division of the Department of Health which address risk factors such as poor nutrition, physical activity and tobacco smoking provide guidance for the selection of strategies specific to each risk factor. The across-government Physical Activity Taskforce which was established by the state Government in December 2000, will provide new directions for physical activity promotion in Western Australia.

DEVELOPMENT PROCESS

Development of the Healthy Lifestyles strategic framework was informed by literature review, key informant interviews and a series of focus group discussions with stakeholders around Western Australia. Stakeholders included regional public health units and health services, Aboriginal Medical Services, Divisions of General Practice, relevant non-government health organizations, consumer representatives and health service planners, purchasers and policy makers in the DoH, regional health services and other relevant organizations.

The focus of the consultations was to determine current actions and visions related to primary prevention of diabetes and cardiovascular disease and to explore ways to move towards a best practice approach. It is intended that the Healthy Lifestyles strategic framework will support and complement prevention plans and activities already in place at the health service level and be in a format useful to major stakeholders. A draft report of first round consultations was circulated to key stakeholders for feedback before development of the Healthy Lifestyles strategic framework.

FOCUS OF THIS DOCUMENT

This document describes the vision, goals, objectives and principles for the primary prevention of cardiovascular disease and diabetes. It also suggests for each objective, key activity areas and responsibilities that need to be considered when developing policies, strategies and interventions to meet local needs. The time frame specified for the strategy is five years, but it may take longer to achieve some objectives. For this reason actions are indicated as short term (S) (one to two years), medium term (M) (three to five years) and long term (L) (five to ten years) to achieve their desired outcomes.

VISION FOR 2007

1. Individuals, service providers and the community are thinking and talking about health actions and programs to improve lifestyles.

2. Programs and activities are relevant and accessible to everyone.

3. Health service providers in the regions are identifying and removing barriers to healthy lifestyles in collaboration with other community stakeholders.

4. High level decision makers are committed advocates of primary prevention.

5. High level decision makers at national, state and regional level are working together in partnership with other sectors to create a policy environment that makes it easy for communities to remove barriers to healthy lifestyles.

6. Memoranda of understanding between service providers and funding bodies specify outputs that support healthy lifestyles.

7. Service providers, funding bodies and community representatives agree on the outputs and how they are to be met.

8. An information system is established that meets the needs of the participants including funding bodies, planners, providers, and community.

GOALS

1. To increase the proportion of Western Australians aware of the impact of diabetes and cardiovascular disease on individuals and society, and the steps that they can take as individuals, families and communities to prevent the illnesses and their complications (S)[19].

2. To increase the proportion of the population engaging in healthy eating and regular physical activity and reduce the proportion engaging in tobacco smoking (M).

3. To slow the trend of the increasing proportion of the population who are overweight or obese (M).

4. To reduce the proportion of the population who are overweight or obese (L).

5. To reduce disparities (including differences that occur by socioeconomic status, gender, ethnicity and location) among different segments of the Western Australian population with regard to the risk factors and health outcomes identified in this framework (M-L).

6. To create and sustain the partnerships, systems and leadership needed to achieve these goals (S).

7. To reduce the projected incidence and prevalence of morbidity and premature mortality in Western Australia associated with type 2 diabetes and cardiovascular disease (L).

STRATEGIC OBJECTIVES

1. Generate an information base for action.

2. Establish new, or sustain and build on existing, effective primary prevention programs to promote healthy lifestyles and risk factor reduction.

3. Address issues outside the health sector which influence the achievement of healthy lifestyles.

4. Ensure health sector reforms responsive to the need for primary prevention.

[19] (S) Short term, one to two years (M) Medium term, three to five years (L) Long term, six to ten years

KEY PRINCIPLES AND ACTIONS TO ACHIEVE STRATEGIC OBJECTIVES

Objective 1: Generate an information base for action

Principles

Generation of relevant, timely, local data

For relevant policy formulation and planning and evaluation of interventions, reliable, relevant, timely data are needed concerning morbidity and mortality from diabetes and cardiovascular disease, as well as the level of exposure to risk factors and their determinants. In many cases, health data that are currently available are not sufficient to support local level planning and monitoring of integrated strategies.

The Healthy Lifestyles strategic framework promotes mechanisms for surveillance information to be available to contribute to policy formulation, planning, advocacy and program evaluation at relevant levels. Ideally this should be integrated with state and national-level data collection systems.

Evidence based approach

Ideally, the implementation of the Healthy Lifestyles strategic framework will incorporate policies, programs and infrastructure that have been evaluated and shown to be effective in achieving outcomes that lead to health gain in a defined population. A body of information is already available in this area although there are still many gaps. The review of primary prevention of type 2 diabetes conducted by UWA for the DoH[20], a review of 'best buys' in chronic disease control[21] conducted by Territory Health Service, National Evidence Based Guidelines for the Management of Type 2 Diabetes[22], and a guide for divisions of general practice on primary prevention of cardiovascular disease[23], are of particular relevance. Reviews of effectiveness of interventions in nutrition[24], smoking cessation[25] and physical activity[26] are available but need to be updated and reviewed in the Australian context.

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[20] Review of Primary Prevention of Type 2 Diabetes in Western Australia prepared for the DoH by Health Promotion Evaluation Unit, Department of Public Health, University of WA
[21] Territory Health Services. Preventable Chronic Diseases Strategy-the Evidence Base. Best buys and key result areas in chronic disease control. August 1999
[22] National Evidence Based Guidelines for the Management of Type 2 Diabetes. Public consultation draft prepared by Australian Centre for Diabetes Strategies, Prince of Wales Hospital for the Diabetes Australia Guideline Development Consortium March 2000
[23] Support and Evaluation Resource Unit in Public Health and Health Promotion. Primary Prevention of Cardiovascular Disease. A guide for Divisions of General Practice. University of Melbourne 1998
[24] Contendo N et al Nutrition education and implications. Journal of Nutrition Education 27(6), 1995
[25] Fiore et al. Treating tobacco use and dependence: clinical practice guideline. Rockville (MD): US Department of Health and Human Services, Public Health Service. 2000
[26] American Journal of Preventive Medicine special edition on Physical Activity Interventions

A recent discussion paper[27] from the National Public Health Partnership provides a guide to evaluating evidence on public health interventions. High levels of evidence such as controlled trials are desirable but it is recognized that these are difficult to implement for many primary prevention interventions. The Healthy Lifestyles strategic framework promotes appropriate evaluation of interventions. Dissemination of the results is also crucial to allow others to learn from experience and to adopt an evidence-based approach.

Actions

1. Develop a diabetes and cardiovascular diseases behavioural risk factor monitoring and surveillance system linked at local, state, and where possible, national level. This should incorporate appropriate existing data collections and include awareness of risk factors, prevalence of risk factors and their determinants, and be able to be integrated with morbidity and mortality data.

2. Develop a mechanism for behavioural risk factor surveillance information to contribute to policy making, advocacy and the evaluation of programs in primary health care.

3. Conduct community audits to establish gaps in local facilities and programs that support healthy lifestyles.

4. Develop and regularly update a comprehensive evidence base for chronic disease prevention (including cost effectiveness studies), and an accompanying dissemination strategy.

5. Support pilot projects to demonstrate effectiveness of interventions at local level.

6. Allocate time and resources (funds and skilled staff) for formative research in program development and process evaluation.

7. Develop and disseminate guidelines on the level of evaluation, performance indicators and reporting needed for program implementation

8. Develop key performance indicators to ensure that actions are performed and sustained.

[27] Rychetnik L and Frommer M. A Proposed Schema for Evaluating Evidence on Public Health Interventions. A discussion paper prepared for the National Public Health Partnership. National Public Health Partnership, Melbourne. May 2000

Objective 2: Establish and sustain effective primary prevention programs to promote healthy lifestyles and risk factor reduction.

Principles

Primary prevention

The following definition of primary prevention has been adopted in this framework: *Primary prevention is the protection of health by measures that reduce, eliminate or control causes and determinants of ill-health. Primary prevention programs are those addressing risk factors for asymptomatic people in the community.*

Modifiable lifestyle-based risk factors such as physical inactivity, poor nutrition and smoking are the main focus in this primary prevention strategic framework. The Healthy Lifestyles strategic framework also recognises that the presence or absence of these risk factors in individuals is linked to the broader social, economic and physical environment of the individual and the community in which they live.

Screening for pre-clinical conditions such dyslipidemia or impaired glucose tolerance is considered to be secondary rather than primary prevention.

Population approach

The focus of the Healthy Lifestyles strategic framework is on a population approach. This seeks to alter or eliminate lifestyle and environmental risk factors affecting the population as a whole. It is based on the knowledge that by far the greatest number of disease cases arises from that majority of the population who are not seen as "at risk"; and that small changes in this group can produce much greater community benefit than large changes in a small number of high risk individuals[28, 29]. A population focus does not exclude consideration of the needs of different populations and high risk groups.

The Healthy Lifestyles strategic framework incorporates the risk factor prevention needs of Aboriginal people, rather than separating these into a different document. In doing so, it acknowledges that different strategies and approaches are required to address their special needs, particularly in the area of determinants of health.

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[28] Rose G Sick individuals and sick populations. Inter J Epidemiol. 14:32-38, 1985
[29] Syme S L Individual vs. Community Interventions in Public Health Practice: Some thoughts about a new approach. Health Promotion Matters (2): 2-9, 1997

Risk factor approach

Most of the major non-communicable diseases - type 2 diabetes, cardiovascular disease, obesity, hypertension, cancers, chronic airways disease and renal disease - are linked by common preventable risk factors related to lifestyle. These factors are unhealthy diet, physical inactivity and tobacco smoking. Poor environmental health conditions and alcohol misuse may also contribute. The World Health Organisation (WHO)[30] recommends that action to prevent these diseases should focus on controlling the risk factors in an integrated manner. There is also recognition at international level[31] that many of the causal risk factors are deeply entrenched in the social and cultural framework of each society.

The Healthy Lifestyles strategic framework takes a common risk factor reduction approach by focusing on nutrition, physical activity and smoking rather than on diseases. Benefits expected with this approach include reduced duplication of services, improved coordination of efforts and the opportunity for a more integrated and strategic approach to risk factor reduction.

Promotion of well being and an holistic approach to health

Consultation with service providers emphasised the need to focus on well being and an holistic approach to health, not just establishing links between lifestyle messages and prevention of chronic diseases.

For Aboriginal people particularly, the health and well being of people is connected to their environment, culture, language and traditions. Health is not just the physical well being of the individual but the social, emotional and cultural well being of the whole community.

A focus on well being was seen as a positive approach to primary prevention that is more appealing to young people and those less likely to be concerned about the long term consequences of their actions.

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[30] WHO Global Strategy for the Prevention and Control of non-communicable diseases. Report by Director General, 53rd World Health Assembly, A53/14, 22 March 2000
www.who.int/wha-1998/IntWhaEb/intro.html
[31] Marmot M. Social determinants of health: from observation to policy. Medical Journal of Australia 172: 379-382, 2000

Life course approach

Current thinking[32] is that the origins of chronic diseases such as diabetes and coronary heart disease may be established in utero and early childhood and aggravated by lifestyle exposures such as weight gain, physical inactivity and substance abuse. Relevant childhood exposures include low birth weight, malnutrition and repeated childhood infections. Lifestyle habits such as diet, physical activity and substance use are learned during childhood and adolescence and are difficult to change in adulthood. Maternal health and nutrition may also have a significant impact on the health of the next generation. Even in middle and older age, changes in lifestyle such as smoking cessation, improved diet and achievement of a healthy weight range can delay or prevent the onset of disease.

The Healthy Lifestyles strategic framework acknowledges the need for primary prevention in all life stages.

Comprehensive approach

Experience[33,34] indicates that a comprehensive approach grounded in theories of behaviour change[35] is required to change risk factors at a population level. Successful community-based interventions require community participation, supportive policy, appropriate legislation and collaboration within and between sectors as well as education programs to increase awareness, knowledge, skills and self-efficacy. The Health Lifestyles strategic framework promotes a comprehensive approach with a range of interventions at policy, program and infrastructure level.

Actions

1. Establish new, and sustain and build on existing, integrated multi-level intersectoral programs to address risk factors. Programs should include media promotions, educational initiatives in different settings, and policies to support environmental change.

2. Establish evidence-based, integrated programs to address lifestyle risk factors and well being in all local health services, Divisions of General Practice and Aboriginal medical services.

3. Encourage and support the provision of education on lifestyle factors and well being through general community programs outside the health sector.

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[32] Barker DJ Maternal nutrition, fetal nutrition, and disease in later life. Nutrition, 13:807-813, 1997
[33] Holman D Something old, something new: perspectives on five 'new' public health movements. Health Promotion Journal of Australia 2(3):4-11,1992
[34] Syme S L Individual vs. Community Interventions in Public Health Practice: Some thoughts about a new approach. Health Promotion Matters (2): 2-9, 1997
[35] Glanz K Theory at a Glance. National Institutes of Cancer.
http://rex.nci.nih.gov/NCI_Pub_Interface/Theory_at_glance/HOME.html

4. Develop greater linkages between media campaigns and community level activities including providing more resources for community level initiatives to build on media campaigns.

5. Review and adapt existing chronic disease prevention "toolkits" and technical resource documents/ manuals to assist integrated approaches to chronic disease prevention at regional and local levels. These should include "lessons learnt" from recent or current interventions and models of good practice, as well as guidelines and resources to support community consultation and integrated action.

6. Initiate collaborative development between health service providers of integrated educational resources suitable for families and community groups using accessible modes such as web-based programs.

7. Adopt a whole family and community approach rather than an individual approach in communities.

8. Develop programs that are consistent with the skills and cultural backgrounds of participants eg Aboriginal, non-English speaking, farmers, miners.

9. Ensure that all women have access to community-based, appropriate and effective antenatal programs.

10. Support mental health promotion initiatives that improve self-esteem, decision-making and feelings of control over lifestyle.

Objective 3: Address issues outside the health sector which influence healthy lifestyles

Principles

Intersectoral approach

The development of diabetes and cardiovascular disease, and their risk factors are inextricably linked with the broader socio-economic determinants of health and quality of life, particularly education and employment[36]. A conceptual framework for identifying the relationship between socioeconomic status and health in Australia has been proposed by Turrell and Mathers[7] and reproduced in Appendix 1. Lifestyle choices are influenced by social, economic and physical environment. Government policies and global forces in turn also affect these environments. Influences outside the health sector will need to be assessed and tackled as part of the Healthy

[36] Turrell G and Mathers C. Socioeconomic status and health in Australia. Medical Journal of Australia 172:434-438, 2000

Lifestyles strategic framework to prevent diabetes and cardiovascular disease. It is important that health care services do not operate in isolation from other services and that they develop strategic partnerships with a range of sectors outside the health sector at state, regional and local level. These sectors include but are not limited to: Family and Children's Services, Housing, Transport, Education, Agriculture, Commerce and Trade and Local Government. It is essential that community representatives are included in partnerships and have input into decisions that impact on lifestyles and other determinants of health.

Community participation

Participation by individuals, special interest groups and community leaders in identifying needs and developing and implementing interventions ensures a good basis for successful services and programs. Community participation in program development helps to ensure that interventions are relevant and meet the expressed needs of the community. Participation also helps to build the capacity and self-reliance of individuals and community organisations to take sustainable action on issues without continued input from external agencies[37].

Actions

1. Analyse community audits to identify opportunities for collaboration between health and other sectors and develop formal alliances to implement agreed joint projects.

2. Foster community development to advocate for better access to good food and environments that support increased levels of physical activity.

3. Help communities to identify problems that impact on lifestyle and health and encourage them to identify workable solutions.

4. Work with local community members to foster leadership and community empowerment.

5. Work with other sectors to ensure healthy public policy that enables healthy lifestyles.

6. Require evidence of effective and sustained collaboration between relevant stakeholders as a condition of funding primary prevention initiatives.

7. Provide incentives to foster healthy environments and to increase access to healthy foods eg contracts with store managers and appropriate training to implement health promotion initiatives.

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[37] Marshall J and Craft K. New Vision for Community Health Services for the Future report. Perth. Western Australian Health Department 2000

8. Support initiatives that increase the general education, literacy and life skills of Aboriginal people and other community members.

9. Support initiatives that improve community infrastructure eg provision of adequate food storage and cooking facilities.

10. Support initiatives that improve infrastructure that promotes physical activity eg parks, swimming pools, footpaths.

11. Support initiatives that improve employment prospects.

12. Support initiatives that increase leisure opportunities.

13. Support initiatives that increase access to locally grown produce.

Objective 4: Ensure health sector reforms are responsive to the need for primary prevention

Principles

Coordinated approach within the health sector

In Western Australia, a range of government and non-government professional and private organisations set policy, provide funding and/or deliver services relevant to diabetes, cardiovascular disease, nutrition, physical activity and smoking. These activities occur from national, state and regional perspectives. These organisations include but are not limited to:

Department of Health, Western Australia: including Public Health, Community Health, General Health Purchasing, Office of Aboriginal Health, Office of the Chief Medical Officer, directors and nominated officers of the regional Public Health Units, Health Service managers, Diabetes and Chronic Disease coordinators
ACCHOs
Aboriginal Medical Services
Divisions of General Practice
Diabetes Australia (WA)
Heart Foundation
Cancer Foundation
Diabetes Services Taskforce and regional steering committees.

The intention of the Healthy Lifestyles strategic framework is to promote partnerships and alliances between these organisations to facilitate a coordinated effort, reduce duplication, reduce the burden on local level service delivery agents, and provide a co-ordinated approach to other sectors.

Integration of primary prevention with the continuum of care

Although the Healthy Lifestyles strategic framework specifically addresses population approaches to primary prevention of cardiovascular disease and diabetes, it is essential that there is integration with programs that address individuals and the continuum of care in these conditions.

The effectiveness of programs that provide screening to identify and support individuals at high risk of chronic diseases can be enhanced by population-level initiatives to increase awareness of risk factors, and to change environments to make healthy choices easier choices.

Innovations in health care delivery supported at Commonwealth level such as Enhanced Primary Care, Chronic Disease Self Management initiative and Coordinated Care Trials, as well as state-based initiatives such as Integrated Diabetes Care, provide opportunities to integrate population-based primary prevention initiatives with extended care of individuals.

Integrated public health practice at local level

National and state public health efforts have predominantly been organised around single purpose (vertical) programs addressing various diseases or risk factors. Most people and communities experience a range of health issues and risk factors at the same time, so at the service delivery level better coordination of services to address each of these is warranted. The program delivery and accountability requirements of different programs place unreasonable demands on local health care providers. Common operational problems include different service providers providing related services to the same population, different programs addressing the same risk factors without reference to each other, overburdening of generalist staff and duplication of administrative systems.

The National Strategies Coordination Working Group of the National Public Health Partnership has recognised this problem and has released a discussion paper on the issue[38]. For the purposes of the discussion paper, integrated public health practice is seen as encompassing the following elements:

- Recognising and responding to the inter-relatedness of health determinants and their multiple health outcomes.
- Shared investment in capacity building between health gain programs.
- Recognising the need for relevance to the individual and community's living experience.
- Involving coordinated action across programs and across sectors based on an agreed strategy.

The Healthy Lifestyles strategic framework endeavors to encompass all these elements.

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[38] Draft Discussion Paper- Integrated Public Health Practice: Supporting and Strengthening Local Action. National Public Health Partnership, Melbourne. April 2000

Funding and Resources

Many programs addressing chronic disease need to be sustained over a long period to demonstrate a health benefit. Currently, funding of new initiatives in the health care system are usually derived from short term project grants from various sources or from reallocation of current funding and resources. Short term program grants are characteristically vertically integrated and of one to three years duration. This time frame is often too short to allow program development, implementation, evaluation, modification and development of infrastructure for sustainability. Key requirements for reallocation of existing resources are evidence to justify a change, a priority setting framework, leadership and commitment, and flexible structures and workforce to implement changes. Implementation of the strategic framework needs to address systematic ways to provide resources to test new initiatives as well as to integrate successful interventions into existing resources.

Consistency with regional plans

The extent of regional plans was discussed under the policy context of this strategy. The strategic objectives of the Healthy Lifestyles framework are consistent with the goals of the WHO international guidelines for prevention of non-communicable chronic diseases, and action areas specified at the national level in Australia. The intention in implementing the Healthy Lifestyles strategic framework is to identify actions and programs that may be put in place at regional and health service levels to address the strategic objectives. Suggestions are made in the tables that follow but these may be modified to best meet local needs.

Workforce capacity

Different models of integrated practice may require a different spread of skills in the workforce. The introduction of new programs may also affect the service delivery unit by changing systems or work practices. Training programs and management of organisational change are important considerations in implementing Healthy Lifestyles.

Actions

Change the focus

1. Change the health system focus from illness to promoting and supporting wellness through healthy lifestyles.

Management reforms

2. Transform the role of health care managers by vesting managers with the responsibility for the effective management of resources to promote and maintain the health of a defined population.

3. Increase the profile of primary prevention by developing key performance indicators for primary prevention outcomes and requiring health services to report on them.

Planning

4. Develop DoH policy in consultation with service providers including local, regional and Aboriginal health services, public health units and non-government organisations. Allow local interpretation of policy to meet local needs.

5. Negotiate funding processes and reporting mechanisms between the DoH and service providers that meet minimum requirements of both parties. Balance accountability requirements with minimal bureaucracy.

Coordination within the health sector

6. At state level, establish a chronic diseases prevention task force (CDPTF) with representation from key sectors that focuses on people and their lifestyles and provides leadership in health sector program planning, implementation and evaluation.

7. At local level, establish formal mechanisms for collaboration between government and non-government health organisations on policy development and planning, and implementation and evaluation of programs that promote healthy lifestyles. (Consultations suggested that a dedicated coordinator was needed to facilitate this collaboration.)

8. Identify barriers to effective collaboration and coordination within regions and local service areas and plan initiatives to overcome these barriers. eg teleconferencing to overcome geographic distance and reduce time spent travelling.

9. Require evidence of effective and sustained collaboration between relevant stakeholders as a condition of funding primary prevention programs.

10. Establish formal mechanisms for better liaison between statewide program planners and local service providers.

Resource allocation

11. Department of Health and health services to allocate and quarantine adequate funding for primary prevention based on identified program needs.

12. Provide funding for pilot demonstration projects with the capacity to sustain funding if successful.

13. Develop funding arrangements that support sustainability of programs shown to be successful by appropriate evaluation.

14. Introduce a flexible funding cycle to allow realistic time for program development, implementation and evaluation.

15. Include appropriate time and resources in funding applications and allocations for collaboration and development of partnerships.

Adequate and appropriate workforce

16. Commission a review to provide staffing benchmarks for effective implementation of primary prevention in a defined region.

17. Encourage recruitment flexibility at health service level to employ the type of staff needed to plan, implement and evaluate population-based primary prevention interventions.

18. Ensure an adequate workforce to reinforce and enable prevention messages, including improved access to and demand for affordable food eg community stores, school canteens.

19. Ensure adequate positions, appropriate levels of pay, and skills development for primary prevention especially for health professionals working in rural and remote areas.

20. Ensure adequate numbers of Aboriginal and other culturally appropriate people in the health workforce both at planning and service delivery levels.

21. Encourage the training and use as educators of culturally appropriate lay workers such as community leaders with personal experience of risk factor reduction.

Staff development

22. Promote the concept that prevention is everybody's business.

23. Orient all health service managers and decision-makers to the importance of lifestyle programs in preventing diabetes and cardiovascular disease.

24. Support provision of health care provider training programs on risk factors and preventive best practice.

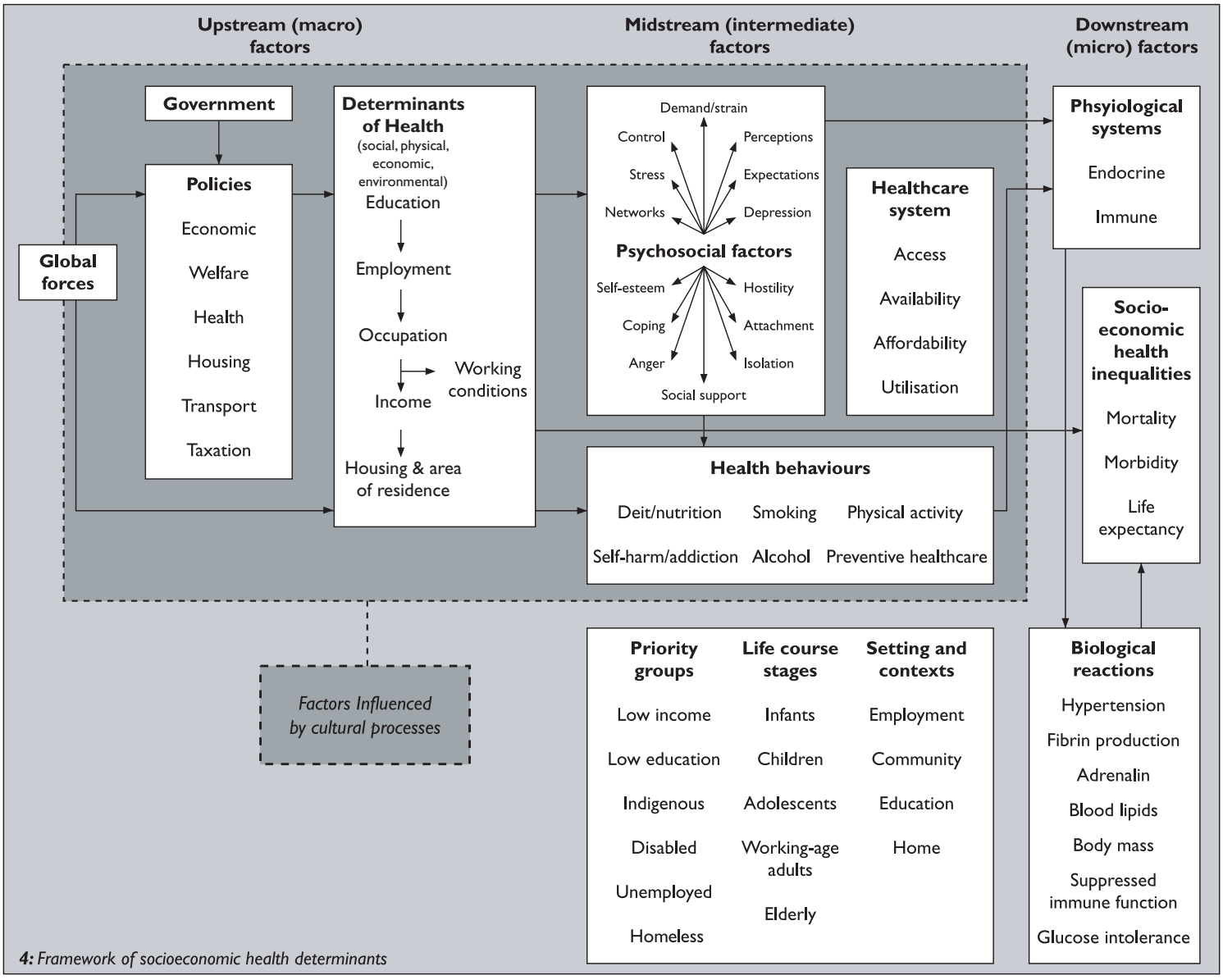
25. Implement collaborative programs that provide experiential learning by all health disciplines of primary prevention approaches.

26. Support recommendations of the National Workforce Development project of the NPHP[39].

[39] NPHP National Workforce Development Initiative. www.nphp.gov.au

APPENDIX 1

Framework of Socioeconomic Health Determinants



4: Framework of socioeconomic health determinants

Turrell G and Mathers C. Socioeconomic status and health in Australia. Medical Journal of Australia 172:434-438, 2000

APPENDIX 2
TABLE OF ACTIONS TO ADDRESS OBJECTIVES, RESPONSIBILITIES AND TIMEFRAMES
Objective 1: GENERATE AN INFORMATION BASE FOR ACTION

Activity	Mechanism	Role of	Time frame SML
1. Develop a diabetes and cardiovascular diseases behavioural risk factor monitoring and surveillance system linked at local, state, and where possible, national level. This should incorporate existing relevant data bases and include awareness of risk factors, prevalence of risk factors and their determinants, and be able to be integrated with morbidity and mortality data.	DoH planning Purchasing plans Local planning	DoH, AIHW, PHUs, Universities, CDPTF, DGP	M
2. Develop a mechanism for behavioural risk factor surveillance information to contribute to policy making, advocacy and the evaluation of programs in primary health care.	DoH planning PHD planning Local planning	DoH, Health service managers, PHUs, Nongovernment sector, CDPTF, HCC	M
3. Conduct community audits to establish gaps in local facilities and programs that support healthy lifestyles.	Local planning & data collection	PHUs, ACCHOs, Health service managers, HCC	S
4. Develop and regularly update a comprehensive evidence base for chronic disease prevention (including cost effectiveness studies), and an accompanying dissemination strategy.	DoH purchasing PHD planning	PHD statewide programs, Universities, CDPTF	S
5. Support pilot projects to demonstrate effectiveness of interventions at local level.	DoH planning Purchasing plans Local planning	PHUs, Health service managers, ACCHOs, DGP, PHD statewide programs, Universities, Healthway, CDPTF	S
6. Allocate time and resources (funds and skilled staff) for formative research in program development and process evaluation.	DoH planning Purchasing plans Local planning	PHUs,Health service managers, PHD statewide programs, Universities, Healthway	S
7. Develop and disseminate guidelines on the level of evaluation, performance indicators and reporting needed for programs implemented.	DoH planning Purchasing plans	PHUs, PHD, Universities, Healthway, CDPTF	S
8. Develop key performance indicators to ensure that actions are performed and sustained.	DoH planning Purchasing plans	DoH, PHUs, Health service managers	S

Objective 2: ESTABLISH AND SUSTAIN EFFECTIVE PRIMARY PREVENTION PROGRAMS TO PROMOTE HEALTHY LIFESTYLES AND RISK FACTOR REDUCTION.

Activity	Mechanism	Role of	Time frame SML
1. Establish new, and sustain and build on, existing integrated multi-level intersectoral programs to address risk factors. Programs should include media promotions, educational initiatives in different settings, and policies to support environmental change.	DoH planning Purchasing plans Local planning	PHUs, Health service managers, PHD statewide programs, CDPTF and risk factor sub-groups, Non-government sector, Universities, Healthway	S-M
2. Establish evidence-based, integrated programs to address lifestyle risk factors and well being in all local health services, divisions of general practice and Aboriginal medical services.	DoH planning Purchasing plans Local planning	PHUs, ACCHOs, DGP, Health service managers, PHD statewide programs, Non-government sector, CDPTF, Universities, Healthway, HCC	M
3. Encourage and support the provision of education on lifestyle factors and well being through general community programs outside the health sector.	Purchasing plans Local planning	PHUs, ACCHOs, Health service managers, PHD statewide programs, Non-government sector, CDPTF, HCC, Universities, Healthway	S-M
4. Develop greater linkages between media campaigns and community level activities including providing more resources for community level initiatives to build on media campaigns.	DoH planning Purchasing plans Local planning	PHUs, ACCHOs, DGP, Health service managers, PHD statewide programs, Non-government sector, CDPTF, Healthway	S
5. Review and adapt existing chronic disease prevention "toolkits" and technical resource documents/ manuals to assist integrated approaches to chronic disease prevention at regional and local levels. These should include "lessons learnt" from recent or current interventions and models of good practice, as well as guidelines and resources to support community consultation and integrated action.	DoH planning Purchasing plans	PHD statewide programs, ACCHOs, Non-government sector, CDPTF, Universities, Healthway	M

6. Initiate collaborative development between health service providers of integrated educational resources suitable for families and community groups using accessible modes such as web-based programs.	DoH planning Purchasing plans Local planning	PHUs, ACCHOs, DGP, PHD statewide programs, Non-government sector, CDPTF, Universities, Healthway	M
7. Adopt a whole family and community rather than individual approach in communities.	DoH planning Purchasing plans Local planning	PHUs, ACCHOs, DGP, Health service managers, PHD statewide programs, Non-government sector, CDPTF, Healthway	S
8. Develop programs that are consistent with the skills and cultural backgrounds of participants eg Aboriginal, non-English speaking, farmers, miners.	Purchasing plans Local planning	PHUs, ACCHOs, DGP, Health service managers, PHD statewide programs, Non-government sector, CDPTF, Healthway	S
9. Ensure that all women have access to community-based, appropriate and effective antenatal programs.	DoH planning Purchasing plans Local planning	PHUs, ACCHOs, DGP, Health service managers, CDPTF, Healthway	M
10. Support mental health promotion initiatives that improve self-esteem, decision-making and feelings of control over lifestyle.	DoH planning Purchasing plans Local planning	PHUs, ACCHOs, Health service managers, DGP, PHD statewide programs, non-government sector, CDPTF, Healthway	S

Objective 3: ADDRESS ISSUES OUTSIDE THE HEALTH SECTOR WHICH INFLUENCE HEALTHY LIFESTYLES

Activity	Mechanism	Role of	Time frame SML
1. Analyse community audits to identify opportunities for collaboration between health and other sectors and develop formal alliances to implement agreed joint projects.	DoH planning Local planning	PHUs, ACCHOs PHD statewide programs, non-government sector, CDPTF, Universities	S
2. Foster community development to advocate for better access to good food and environments that support increased levels of physical activity.	DoH planning Purchasing plans Local planning	PHUs, ACCHOs, non-government sector, CDPTF, Healthway	S-M
3. Help communities to identify problems that impact on lifestyle and health and encourage them to identify workable solutions.	DoH planning Purchasing plans Local planning	PHUs, ACCHOs, DGP, Health service managers, Healthway	S-M
4. Work with local community members to foster leadership and community empowerment.	DoH planning Purchasing plans Local planning	PHUs, ACCHOs, DGP Health service managers, CDPTF, Universities, Healthway	S-M
5. Work with other sectors to ensure healthy public policy that enables healthy lifestyles.	DoH planning Purchasing plans Local planning	PHUs, ACHHOs, Health service managers, PHD statewide programs, CDPTF, non-government sector, Universities, Healthway	S-M
6. Require evidence of effective and sustained collaboration between relevant stakeholders as a condition of funding primary prevention initiatives.	DoH planning Purchasing plans Local planning	DoH purchasing, Health service managers, Healthway	S
7. Provide incentives to foster healthy environments and to increase access to healthy foods eg contracts with store managers and appropriate training to implement health promotion initiatives.	Purchasing plans Local planning	PHUs, ACCHOs, Health service managers, CDPTF, non-government sector, Universities, Healthway	M-L

8. Support initiatives that increase the general education, literacy and life skills of Aboriginal and other community members.	DoH planning Purchasing plans Local planning	PHUs, ACCHOs, Health service managers, PHD statewide programs, CDPTF, non-government sector, Universities, Healthway	M
9. Support initiatives that improve community infrastructure eg provision of adequate food storage and cooking facilities.	DoH planning Purchasing plans Local planning	PHUs, ACCHOs, PHD statewide programs, CDPTF, non-government sector, Healthway	S-M
10. Support initiatives that improve infrastructure that promotes physical activity eg parks, swimming pools, footpaths.	DoH planning Purchasing plans Local planning	PHUs, ACCHOs, PHD statewide programs, Health service managers, non-government sector, CDPTF, Healthway	M
11. Support initiatives that improve employment prospects.	DoH planning Purchasing plans Local planning	PHUs, ACCHOs, Health service managers, PHD statewide programs, CDPTF, Healthway	M
12. Support initiatives that increase leisure opportunities.	DoH planning Purchasing plans Local planning	PHUs, ACCHOs, Health service managers, PHD statewide programs, CDPTF, Healthway	S-M
13. Support initiatives that increase access to locally grown produce.	DoH planning Purchasing plans Local planning	PHUs, ACCHOs, Health service managers, PHD statewide programs, CDPTF, Healthway	S-M

Objective 4: ENSURE HEALTH SECTOR REFORMS ARE RESPONSIVE TO THE NEED FOR PRIMARY PREVENTION

Activity	Mechanism	Role of	Time frame SML
1. Change the health system focus from illness to promoting and supporting wellness through healthy lifestyles.	Advocacy DoH planning Local planning	DoH, PHUs, ACCHOs, DGP, Health service managers, PHD statewide programs, non-government sector, CDPTFs, Universities, Healthway	L
2. Transform the role of health care managers by vesting managers with the responsibility for the effective management of resources to promote and maintain the health of a defined population.	Advocacy DoH planning Purchasing plans Local planning	DoH, PHUs, Health service managers, ACCHOs	M
3. Increase the profile of primary prevention by developing key performance indicators for primary prevention outcomes and requiring health services to report on them.	DoH planning Local planning	DoH, PHUs, ACCHOs, Health service managers, PHD statewide programs	S-M
4. Develop DoH policy in consultation with service providers including local, regional and Aboriginal health services, PHUs and non-government organisations. Allow local interpretation of policy to meet local needs.	DoH planning Local planning	DoH, PHUs, DGP, ACCHOs, Health service managers, non-government sector, PHD statewide programs, CDPTF	S-M
5. Negotiate, funding processes and reporting mechanisms between the DoH and service providers that meet minimum requirements of both parties. Balance accountability requirements with minimal bureaucracy.	DoH planning Purchasing plans Local planning	DoH, PHUs, ACCHOs, DGP, Health service managers, PHD statewide programs	M

6. At state level, establish a chronic diseases prevention task force (CDPTF) with representation from key sectors that focuses on people and their lifestyles and provides leadership in health sector program planning, implementation and evaluation.	State level planning	PHD, statewide programs, non-government sector, PHUs, Aboriginal Health, Universities, Healthway	S
7. At local level, establish formal mechanisms for collaboration between government and non-government health organisations on policy development and planning, implementation and evaluation of programs that promote healthy lifestyle. One mechanism suggested by consultations was appointment or designation of a chronic diseases prevention coordinator.	Local planning	PHUs, ACCHOs, DGP, Health service managers, PHD statewide programs, CDPTF	S
8. Identify barriers to effective collaboration and coordination within regions and local service areas and plan initiatives to overcome these barriers. eg teleconferencing to overcome geographic distance and reduce time spent travelling.	Local planning	PHUs, ACCHOs, DGP, Health service managers	S
9. Require evidence of effective and sustained collaboration between relevant stakeholders as a condition of funding primary prevention programs.	Purchasing plans	DoH purchasing, Health service managers, Healthway	S
10. Establish formal mechanisms for better liaison between state-wide program planners and local service providers.	DoH planning Purchasing plans Local planning	PHUs, ACCHOs, DGP, PHD statewide programs, CDPTF	S
11. Department of Health and health services to allocate and quarantine adequate funding for primary prevention based on identified program needs.	DoH planning Purchasing plans Local planning	DoH purchasing, PHUs, ACCHOs, DGP, Health service managers, PHD statewide programs	S-M
12. Provide funding for pilot demonstration projects with capacity to sustain funding if successful.	DoH planning Purchasing plans Local planning	DoH purchasing, PHUs, ACCHOs, DGP, Health service managers, PHD statewide programs, Healthway	M

13. Develop funding arrangements that support sustainability of programs shown to be successful by appropriate evaluation.	DoH planning Purchasing plans	DoH purchasing, PHUs, ACCHOs, DGP, Health service managers, PHD statewide programs, Universities, Healthway	M
14. Introduce a flexible funding cycle to allow realistic time for program development, implementation and evaluation.	DoH planning Purchasing plans	DoH, PHUs, ACCHOs, DGP, Health service managers, PHD statewide programs, Healthway	M
15. Include appropriate time and resources in funding applications and allocations for collaboration and development of partnerships.	DoH planning Purchasing plans Local planning	PHUs, ACCHOs, DGP, Health service, managers, PHD statewide programs, CDPTF, Healthway	S-M
16. Commission a review to provide staffing benchmarks for effective implementation of primary prevention in a defined region.	Research DoH planning Purchasing plans Local planning	PHUs, ACCHOs, Health service managers, Universities	S-M
17. Encourage recruitment flexibility at health service level to employ the type of staff needed to plan, implement and evaluate population-based primary prevention interventions.	Local planning	PHUs, ACCHOs, Health service managers	S
18. Ensure adequate workforce to reinforce and enable prevention messages, including improved access to and demand for affordable food eg community stores, school canteens.	Local planning	PHUs, ACCHOs, Health service managers, PHD statewide programs, Non-government sector	M
19. Ensure adequate positions, appropriate level of pay, and skills development for primary prevention especially for health professionals working in rural and remote areas.	DoH planning Local planning	PHUs, ACCHOs, DGP, Health service managers	M
20. Ensure adequate numbers of Aboriginal and other culturally appropriate people in the health workforce both at planning and service delivery levels.	DoH planning Local planning	Aboriginal Health, PHD, PHUs, ACCHOs, DGP, Health service managers	M

21. Encourage the training and use as educators of lay workers such as community leaders with personal experience of risk factor reduction.	Local planning	PHUs, ACCHOs, DGP, Health service managers, PHD statewide programs, Non-government sector	S-M
22. Promote the concept that prevention is everybody's business.	Advocacy DoH planning Local planning	PHUs, Health service managers, ACCHOs, DGP, PHD statewide programs, Non-government sector, Universities, Healthway	S-L
1. Orient all health service managers and decision-makers about the importance of lifestyle programs in preventing diabetes and heart disease.	Advocacy Local planning	PHUs, ACCHOs, DGP, Health service managers, PHD statewide programs, Non-government sector, Universities, Healthway	S-L
24. Support provision of health care provider training programs on risk factors and preventive best practice.	DoH planning Purchasing plans Local planning	PHUs, ACCHOs, DGP, Health service managers, PHD statewide programs, Non-government sector, Universities, Healthway	S-L
25. Implement collaborative programs that provide experiential learning by all health disciplines of primary prevention approaches.	DoH planning Purchasing plans Local planning	PHUs, ACCHOs, DGP, Health service managers, PHD statewide programs, Non-government sector, Universities, Healthway	S-L

26. Support recommendations of the National Workforce Development project of the NPHP.	DoH planning Purchasing plans Local planning	PHUs, Health service managers, ACCHOs, DGP, Statewide programs, Non-government sector, Universities, Healthway	S-L

Table abbreviations and definitions

- **S:** Short term, one to two years
- **M:** Medium term, three to five years
- **L:** Long term, six to ten years

ACCHO: Aboriginal Community Controlled Health Organisation
CDPTF: Chronic Diseases Prevention Task Force (see Objective 4, Action 6)
DGP: Division of General Practice
HCC: Health Consumers' Council
Non-government sector: Non-government health sector such as Heart Foundation, Diabetes Australia
PHD statewide programs: Public Health Division statewide programs eg Nutrition, Quit
PHU: Public Health Units

APPENDIX 3

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A number of other people have also commented on this document. Their contribution is acknowledged and appreciated.