Western Australian Health Promotion Strategic Framework 2012–2016

Working together to promote health and prevent chronic disease and injury in our communities
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Note on terminology
The use of the term “Aboriginal” within this document refers to Australians of both Aboriginal and Torres Strait Islander descent. The word “Indigenous” is retained where it is included as part of an already existing formal title.

Acknowledgements
The Chronic Disease Prevention Directorate led the development of the Health Promotion Strategic Framework 2012–2016 (HPSF), with input and advice from a range of diverse perspectives. More than ninety organisations and individuals responded to the public consultation period for the HPSF between April–July 2012 and the Chronic Disease Prevention Directorate is grateful for their thoughtful and constructive comments.
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Foreword

Too many Western Australians are dying prematurely, or living with illness and disability, due to preventable chronic disease and injury.

In recognition of this growing problem, WA Health has joined forces with other Australian states and territories in the National Partnership Agreement on Preventive Health (NPAPH), which was established to address the rising prevalence of lifestyle-related chronic diseases, with a focus on obesity, tobacco use and harmful alcohol use.

The Health Promotion Strategic Framework 2012–2016 outlines WA Health’s priorities for meeting its obligations under the NPAPH and its plan to lower the incidence of avoidable chronic disease and injury by facilitating improvements in health behaviours and environments over the next five years.

This document builds on the previous Framework (2007–2011), which emphasised the importance of understanding and addressing the contributing factors to ill-health, integrating health messages across all Government policy, and working with key partners to achieve the goal of a healthier community.

I am confident that by building upon our strong working relationships with Government, non-government, industry, education and community partners, we can achieve healthier, longer and better quality lives for all Western Australians.

Kim Snowball
DIRECTOR GENERAL

December 2012
Executive summary

About the WA Health Promotion Strategic Framework 2012–2016

- The WA Health Promotion Strategic Framework 2012–2016 (HPSF) sets out WA Health’s strategic directions and priorities for the prevention of avoidable chronic disease and injury over the next five years.
- The goal of the HPSF is to lower the incidence of avoidable chronic disease and injury in WA by facilitating improvements in health behaviours and environments.
- The main target populations for the HPSF are people who are currently well, and those who are at risk of developing disease or experiencing injury. These groups are reached by adopting a “whole of population” approach.
- A conceptual overview of the HPSF is provided in Figure 1 (page 11).

Who will use the Health Promotion Strategic Framework?

- The main readership of the HPSF is likely to be Government departments and agencies, non-government organisations, and health, medical and other professional and voluntary organisations with a direct involvement in health promotion. However to achieve the goal of a healthier State, a wide range of organisations, groups and individuals will need to be involved across trade and industry, public and private sector workplaces, educational bodies, local government authorities, community groups, the general public and the media.
- The HPSF sets broad strategic priorities to achieve the greatest health gain for the WA community, but decisions regarding appropriate interventions will differ between organisations and settings, depending on their responsibilities and priorities.
- The HPSF emphasises the importance of building strong and supportive partnerships across sectors to work towards the common goal of improving the population’s health. An important measure of the HPSF’s success will be its ability to act as a catalyst for cooperation and concerted action.

Links with other health policies

- The HPSF complements Commonwealth and State policies which support better health for Western Australians. These include policies which specifically address the health of Aboriginal people; mental illness; communicable diseases including sexually-transmitted diseases; and prevention and management of chronic disease in people who have already been diagnosed with a health condition.

Our state of health

- The average life expectancy for most Western Australians is longer than ever before, due to successful disease control measures, safer living and working conditions, better nutrition, and a reduction in smoking.\(^1,2\)
- However this positive trend has not been observed in all population groups. Aboriginal life expectancy is on average 12 years lower for men, and 10 years lower for women than for other Australians. Most of the difference in life expectancy between Aboriginal people and the overall population is due to higher incidence of chronic diseases.\(^3\)
- The State’s demographic profile is changing, as the proportion of older Australians increases in relation to younger groups, and the State’s population continues to grow.\(^4\)
Obesity has overtaken tobacco as the largest contributor to sickness and death in WA, and the overall prevalence of obesity continues to increase. Growth in the ageing population and the impact of obesity and other lifestyle and biomedical factors will have a profound effect on future demand for health and support services, with important economic and workforce implications for the State and Commonwealth health systems.

**Chronic disease and injury in WA**

- Chronic diseases include heart disease, stroke, some types of cancer, type 2 diabetes and respiratory diseases such as chronic obstructive pulmonary disease and asthma.
- Chronic diseases are a major contributor to the total burden of disease, and are the leading cause of potentially avoidable deaths in WA.
- Compared with other disease groups, injuries were the fourth most common cause of death in WA between 2000 and 2007.
- The risk of developing chronic disease and experiencing unintentional injury can be reduced by avoiding: being overweight or obese; poor diet and excessive energy intake; insufficient physical activity; tobacco use; and harmful levels of alcohol use.
- In 2011, over half (51%) of Western Australians aged 16 and over reported being diagnosed with at least one chronic health condition or having been injured in the past year.
- Between 2006–2010, injuries were the leading cause of death among children and adults under the age of 44 in WA.
- People who are disadvantaged or live outside major cities, and people who live with a disability or mental illness are generally at greater risk of chronic disease or injury.
- Aboriginal people have a higher risk of developing chronic disease and suffering injury. About 80% of the mortality gap between Aboriginal people and other Australians aged between 35–74 is due to potentially avoidable chronic diseases.
- Some culturally and linguistically diverse communities also have a higher prevalence of risk factors for disease. This may be due to cultural and social reasons related to their country of origin, or because they may be at greater risk of being disadvantaged.
- Between 2005–2011, chronic diseases and injury cost an estimated $4.3 billion in hospitalisation in WA. A proportion of these hospitalisations could have been avoided.

**Complex health problems need comprehensive solutions**

- The HPSF recognises the importance of the influences of the social, cultural and physical environment on health behaviours, as well as the effect of individual circumstances on shaping personal priorities and decision-making about health and other behaviours.
- Addressing complex health issues requires comprehensive solutions; intersectoral collaboration beyond the immediate health sphere; and a long term vision. The importance of working in partnerships is understood and actively supported by WA Health.
Population-wide interventions should be complemented by specific strategies to target hard-to-reach groups, and those who are most vulnerable to developing preventable chronic disease or experiencing injury.

Whose health will benefit from this Framework?
- Chronic disease and injury directly or indirectly have an impact on all Western Australians. It is sound public health practice to place population-wide approaches at the centre of health promotion strategies for curbing the epidemic of chronic disease and reducing injury.
- However, some groups are more vulnerable, or are at greater risk of developing chronic disease and injury, due to their age or circumstances; and the population also includes hard-to-reach groups; groups for whom mainstream programs may not be accessible, culturally relevant or appropriate; and those who are more vulnerable to preventable chronic disease or injury. For these groups, additional targeted interventions may be needed.

A framework for action
- The HPSF adopts a comprehensive approach to health promotion by using a broad range of intervention “levers.” These are:
  - development of healthy policy at government and organisation level
  - legislation and regulation
  - economic interventions
  - creating environments for living, working and relaxing which support healthy behaviours
  - raising public awareness and engagement
  - community development
  - targeted interventions
  - strategic coordination, building partnerships and capacity building.
- Priorities for each type of intervention are identified for the HPSF’s key areas. These are:
  - eating for better health
  - a more active WA
  - maintaining a healthy weight
  - making smoking history
  - reducing harmful alcohol use
  - creating safer communities.

Putting policy into practice
- Building strong, cooperative partnerships is central to implementation of the HPSF. A broad range of sectors have a role to play in supporting healthy living, including industry, education, the parks and recreation sectors, non-government organisations, and all levels of government.
- WA Health sets targets for reduction in chronic disease and injury which are measured against Key Performance Indicators (KPIs). The Government of WA is also committed to meeting targets set out in National Agreements.
- Progress in implementation and measuring effectiveness of interventions to reduce the incidence of chronic disease and injury may be assessed by using qualitative or quantitative measures, or both, depending on the interventions which are being measured.
Informing future planning

- WA Health will monitor health promotion activities to build the evidence base about activities in this State, and continue to monitor and critically review strategies, programs and evidence originating from elsewhere in Australia and where relevant, internationally.

- WA Health places priority on developing structured ways of sharing and building on knowledge with key partners and stakeholders.

- The value and importance of a collaborative and consultative approach to research priority setting is well-recognised. WA Health will seek ways of focussing the research agenda, as well as capitalising and building on research capacity in this State.
**Figure 1: Conceptual overview of the Western Australian Health Promotion Strategic Framework 2012–2016**

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<td>• Improve food security</td>
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Introduction

About the Health Promotion Strategic Framework 2012–2016
The WA Health Promotion Strategic Framework 2012–2016 (HPSF) builds on the previous HPSF (2007–2011) and sets out WA Health’s strategic directions and priorities for the prevention of chronic disease and injury over the next five years.

The goal of the HPSF is to lower the incidence of avoidable chronic disease and injury in WA by facilitating improvements in health behaviours and environments.

The target populations for the HPSF are people who are currently well, and those who are at risk of developing disease or experiencing injury by engaging in risky lifestyle behaviours. These groups are reached by adopting a “whole of population” approach.

There is an important role for health promotion across the continuum of care. This is addressed in complementary frameworks and policies of WA Health.

Strategies to encourage healthier and safer populations require a sustained and long term investment in health promotion (Box 1) and an integrated approach which takes into account the wider socioeconomic, cultural and environmental conditions which shape behaviour.

Box 1: What is meant by health promotion?
WA Health uses the World Health Organization’s broad definition of health promotion, which states that: “Health promotion represents a comprehensive social and political process, it not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health. Health promotion is the process of enabling people to take control over the determinants of their health and thereby improve their health.”

Effective health promotion operates on a number of levels. It includes policy development by governments and organisations; legislation and regulation; economic interventions; creating environments for living, working and relaxing in which support healthy behaviours; raising public awareness and engagement; community development; providing targeted interventions; and strategic coordination; building partnerships, and capacity building to maximise impact and develop a sustainable framework for ongoing action.

This HPSF identifies priorities in each of these key areas, and encourages a coordinated, consistent, evidence-based approach to achieve best practice. Where there is a lack of evidence for successful interventions, then initiatives underpinned by sound theoretical basis or expert opinion are to be encouraged.
Who will use the Health Promotion Strategic Framework?

The HPSF has been developed for use by all agencies and organisations with an interest in promoting better health in WA. Achieving a healthier WA will require the involvement of many partners, including Government departments and agencies; non-government organisations; professional and voluntary organisations; trade and industry groups; educational bodies; public and private sector workplaces; health professionals; community groups, the general public and the media. Each of these groups has the power to contribute to better health in their own way, and many are already doing so. The HPSF sets broad strategic priorities to achieve the greatest health gains for the WA population. Decisions regarding appropriate interventions will differ between organisations and settings, depending on their responsibilities and priorities.

Many local governments in WA are working hard to build healthier communities. At the time of writing, a new Public Health Act for WA is being developed, with the aim of offering better protection for and promoting the health of the public, and of reducing the incidence of preventable illness and injury. The HPSF will help guide local governments in setting health promotion objectives and priorities for their communities.

The HPSF emphasises the importance of building strong and supportive partnerships across sectors to work towards the common goal of improving the population’s health, and demonstrates that our ability to bring about these changes depends on developing close partnerships with other sectors and the community. An important measure of the HPSF’s success will be its ability to act as a catalyst for cooperation and concerted action.

Links with State and Commonwealth health policies and agreements

WA Health’s overarching policy, the WA Health Strategic Intent, envisions “healthier, longer and better quality lives for all Western Australians.” The Strategic Intent affirms the Government’s commitment to health promotion, illness prevention and early intervention, and to working towards closing the gap in health and wellbeing between Aboriginal and non-Aboriginal Western Australians.

The HPSF complements, and is not intended to duplicate or replace the range of policies which address different or specific aspects of health in WA. For example:

- **The health of Aboriginal people** is specifically addressed in several major policy and program areas. These include initiatives implemented under the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, and State policy frameworks developed by the Office of Aboriginal Health (http://www.aboriginal.health.wa.gov.au/), WA Country Health Services (http://www.wacountry.health.wa.gov.au/), the Drug and Alcohol Office (http://www.dao.health.wa.gov.au/) and the Mental Health Commission (http://www.mentalhealth.wa.gov.au/)

- **Mental health issues** are addressed by the Mental Health Commission in policies which include Mental Health 2020: Making it personal and everybody’s business and the Western Australian Suicide Prevention Strategy 2009–2013, available from http://www.mentalhealth.wa.gov.au/

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e A summary of programs and projects undertaken during 2011 to reduce the risk of chronic disease in WA may be found here: http://www.public.health.wa.gov.au/2/1649/2/chronic_disease_prevention_stocktake.pm

- **Alcohol and other drugs policies** are developed across Government, and coordinated by the Drug and Alcohol Office. The *Drug and Alcohol Interagency Strategic Framework for Western Australia 2011–2015* and other resources are available from http://www.dao.health.wa.gov.au/Informationandresources/Nationalandstatepolicies.aspx

- **Communicable (infectious) diseases**, including sexual health and associated chronic diseases which may arise from infectious diseases, are addressed in plans and policies managed by the Communicable Disease Control Directorate within the Public Health and Clinical Services Division of the WA Department of Health. For more information, visit: http://www.public.health.wa.gov.au/1/1078/2/infectious_diseases_sexual_health_and_immunisation.pm


- **Injury prevention** is also addressed in the *WA Non-Major Trauma Framework*, and **falls prevention** is addressed in the *Falls Prevention Model of Care for the Older Person in Western Australia*. These documents are available from http://www.healthnetworks.health.wa.gov.au/home


- **Active ageing** is led by the Department for Communities through the *Seniors Strategic Framework*, available from http://www.communities.wa.gov.au/serviceareas/seniors/Pages/default.aspx

In the past, state tobacco policy has been addressed in a separate *Western Australian Tobacco Action Plan*. Tobacco control policy is now included in the HPSF.

WA Government Departments of Sport and Recreation; Education; Planning; Transport; Environment and Conservation; Communities; and Corrections also develop policies and strategies which provide for the support and promotion of healthier lifestyles for Western Australians.

At a national level, the HPSF is aligned with major health agreements between the Commonwealth and the WA Government, including the *National Partnership Agreement on Preventive Health*[^16] (Box 2), the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes*[^17] (Box 3) and the *National Healthcare Agreement*.[^18]
Box 2: The National Partnership Agreement on Preventive Health

The National Partnership Agreement on Preventive Health (NPAPH) is an agreement between the Commonwealth and all States and Territories. It is the largest investment ever made by an Australian Government in disease prevention, providing $932 million nationally between 2009 and 2018.

The aim of the NPAPH is to address the rising prevalence of lifestyle-related chronic diseases and encourage the adoption of healthy behaviours, with a focus on the priority areas of smoking, nutrition, physical activity and alcohol. Under the NPAPH, WA Health and its partners are delivering programs aimed at children through settings such as schools, child care centres, community health centres and other community settings; and programs targeting the adult population via workplace and community-based programs. Local activities complement national level campaigns.

The NPAPH also provides funding to help build up knowledge and expertise about preventing illness and disease associated with lifestyle risk factors.

For more information, see the NPAPH website:

In WA, more than $117 million has been allocated to Closing the Gap programs over four years. Our footprints—a traveller’s guide to the COAG implementation process in Western Australia provides further information on Closing the Gap programs in WA.

Box 3: The National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes

This important agreement spans 2009–2013 and identifies five priority areas to “close the gap” between Aboriginal health outcomes and the rest of the Australian population. These are: tackling smoking; providing a healthy transition to adulthood; making Aboriginal health everyone’s business; delivering effective primary health care services; and better coordinating the patient journey through the health system. The agreement provides funding for a range of programs aimed at reducing chronic disease in Aboriginal people by addressing the lifestyle risk factors of tobacco use, poor diet and insufficient physical activity.

Closing the Gap acknowledges the importance of adopting an holistic, life stage approach to reaching its objectives. The agreement also recognises the need to work across government to address the underlying social determinants of poor health, including education, housing and employment.

The HPSF is consistent with national health strategies including the National Chronic Disease Strategy and the National Drug Strategy 2010–2015. The policy framework proposed by the HPSF also accords with World Health Organization recommendations for preventing chronic disease and injury.

Links to other important Commonwealth and State policies are included in the Appendix.
Part 1 Our state of health
Part 1 Our state of health

Overview

Most of the population can expect to live longer

- Australians have among the longest life expectancies in the world. Current life expectancy for today’s infants is 79.5 years for males and 84 years for females, and it is continuing to increase. More Western Australians are leading longer, healthier and injury-free lives due to a range of factors, including improved control of many infectious diseases, better sanitation and hygiene, safer living and working conditions, and advances in medical knowledge and health care technology. Better nutrition, lower prevalence of smoking and health promotion measures have also contributed to a longer life expectancy.

- These overall improvements have not, however, been observed in all population groups. Aboriginal life expectancy is on average 12 years lower for men, and 10 years lower for women than for other Australians. Most of the difference in life expectancy between Aboriginal people and the overall population is due to higher incidence of chronic diseases.

The Western Australian population is getting older

- The WA population profile, as elsewhere in Australia, is changing. Increased life expectancy and lower birth rates mean that the proportion of older Australians is increasing in relation to younger groups, a trend which is set to continue. According to estimates by the Australian Bureau of Statistics, the percentage of the Australian population aged 65 and older could increase from 13% in 2007 to 23% by 2056.

... and increasing in number,

- Interstate and overseas migration continues to fuel WA’s population growth, as well as natural increase through births. By 2056, the population of WA is projected to double to more than 4.3 million people, and the population of Perth could increase from 1.6 million people in 2007, to 3.4 million people.

as well as size

- Obesity has overtaken tobacco use as the largest contributor to sickness and death in WA, and the overall prevalence of obesity continues to increase. The impact of obesity on population health is so substantial that without intervention, it has the potential to reverse the improvements in life expectancy gained over recent years.

- Other important contributors to ill health in the population include smoking, lack of physical activity, high blood pressure, high blood cholesterol, harmful alcohol use and poor nutrition.

Growth in the ageing population and the impact of obesity and other lifestyle and biomedical factors will have a profound effect on future demand for health and support services. The incidence of health problems associated with ageing, including chronic diseases, injury due to falls, disability and dementia is likely to escalate in coming decades, with important economic and workforce implications for the State and Commonwealth health systems. Wherever possible, effective preventive measures must be introduced as a matter of priority.

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1 These ABS projections are largely based on current trends in fertility, life expectancy at birth, net overseas migration and net interstate migration.
The *Health Promotion Strategic Framework* focuses on preventing chronic disease and injury in the Western Australian population.

**Understanding chronic disease and injury**

Chronic diseases are non-infectious health conditions which usually have a number of contributing factors, develop gradually, and have long-lasting effects. Some diseases may lead to many years of disability and require long-term management, while others cause premature death. Chronic diseases have substantial health, economic and social consequences. They are a major contributor to the total burden of disease, and are also the leading cause of potentially avoidable deaths in WA.

Chronic diseases are complex, and vary in nature, causality and health implications. Chronic diseases include heart disease, stroke, some types of cancer, type 2 diabetes and lung diseases such as chronic obstructive pulmonary disease and asthma. Chronic kidney disease, oral diseases, osteoarthritis and osteoporosis are other common chronic diseases.

Once they have developed, most chronic diseases cannot usually be completely cured, but it is possible to reduce the risk of developing many diseases, or to reduce their severity, by avoiding the following lifestyle risk factors:

- Being overweight or obese;
- Poor diet and excessive energy intake;
- Insufficient physical activity;
- Smoking; and
- Harmful levels of alcohol use.

Preventing injury is often considered in partnership with approaches to prevent chronic disease, because addressing lifestyle risk factors may also help reduce the incidence of unintentional injury in the community. People who already have a chronic disease may also be at greater risk of injury. For example, people with osteoporosis are more likely to fracture or break bones if they fall.

There are also important links between mental health, chronic disease and risk of injury. People with chronic disease are more likely to report having a mental disorder than people who do not have a chronic disease, and people with mental illness are more likely to experience chronic diseases due to a higher prevalence of lifestyle risk factors. People with mental illness are also at greater risk of injuring themselves (accidentally or deliberately) and experiencing injury at the hands of others.

**What do we mean by prevention?**

In the HPSF, ‘prevention’ refers to reducing the risk of developing chronic disease or being injured through modifying risk factors.

The main focus for the HPSF is people who are currently well, and those who are at risk of disease or injury because they engage in risky lifestyle behaviours. In addition there is also an important role for prevention in people who are already diagnosed with a chronic disease. For these people, it is important to help prevent disease progression, to avoid the onset of other chronic diseases or health problems, and to reduce the risk of injury.

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Footnotes:

- Burden of disease is a measure which takes account of the amount of disability and sickness associated with a condition or injury, as well as the number of deaths.
- Injury and death due to self-harm are not directly addressed by the *WA Health Promotion Strategic Framework*. The Mental Health Commission develops policy and planning for mental health in this State. This includes the *Western Australian Suicide Prevention Strategy 2009–2013*. Visit: [http://www.mentalhealth.wa.gov.au/Homepage.aspx](http://www.mentalhealth.wa.gov.au/Homepage.aspx)
The HPSF does not directly address health promotion interventions for people who are already unwell. Strategies for health promotion in these population groups are provided in companion policy documents developed by WA Health. Some of these are listed on pages 13–14.

Chronic disease and injury in WA at a glance

Chronic disease and injury cause substantial deaths and illness

- Nearly two-thirds (64%) of all deaths in Western Australians aged under 75 in 2006 could potentially have been avoided. The majority of these deaths were due to chronic disease or injury.\(^1\)
- Nearly one third (30%) of the total burden of disease and injury\(^i\) (including deaths, disability, and loss of quality of life) in WA in 2006 was due to preventable risk factors. Excess body weight, smoking and physical inactivity were the leading causes of deaths, disability and loss of quality of life.\(^5\)
- Compared with other disease groups, injuries\(^j\) were the fourth most common cause of death in WA between 2000–2007.\(^7\)
- Between 2006–2010, injuries were the leading cause of death among children and adults under the age of 44 in WA.\(^9\)

The main modifiable risk factors for chronic disease are common...

Among WA children in 2011:

- Almost one in five (19%) of 5–15 year olds were overweight or obese,\(^{40k}\)
- Fewer than half (46%) of children aged 5–15 met the recommended guidelines for physical activity,\(^{40l}\) and
- Nearly seven out of ten (69%) of WA children aged 4–15 consumed their recommended daily intake of fruit, but only half (50%) met their recommended daily intake of vegetables.\(^{40m}\)

Among WA 12–17 year olds in 2011:

- Almost one in five (18%) reported drinking in the previous week, and of this group, more than one third (36%) drank at levels that placed them at risk of injury on a single occasion of drinking.\(^{42n}\) and
- Six percent were current smokers.\(^{43o}\)

\(^1\) This report only included disability and death due to injury which was attributable to tobacco, alcohol and illicit drug use. Suicide and self-harm were included.
\(^j\) Including suicide and self-harm.
\(^k\) According to standard international definitions.\(^{39}\)
\(^i\) based on the National physical activity guidelines for Australians—see Box 8.
\(^l\) based on the Dietary guidelines for children and adolescents in Australia, 2003.\(^{41}\)
\(^m\) based on the Australian guidelines to reduce health risks from drinking alcohol—see Box 12.
\(^n\) Defined as having smoked in the week prior to the survey.
Among WA adults aged 16 and over in 2011:

- Two-thirds (66%) were overweight or obese,\(^p\)
- Almost half (47%) did not get enough physical activity,\(^l\)
- Nearly two in five (38%) drank at a level which placed them at risk of lifetime risk of harm from alcohol-related disease or injury,\(^n\)
- About half included enough fruit in their diet (49%), but only about one in ten (11%) ate the recommended five serves of vegetables daily,\(^p\) and
- Eleven percent were daily smokers.

...and are responsible for a number of different diseases and health problems

- Being overweight or obese, having a poor diet, not getting enough exercise, smoking, and harmful levels of drinking contribute to many different kinds of chronic disease, and also increase the risk of injury (Table 1).
- Having multiple risk factors may increase the chance of developing chronic disease,\(^32\)

Many Western Australians suffer from chronic disease or injury...

- In 2011, about half (51%) of men and women aged 16 and over reported being diagnosed with at least one chronic health condition or having been injured in the past year,\(^8\) and one quarter (25%) of the population aged 16 and over had sought attention from a health professional for an injury in the past year,\(^6q\)
- The risk of developing a chronic disease increases with age,\(^32\)
- Males are more than twice as likely to die from injury as females,\(^7\)

...but some people are more at risk than others

- People who are disadvantaged, or who live outside major cities,\(^10\) and people who live with a disability or mental illness,\(^11\) are generally at greater risk of chronic disease or injury because of a higher prevalence of most risk factors.
- Some culturally and linguistically diverse communities also have a higher prevalence of risk factors for disease.\(^13\) This may be due to cultural and social reasons related to their country of origin, or because they may be at greater risk of being disadvantaged.

Aboriginal people have much greater risk of chronic disease and injury

- Aboriginal people overall experience a greater burden of disadvantage, disability and mental illness, and have a higher risk of developing preventable chronic disease and suffering injury,\(^12\)
- Aboriginal life expectancy is on average 12 years lower for men and 10 years lower for women than for other Australians. About 80% of the mortality gap between Aboriginal people and other Australians aged between 35–74 is due to chronic diseases,\(^3\)

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\(^p\) Based on definitions used in the *Dietary guidelines for Australian adults*.\(^44\)

\(^q\) Chronic conditions included ever having been diagnosed with arthritis; heart disease; stroke; diabetes; osteoporosis; cancer (excluding skin cancer); a respiratory condition lasting 6 months or more; or a current diagnosis of asthma. Injury was defined as an injury in the past 12 months that required treatment by a health care professional.
Preventing chronic disease and injury makes good economic sense

- Between 2005–2011, chronic diseases\(^1\) and injury\(^2\) cost an estimated $4.3 billion in hospitalisation in WA,\(^3\) a proportion of which could have been avoided.\(^4\)

- In 2011 alone, chronic diseases cost an estimated $425 million, and injury a further $327 million in hospitalisation costs, a proportion of which could have been avoided. Heart and circulatory diseases accounted for an estimated $223 million, which was more than half (52%) of hospitalisation costs due to chronic disease. Injury due to falls was responsible for more than 40% ($140 million) of the total estimated hospitalisation costs attributed to injury in WA.\(^5\)

- These figures do not include costs of other medical and health care, losses in productivity, and the financial and social impact on individuals and their families.

- As the proportion of the State's ageing population continues to increase, costs associated with chronic disease and injury are expected to rise as well.

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\(^1\) Including some cancers, diabetes, cardiovascular disease, COPD and asthma.

\(^2\) Excluding intentional self-harm, injury due to medical complications, external causes of undetermined intent, and other external causes of morbidity and mortality.

\(^3\) Cost estimates are based on Australian Refined Diagnosis Related Group (AR-DRG) average costs sourced from the Department of Health and Ageing.

Table 1: **Associations between risk factors and selected chronic diseases and injury**

<table>
<thead>
<tr>
<th>Risk factors</th>
<th>Cardio-vascular diseases</th>
<th>Type 2 diabetes</th>
<th>Mental health</th>
<th>Chronic kidney disease</th>
<th>Some cancers</th>
<th>Injury</th>
<th>Osteoporosis</th>
<th>Oral diseases</th>
<th>Arthritis</th>
<th>Asthma</th>
<th>COPD*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Behavioural</strong></td>
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<tr>
<td>Tobacco smoking</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
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<td>✔</td>
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<td>✔</td>
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<tr>
<td>Physical inactivity</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
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<tr>
<td>Harmful alcohol use</td>
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<td>✔</td>
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<td>✔</td>
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<tr>
<td>Poor nutrition</td>
<td>✔</td>
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<tr>
<td><strong>Biomedical</strong></td>
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<tr>
<td>Overweight and obesity</td>
<td>✔</td>
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<td>✔</td>
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<td>High blood pressure</td>
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<td>High blood cholesterol</td>
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<tr>
<td>Early life factors (including low birthweight)</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
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</tbody>
</table>

*COPD: Chronic obstructive pulmonary disease includes chronic bronchitis, emphysema, and bronciectasis.

Sources: AIHW, National Advisory Committee on Oral Health.

**A closer look at the causes of chronic disease and injury**

It is well known that being overweight and unfit are bad for heart health; that smoking causes lung cancer; and that drink-driving leads to road crashes. But to reduce the rate of preventable injury, disability, disease and death in the community, then it is important to look at the causes of the causes: the underlying factors which lead to taking up smoking; or to gaining weight and not getting enough physical activity; as well as broader issues such as society’s attitudes to alcohol use and how easy or affordable it is to buy and prepare nutritious foods.
The main determinants of health

There are many positive changes that individuals and families can make, but if the environment in which they exist—where they live, work and play, interact and experience life—is not conducive to health, the impact on individual behaviours may be severely limited.—National Preventative Health Taskforce.

A range of interrelated factors contribute to health outcomes (Figure 2). Personal factors—our age, gender and genes—are affected by individual lifestyle behaviours, which are in turn shaped by family, social and community influences. The immediate environment, including how and where we live; access to education, employment and information; availability and affordability of nutritious food; as well as access to safe and adequate health care, services and information have an impact on opportunities and behaviours. Beyond this, broader influences include societal, religious and cultural attitudes and norms; government; national identity; and overarching socioeconomic conditions.

These influences impact on personal health to a greater or lesser extent at all stages of life (see Box 4—A “whole of life” approach to preventing chronic disease and injury).

Figure 2: The main determinants of health as conceptualised by Dahlgren and Whitehead.

![Figure 2: The main determinants of health as conceptualised by Dahlgren and Whitehead.](image)

As well as understanding how the social, cultural and physical environment influences health behaviours, it is also important to understand how individual circumstances affect personal priorities and choices about health and other behaviours. One model which helps to explain this in general terms is shown in Figure 3.

The most fundamental human concerns (Level 1) revolve around the basic physiological requirements of living—air, water, food and shelter. Once the fundamental needs for survival are met, then the next priority is safety, including personal, family and financial security. Following this is the need for love and a sense of belonging, followed by esteem. Esteem encompasses confidence, self-respect, respect of others and personal achievement. The final stage is self-actualisation, which is being able to reach one’s full potential. This model, as proposed by Maslow, helps us understand how immediate basic needs must be met before an individual is likely to place priority on changing lifestyle behaviours which may appear to offer a distant benefit of better health. It also helps put into context the complex role played by certain lifestyle risk factors which are closely linked to social bonding (Level 3), such as alcohol and tobacco use.
Figure 3: **Maslow’s hierarchy of needs.**

<table>
<thead>
<tr>
<th>Level 5 — Self-actualisation — Fulfilling personal potential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 4 — Esteem — Confidence; respect; achievement</td>
</tr>
<tr>
<td>Level 3 — Sense of belonging; love</td>
</tr>
<tr>
<td>Level 2 — Safety and security</td>
</tr>
<tr>
<td>Level 1 — Physiological needs (food; shelter)</td>
</tr>
</tbody>
</table>

The relative importance of and the specific elements of these levels may vary between cultural groups.

Effective health promotion therefore takes account of individual and community circumstances and influences, as well as the broader contexts which shape lifestyle behaviours.

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**Box 4: A “whole of life” approach to preventing chronic disease and injury**

A “whole of life” approach to preventing chronic disease and injury acknowledges that at every stage of life, there is the potential to prevent the development of disease or risk of injury, and improve health and wellbeing.

The risk of developing chronic disease begins even before birth. Maternal health and nutrition, and exposures to risk factors such as alcohol and tobacco use impact on infant and child health. Breastfeeding in infancy and good nutrition in childhood help to protect against obesity, and the early onset of chronic diseases. Home, school, neighbourhood and cultural environments shape eating behaviours and patterns of physical activity during childhood, and set the stage for attitudes towards tobacco, alcohol and other drug use during adolescence.

In adulthood, pregnancy and parenthood mark a key time for re-evaluating lifestyle behaviours. Adults with unhealthy lifestyle behaviours are at greatest immediate risk of developing chronic diseases and suffering injury, and significant health gains can be made by bringing about changes in unhealthy practices. Other key opportunities arise for promoting healthy lifestyles as adults develop symptoms of, or are diagnosed with chronic diseases, and become aware of increasing rates of illnesses and deaths among family and friends.

The risk of developing a chronic disease increases with age. Adopting healthier behaviours can slow disease progression, improve health outcomes, and prevent the onset of additional health problems. Moving into older age provides opportunities for promoting active and healthy ageing.

Adopting a healthier lifestyle at any age can improve health and increase vitality.
Complex health problems need comprehensive solutions

The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by non-governmental and voluntary organisations, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health.—The Ottawa Charter, World Health Organization.

To reduce the impact of preventable chronic disease and injury, and improve health outcomes for Western Australians, we must raise and broaden awareness about health issues and how to address them in the community. Government must take a leading role in setting the agenda for reform, informing debate, making sure that credible, reliable information is widely communicated, and forming multisectoral and multilevel links so that health considerations become an essential component of policy development. The role of the non-government sector is critical. The importance of working in partnerships is recognised and actively supported by WA Health (see Part 4).

Changing attitudes and behaviours and introducing the systemic changes needed to support and sustain healthier ways of living are not objectives which can necessarily be attained quickly. A long term vision is required in order to meet the challenge of improving health outcomes in WA.

Whose health will benefit from this Framework?

Chronic disease and injury directly or indirectly have an impact on all Western Australians. It is sound public health practice to place population-wide approaches at the centre of health promotion strategies for curbing the epidemic of chronic disease and reducing injury. A small shift in the average population levels of several risk factors can lead to a large reduction of the burden of chronic disease. Therefore the HPSF fundamentally espouses a whole of population approach. However, it is also understood that some groups are more vulnerable, or are at greater risk of developing chronic disease and injury, due to their age or circumstances. For these groups, additional targeted interventions are needed. The importance of targeting critical life stages and age-groups is embodied in the “whole of life” approach to chronic disease and injury, outlined in Box 4.

Groups within the population who are at risk due to circumstance rather than stage of life include those living in socially or economically disadvantaged circumstances. Disadvantage is closely linked with a higher likelihood of experiencing chronic disease and injury, and poorer health outcomes.

Interventions intended for people living with disadvantage must take into account the complexity of disadvantage and its impact on health behaviours and outcomes, and the barriers it can pose to behavioural change. These interventions should also consider and help address the generally lower levels health literacy which are associated with disadvantage (Box 5).
Box 5: Health literacy

Health literacy may be defined as “the knowledge and skills needed to understand and use information relating to health issues such as drugs and alcohol, disease prevention and treatment, safety and accident prevention, first aid, emergencies and staying healthy.”\(^{57}\)

The ability to interpret, understand and follow health information depends on being able to apply literacy and numeracy skills to information provided in text, tables and charts. Health literacy influences how an individual navigates the health system, and accesses and responds to information and services. It can therefore directly affect health outcomes.\(^{2}\)

The Australian Bureau of Statistics estimates that about 60% of people aged 15–74 do not have adequate health literacy. Health literacy is lower among people with lesser education and level of income, unemployed people, 15–19 year olds, and the older population.\(^{57}\) It is also lower among people with poorer health status, and some migrant populations.\(^{58}\) Lower health literacy is an indicator for poorer health, including chronic disease,\(^{58,59}\) and may reduce capacity for self-management of disease.\(^{59}\) Higher population levels of health literacy may reduce health-care costs by helping to prevent disease and injury.\(^{2}\)

There are also hard-to-reach groups within the population; groups for whom mainstream programs may not be accessible, culturally relevant or appropriate; and those who are more vulnerable to preventable chronic disease or injury. These groups include:

- Aboriginal people\(^{12}\)
- people with mental illness\(^{11}\)
- people with disabilities\(^{11}\)
- carers and families of people with sickness or disability\(^{2}\)
- populations living in regional and remote areas\(^{32}\)
- some culturally and linguistically diverse populations\(^{13}\)
- new and emerging communities.\(^{60}\)

Well-designed mainstream programs, developed with a view to inclusiveness, have the capacity to be effective in harder-to-reach population groups as well as the wider population. However in some cases it may be necessary to develop unique interventions to meet the needs of specific groups.

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\(^{u}\) New and emerging communities include recently-arrived migrant groups with a small population, which typically lack established personal and community support networks. Many members of these communities will be entering through Australia’s humanitarian program. See: [http://www.omi.wa.gov.au/resources/publications/community_profiles/New_and_Emerging_Communities.pdf](http://www.omi.wa.gov.au/resources/publications/community_profiles/New_and_Emerging_Communities.pdf)
Part 2 A framework for action

The common risk factors contributing to chronic disease prevalence can be modified through cost-effective interventions.—World Health Organization

A comprehensive approach to health promotion requires a combination of interventions which challenge the fundamental causes of chronic disease and injury. These interventions or “levers” can be summarised into eight action areas:

- healthy policies
- legislation and regulation
- economic interventions
- supportive environments
- public awareness and engagement
- community development
- targeted interventions
- strategic coordination, building partnerships and capacity building.

Used in isolation, their impact is reduced. Used in combination, the levers have the potential to cause real change. Table 2 outlines the different components of the comprehensive strategy.

The components of the framework are integrated and inter-dependent. For example, initiatives to improve the built environment as a way of encouraging more physical activity will probably involve operating several “levers”, including the development of appropriate policy; engagement with planning, zoning or building regulatory authorities; and consultation with community groups.

In some cases, interventions will only proceed successfully if one or more levers are engaged first, or at the same time. Development of appropriate healthy policy, based on consultation and endorsement of relevant groups or authorities will often be needed before specific initiatives can be successfully introduced.

Interventions must be coordinated to ensure consistency of approach. As an example, workplace programs to support more nutritious eating behaviours are likely to be undermined if the onsite canteen offers inexpensive, unhealthy food choices. A strong, evidence-based approach informs all components of the Framework. In newly-emerging areas where there is a lack of evidence for successful interventions, then initiatives underpinned by sound theoretical basis or expert opinion are to be encouraged, and outcomes are closely monitored and evaluated.
### Table 2: A framework for the prevention of chronic disease and injury in WA

<table>
<thead>
<tr>
<th>Levers</th>
<th>Some examples of actions which could be taken</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Healthy policies</strong></td>
<td>• Integrate health considerations into government policy and planning across all relevant agencies (such as Departments of Planning, Education, Food and Agriculture).</td>
</tr>
<tr>
<td><em>Who can take action or advocate?</em></td>
<td>• Embed health considerations within the operational policies of organisations, workplaces and schools to support active transport, healthy eating, low risk alcohol use, and proper safety procedures.</td>
</tr>
<tr>
<td></td>
<td>• Adopt flexible work policies to enable mothers to breastfeed.</td>
</tr>
<tr>
<td><strong>Legislation and regulation</strong></td>
<td>• Support the enactment and enforcement of legislation to reduce chronic disease and injury, such as legislation to control tobacco and alcohol availability; promote road safety.</td>
</tr>
<tr>
<td><em>Who can take action or advocate?</em></td>
<td>• Develop and enforce laws and regulations which govern product safety, sales and marketing; clear contents labelling of consumable goods; laws to restrict access of potentially harmful goods to children.</td>
</tr>
<tr>
<td></td>
<td>• Investigate regulatory methods to limit density of alcohol outlets in ways which support low risk alcohol use and do not support harmful alcohol use.</td>
</tr>
<tr>
<td><strong>Economic interventions</strong></td>
<td>• Provide financial incentives to encourage the establishment of health-promoting businesses (such as shops which sell fresh food) in areas which lack access/availability.</td>
</tr>
<tr>
<td><em>Who can take action or advocate?</em></td>
<td>• Create financial incentives to adopt healthy behaviours, for example by reforming taxation on alcohol so that the price of alcohol is increased, and lower strength drinks are more affordable than higher strength drinks.</td>
</tr>
<tr>
<td></td>
<td>• Promote subsidies for first aid training.</td>
</tr>
<tr>
<td></td>
<td>• Provide healthy food choices at competitive prices in canteens, tuck shops and at events.</td>
</tr>
</tbody>
</table>

*continued on next page*
### Levers

#### Supportive environments

**Who can take action or advocate?**
- Governments
- Community groups
- Workplaces
- Schools
- Health professionals
- Health consumers and carers
- Individuals

**Some examples of actions which could be taken**

- Provide neighbourhoods with safe and connected footpaths and cycleways, local amenity, public parks, playgrounds, facilities for physical activity, and adequate public transport.
- Ensure that public, workplace, institutional, school and home environments are designed with safety and facilitation of health behaviours as priorities.
- Ensure reliable and equitable access to a variety of healthy foods.
- Work with the food industry to increase the availability of smaller food and drink portion sizes and reduce salt, sugar, saturated fats and trans-fats in products.
- Provide easy-to-understand information about nutritional content of food choices offered in workplace canteens and public eating places.
- Require the provision of nutritionally acceptable foods in public and other facilities (such as hospitals; schools, childcare centres).
- Limit the density of outlets selling tobacco or alcohol.
- Investigate the impact of density of fast food outlets on eating choices.
- Limit childhood exposure to advertising pressures and role-modelling to eat junk food, or use tobacco or alcohol.
- Promote environments which are supportive of breastfeeding.

#### Public awareness and engagement

**Who can take action?**
- Governments
- Organisations
- Workplaces
- Health professionals
- Schools
- Health consumers and carers
- Individuals

**Some examples of actions which could be taken**

- Develop public education campaigns designed to inform and support the community in modifying lifestyle behaviours.
- Influence professionals, organisations and policy-makers to incorporate consideration of health issues as part of their role.
- Support health professionals in including brief interventions as part of their routine.
- Engage the media as a platform for education and debate.
- Encourage changes at individual and societal level to protect and promote health.

#### Community development

**Who can take action?**
- Governments
- Organisations
- Workplaces
- Schools
- Health professionals
- Communities
- Health consumers and carers
- Individuals

**Some examples of actions which could be taken**

- Work with community groups, local stakeholders, other partners and individuals to define local needs and priorities for better health.
- Adapt mainstream programs and resources for local uses.
- Develop locally-based activities to contribute to healthy lifestyle to suit community needs, such as walking groups; community gardens; farmers’ markets.
- Investigate gaining after-hours access to school sporting and recreational facilities for community purposes.

#### Targeted interventions

**Who can take action?**
- Governments
- Organisations
- Workplaces
- Schools
- Health professionals
- Communities
- Health consumers and carers

**Some examples of actions which could be taken**

- Design and deliver programs to suit
  - specific population groups (such as children, parents or adults, lower SES, Culturally and Linguistically Diverse groups, older people) taking into account health literacy skills
  - particular settings (such as communities, neighbourhoods, workplaces, schools, childcare facilities, residential care settings).
- Adopt policies and practices which support activity in the workplace; such as lunch-time walking groups; showers; bicycle racks; negotiate reduced membership costs at local gym facilities.
Developing healthy policy

WA Health has a significant role to play in the health of all Western Australians. However, as many of the most important influences on the population’s health do not fall within the direct control of the health sector, it is vital to ensure that health and wellbeing are fundamental considerations in public policy development across all sectors.

Making health and wellbeing a shared priority across society has the power to influence the systemic factors which impact on health.\(^{51}\)

This includes (but is not limited to) government departments for planning and urban development, employment, transport, food and agriculture, sport and recreation, the environment, finance, education and tourism, as well as local government. It also embraces industry, non-government organisations, the education sector, professional organisations and the wider community.

Encouraging and supporting agencies and settings including workplaces, schools and community-based organisations to adopt healthy policies and practices helps to extend the reach of health messages, provides a supportive environment for behavioural change, and positively influences cultural norms regarding health behaviours.

Finally, the role of individuals in developing healthy policy should not be overlooked or underestimated. Health consumers and carers have an important contribution to make to the planning, development and delivery of policies and programs to improve health.

Legislation and regulation

Laws and regulations provide the cornerstone for safeguarding and improving public health.\(^{56}\)

Laws can be used to restrict the sales, promotion and use of harmful or potentially harmful substances (such as tobacco and alcohol), or to protect public safety (for example laws on seatbelts in cars and drink-driving). The production, processing, transport, sales and labelling of food are all subject to regulations intended to protect public health and safety.

By introducing and enforcing appropriate legislation to underpin health promoting behaviours, governments demonstrate a firm commitment to healthy public policy and provide a strong foundation for building environments to support health interventions.
While the introduction of legislation is a governmental responsibility, the health sector and the wider community make an important contribution to public debate about the need for regulation, as well as legislative content.

**Economic interventions**

Economic interventions are an effective way of influencing consumer behaviours and consumption patterns. Higher tobacco prices in Australia due to increases in taxation are credited with helping to bring down the prevalence of smoking, particularly in young people. There are also precedents for allocating money raised from taxes on harmful or potentially harmful products to funding of health campaigns. The National Preventative Health Taskforce has identified the potential for tax and other fiscal instruments (including grants, pricing, incentives and subsidies) to be used to influence healthier nutritional behaviours and reduce harmful alcohol use.

**Supportive environments**

All of the environments we encounter—including the town or neighbourhood where we live; workplaces, schools and community settings; our social and cultural networks and in the home – have the potential to influence health outcomes. Environments which support good health may do so by promoting healthy behaviours; by making healthy choices the easier or more attractive choices; by ensuring equitable access to nutritious food; and by denormalising unhealthy or risky behaviours.

Good urban design incorporates well-connected, safe and attractive options for active transport (walking, cycling and public transport) to a variety of locations including schools, shops and workplaces. It also builds in opportunities for physical recreation, and a good mix of housing options. The important contribution of the natural and built environment to community health and wellbeing is recognised by a number of state and national town planning policies.

Adopting healthy policies in specific settings, for example by promoting healthy food options in school and workplace canteens, or by restricting smoking and drinking at public events, all encourage healthier behaviours. The decision of many Western Australians (including smokers) to make their homes smokefree is likely to have helped to drive down smoking rates among young people and adults.

**Public awareness and engagement**

Raising awareness and engaging public interest prompt and motivate the population to consider their lifestyle behaviours and the potential for changing their behaviour to reduce the risk of chronic disease and injury. Engaging the public by providing reliable and consistent information which is relevant at a personal, family, organisational or community level also increases the effectiveness of other health promotion activities.

Mass media campaigns have the capacity to deliver real public health gains if they are well designed and delivered with appropriate reach and intensity.

There are a number of other effective ways of conveying health messages and information. For example, clear product information (such as food and alcohol labelling or health warnings on tobacco packs) has an important role in elevating public awareness and knowledge. Professional groups (such as researchers and health professionals), organisations and the media also have a vital role in disseminating information and contributing to the public discourse about health issues.
Community development

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities—their ownership and control of their own endeavours and destinies.—Ottawa Charter, World Health Organization.55

Community approaches to health promotion take into account the social, cultural, economic, environmental, geographical and other factors which make individual communities distinct. The community is directly engaged in identifying the factors which contribute to ill-health in their particular setting, deciding on priorities and working towards finding and implementing solutions. In some circumstances health and other professionals may work in partnership with communities, participating in decision-making and helping to control implementation of initiatives. In other settings, communities steer their own course, with health professionals acting as co-facilitators.67

Community development applied to health promotion fosters participation, empowerment and sustainability. These important elements help to build more equitable, healthy and resilient communities.

Targeted interventions

Targeted interventions refer to delivery of health interventions in specific settings (such as workplaces, schools, leisure centres and GP surgeries) specific communities (such as remote Aboriginal communities or local government areas) or to particular groups (for example parents, and culturally and linguistically diverse groups), or a combination of these. Targeted interventions need to include, or be part of a larger integrated suite of activities which take account the main and individual determinants of health (see pages 22–23). Targeted interventions also need to take account of, and support the improvement of health literacy skills.

Providing public health messages in specific settings increases the likelihood that they will reach their target audiences, and enables tailoring of messages and associated support activities which will increase their likelihood of success. Many children attend pre-school or childcare and almost all go to school, which means that these settings provide an unrivalled opportunity to reach children and families, and to create health-promoting environments. As a large proportion of the adult population are in employment, workplaces are a powerful setting for introducing health promoting policies and interventions.49 Moreover, healthy policies in workplaces and organisations not only benefit employees, but are cost-effective for employers by reducing absenteeism due to illness and injury.68-70

Healthier and safer behaviours promoted in the workplace or through schools have a “take home” aspect and may influence attitudes and behaviours at home and in other settings.

Community settings are another important setting for delivery of healthy lifestyle interventions. Whole-of-community health promotion interventions which are integrated; involve multiple interventions across multiple settings; target and work with individuals, groups and organisations; and actively involve the community in planning, implementation and evaluation, can be effective in improving health outcomes and reducing health inequalities.71
The health setting is a key environment for health promotion. In 2009–10, 83% of the Australian population had at least one consultation with a GP. There is good evidence that well-planned and delivered interventions in general practice and other health settings can be very successful.

**Strategic coordination, building partnerships and capacity building**

A coordinated approach to health promotion—whether across agencies or wider sectors—ensures that efforts are complementary; the risk of duplication is reduced, and that gaps are identified and filled.

The need for strong and productive partnerships which extend beyond the traditional health sector is intrinsic to delivery of the HPSF. Seeding the development of healthy policies and practices in a wider arena will depend on strengthening and extending existing networks and partnerships, as well as adopting an innovative approach to initiating new ones. Partnership building is discussed further in Part 4.

It is also essential to maximise existing resources through capacity building (Box 6).

**Box 6: Capacity building**

In the context of health promotion, capacity building is the process of developing “sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors, to prolong and multiply health gains many times over.” At a practical level, this concept includes:

1. Building infrastructure to deliver health promotion programs;
2. Building partnerships and organisational environments so that programs are sustained—and health gains are sustained; and

The health sector comprises a large and diverse workforce, and the existing health infrastructure and its networks offer great potential for contributing to health promotion. Nurturing and maintaining a workforce with specialist skills in health promotion is vital, and facilitating ongoing workforce development is a crucial element in maximising opportunities for health promotion. There is a need to ensure awareness of health promotion priorities, and competency in best practice methods to contributing to health promotion across the continuum of care.

Supporting and empowering the health workforce in identifying opportunities for health promotion and delivering advice on healthy lifestyle behaviours is a powerful tool for improving public health.

Associated with this is the need to develop a skilled workforce to undertake research and evaluation of health policies and programs. (See Boosting research capability and setting an agenda for research in Part 4).
Part 3 The five year plan
Part 3 The five year plan

Eating for better health

Good nutrition is essential for healthy growth and development in childhood, and ongoing health and wellbeing, but many Western Australians’ diets are inconsistent with national dietary guidelines. All Western Australians are entitled to equitable access to a safe and nutritious diet.

1. A snapshot of nutrition in Western Australia

- Half (49%) of the WA population aged 16 and over met the recommended minimum intake of two serves of fruit every day, and only 11% met the recommended minimum of five serves of vegetables daily in 2011 (see Box 7—Australian Dietary Guidelines).

- Nearly seven out of ten (69%) of WA children aged 4–15 consumed their recommended daily intake of fruit in 2011, but only half (50%) met their recommended daily intake of vegetables. Older children were less likely to meet recommended daily requirements than younger children.

- In 2011, more than one third (35%) of adults ate meals from fast food outlets at least once a week and two out of five (41%) of children aged 1–15 consumed fast food at least once a week.

- In 2011, more than one third (35%) of adults ate meals from fast food outlets at least once a week and two out of five (41%) of children aged 1–15 consumed fast food at least once a week.

- In 2010, three quarters (75%) of male and more than half (54%) of female secondary school students in WA consumed at least a cup (250ml) of sugar-sweetened beverages per week. National data shows that males aged 16–24 are the highest consumers of soft drinks, drinking an average of almost one litre per day.

- In WA in 2011, seniors (aged 65 and over) were more likely than the rest of the population to suffer from diet-related physiological risk factors such as high blood cholesterol levels and high blood pressure.

- National data show that in 2004–05, metropolitan and regional-dwelling Aboriginal people aged 15 and over were generally less likely to consume recommended amounts of fruit and vegetables than their non-Aboriginal counterparts. Aboriginal people living in remote regions were less likely to eat fruit and vegetables than Aboriginal people in non-remote areas, possibly due to poorer access to fresh produce.

- Although Australian guidelines recommend that babies should be exclusively breastfed in their first six months of life, this was the case for fewer than one in five (19%) of infants in WA in 2011.

- In WA in 2010, foods which were of poorer nutritional value were generally cheaper to buy than fresh fruit, vegetables, meats and dairy foods.

- Food costs rise, and the quality and availability of foods tends to decline with increasing distance from major WA cities. In 2010, a typical healthy food basket cost 24% more in very remote areas.

- In 2011, more than 62,000 (3%) of WA adults reported food insecurity, defined in this survey as having run out of food and being unable to buy more any time within the previous 12 months.
Box 7: Australian Dietary Guidelines (Draft, 2011)\textsuperscript{81}

**Guideline 1:** Eat a wide variety of nutritious foods from these five groups every day:
- Plenty of vegetables, including different types and colours, and legumes/beans;
- Fruit;
- Grain (cereal) foods, mostly wholegrain, such as breads, cereals, rice, pasta, noodles, polenta, couscous, oats, quinoa and barley;
- Lean meat and poultry, fish, eggs, nuts and seeds, and legumes/beans;
- Milk, yoghurt, cheese and/or their alternatives, mostly reduced fat (reduced fat milks are not suitable for children under the age of 2 years);
- And drink water.

**Guideline 2:** Limit intake of foods and drinks containing saturated and trans fats, added salt, added sugars and alcohol.

a. Limit intake of foods and drinks containing saturated and trans fats.
   - Include small amounts of foods that contain unsaturated fats.
   - Low-fat diets are not suitable for infants.

b. Limit intake of foods and drinks containing added salt.
   - Read labels to choose lower sodium options among similar foods.
   - Do not add salt to foods.

c. Limit intake of foods and drinks containing sugars. In particular, limit sugar-sweetened drinks.

d. If you choose to drink alcohol, limit intake.

**Guideline 3:** To achieve and maintain a healthy weight you should be physically active and choose amounts of nutritious food and drinks to meet your energy needs.

- Children and adolescents should eat sufficient nutritious foods to grow and develop normally. They should be physically active every day and their growth should be checked regularly.
- Older people should eat nutritious foods and keep physically active to help maintain muscle strength and a healthy weight.

**Guideline 4:** Encourage and support breastfeeding.

**Guideline 5:** Care for your food: prepare and store it safely.

Promote a shift in dietary intake from excess energy-dense, nutrient-poor foods and drinks to dietary patterns consistent with current guidelines

A healthy diet and good nutrition are essential for good health at all ages. They are critical factors for physical development and general health and aid in the prevention of chronic disease. Many Western Australians are missing out on eating the recommended levels of essential nutritious foods, including fruit and vegetables, and are consuming foods and drinks high in sugar, saturated fats and salt. A number of personal factors can get in the way of healthy eating. Many are not aware of dietary recommendations and are not sufficiently convinced of the importance of a good diet for their own health and their children's health. These factors are compounded by common barriers to healthy eating such as not liking the taste of healthier foods, perceived expense of healthy food options, time constraints and a lack of confidence in the kitchen. Fewer cooking skills are being taught in Australian schools and there is also evidence that skills in basic food selection and preparation may be being lost. This may also be associated with increasing reliance on pre-prepared and convenience foods.

Addressing the factors that determine dietary choices through public education, clear labelling of foods and drinks, and countering the promotion of unhealthy products is vital. Investing in providing accurate, credible and practical information on nutrition and developing food skills can also help to motivate and support individuals in improving their eating habits.

Improve food security

Food security is “the ability of individuals, households and communities to acquire appropriate and nutritious food on a regular and reliable basis using socially acceptable means.” Food security is determined by people’s local food supply and their capacity and resources to access and use that food.

Western Australians do not have equal and reliable access to affordable, nutritious, good quality foods. Eating behaviours are influenced by the cost and availability of food and drink types and the locations of food outlets, including fast food outlets and grocery stores. WA’s food supply delivers energy dense, nutrient poor foods at a cheaper price than nutritious foods. Lower socioeconomic groups, particularly welfare recipients, are particularly disadvantaged by the cost of nutritious foods are less likely to eat according to dietary guidelines, and are more likely to consume more energy-dense, nutrient-poor foods. People living in regional and remote areas face higher prices due to the time and expense of long-distance transport, and have greatly diminished access due to limited food outlets. The range and quality of foods, particularly fresh foods, that is available decreases with increasing distance from the Perth metropolitan area.

How foods are produced, packaged, transported, processed, marketed, accessed, regulated and consumed all have the potential to affect health. A multisectoral, comprehensive approach that engages the agricultural sector, the transport industry, food manufacturers and retailers, and local and state planning authorities is needed to put in place consistent practices and policies to ensure that an affordable, healthy, reliable and environmentally sustainable food supply is available to the whole community.
### 3. Strategic directions for healthier eating in WA, 2012–2016 (Table 3)

**NOTE:** Strategic directions for active living (Table 4) and healthy weight (Table 5) complement and overlap with strategic directions for healthier eating.

<table>
<thead>
<tr>
<th>Healthy policies</th>
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<tbody>
<tr>
<td>Support the development and implementation of organisational policies that encourage and support healthy diet and breastfeeding within key settings, particularly childcare, schools, workplaces and community venues.</td>
</tr>
<tr>
<td>Actively contribute to the development of government policies at all levels which improve equitable, sustainable access to quality healthy and nutritious foods and drinks.</td>
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<table>
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<tr>
<th>Legislation and regulation</th>
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<tbody>
<tr>
<td>Advocate for and support Commonwealth regulatory initiatives in food formulation, labelling and marketing to support healthier eating and reduce consumption of energy dense, nutrient poor foods and soft drinks.</td>
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<tr>
<th>Economic interventions</th>
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<tr>
<td>Support research to identify appropriate fiscal interventions to encourage production of, access to and consumption of healthier foods and drinks.</td>
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<tr>
<th>Supportive environments</th>
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<tbody>
<tr>
<td>Work with food and beverage industries to improve the nutritional quality, cost and availability of foods and drinks; and increase marketing of healthier options.</td>
</tr>
<tr>
<td>Partner with local governments and planning authorities to create environments that maximise local availability of and access to healthy food.</td>
</tr>
<tr>
<td>Seek ways to improve access to quality, affordable, healthy and nutritious foods and drinks among those most vulnerable to poor nutrition.</td>
</tr>
<tr>
<td>Support initiatives that provide accurate, easy to understand nutrition information at point of sale.</td>
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<tr>
<th>Public awareness and engagement</th>
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<tbody>
<tr>
<td>Invest in sustained, high quality statewide public education campaigns that motivate and supports adult and children to adopt a healthy diet.</td>
</tr>
<tr>
<td>Increase access to reliable, practical, culturally-appropriate information about nutritional needs at all stages of life.</td>
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<tr>
<th>Community development</th>
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<tbody>
<tr>
<td>Work with communities and local governments to identify and prioritise actions which will support healthier dietary choices; for example community gardens; farmers’ markets and location of food outlets.</td>
</tr>
</tbody>
</table>
## Targeted interventions

- Build on and support initiatives that increase the availability, access and consumption of healthy, affordable food and drink options in key child and adult settings, such as childcare, schools, workplaces, and hospitals.
- Invest in school and community-based food literacy\(^v\) and food skills development programs targeting key groups, particularly those most at risk of poor nutrition.
- Promote and implement initiatives that support and improve breastfeeding rates.

## Strategic coordination, building partnerships and capacity building

- Continue to work with existing partnerships, and develop new partnerships across all sectors to ensure a coordinated approach to supporting a sustainable, healthier diet for all Western Australians.
- Support skills development among health care professionals and the non-health workforce to deliver initiatives that motivate and support people in making healthy dietary choices.
- Ensure research, evaluation and surveillance structures are in place to build the evidence base of effective interventions and monitor food security, supply, availability, access and intake, and key issues impacting on these.

\(^v\) Food literacy relates to the knowledge of dietary guidelines, menu planning, food purchasing, budgeting, label reading, food selection/shopping, food preparation knowledge and skills.
A more active WA

Regardless of age, all Western Australians need regular physical activity for good physical and mental health.

1. A snapshot of physical activity in Western Australia

- In 2011, 55% of adults aged 16–64 reported being sufficiently active (according to the National Physical Activity Guidelines for Australians—Box 8, and definitions relating to those guidelines—Box 9). This has increased from 47% in 2006.\(^6\)

- As people get older they are less likely to participate in sufficient levels of physical activity. In 2011, about 57% of adults aged 16–44 participated in 30 or more minutes of moderate exercise over five or more sessions in a week. Among those aged 65 and over, 39% engaged in this level of activity.\(^6\)

- Nearly one in four (23%) of people aged 65 and over undertook no leisure time physical activity in 2011.\(^6\)

- In 2009, nearly two in five (39%) of male and female workers in WA reported that their work was mainly sedentary.\(^91\)

- In 2011, almost half (46%) of children aged 5–15 were sufficiently active; 50% of children were insufficiently active; and 4% of children did not engage in any physical activity at all.\(^40\) Younger children (aged 5–9) were more likely to report higher activity levels than older children (aged 10–15).\(^40\)

- Boys aged 5–15 were more likely to achieve sufficient levels of activity than girls aged 5–15 (56% compared to 35%).\(^40\)

- In 2011, two out of five WA children aged 5–15 spent, on average, two or more hours a day on sedentary pursuits (watching television, videos or using a computer). Boys were less likely to be sedentary in 2011 than in previous years, but there was no change in girls’ sedentary behaviour.\(^40\)

- National data collected in 2004–05 found that 75% of Aboriginal adults aged 15 and over were sedentary or engaged in low levels of physical activity.\(^80\)

- In 2008, almost three-quarters (74%) of Aboriginal children aged 4–14 in Australia were reported as being sufficiently active.\(^92\) Remote-dwelling children were more active than those living in cities.\(^92\)

- In 2006, physical inactivity was responsible for 6% of the total burden of disease and injury in WA. More than 1,000 Western Australian deaths were attributable to physical inactivity. The majority of deaths were due to ischaemic heart disease and stroke.\(^5\)

- Premature mortality due to physical inactivity in Australia cost $1.3 billion nationally in hospital and healthcare costs, lost productivity, and economic and social costs in the financial year 2007–08.\(^93\)
Box 8: National Physical Activity Guidelines for Australians

The National Physical Activity Guidelines for Australians provide advice on the levels of activity needed each day for good health. In summary, they state:

For children aged 0–5:
- For healthy development in infants (birth to 1 year), physical activity—particularly supervised floor-based play in safe environments—should be encouraged from birth.
- Toddlers (1 to 3 years) and pre-schoolers (3 to 5 years) should be physically active every day for at least three hours, spread throughout the day.
- For children 2 to 5 years of age, sitting and watching television and the use of other electronic media (DVDs, computer and other electronic games) should be limited to less than one hour per day.
- Children younger than 2 years of age should not spend any time watching television or using other electronic media.
- Children (from birth to 5 years) should not be sedentary, restrained, or kept inactive, for more than one hour at a time, with the exception of sleeping.

For children and teenagers aged 5–18:
- Children and teenagers need at least 60 minutes (and up to several hours) of moderate to vigorous physical activity every day.
- Children and teenagers should not spend more than two hours a day using electronic media for entertainment (eg computer games, TV, Internet), particularly during daylight hours.

For adults:
- Think of movement as an opportunity, not an inconvenience.
- Be active every day in as many ways as you can.
- Do at least thirty minutes of moderate intensity physical activity on most, preferably all, days.
- If you can, also enjoy some regular, vigorous exercise for extra health and fitness benefits.

For older adults:
- Older people should do some form of physical activity, no matter what their age, weight, health problems or abilities.
- Older people should be active every day in as many ways as possible, doing a range of physical activities that incorporate fitness, strength, balance and flexibility.
- Older people should accumulate at least 30 minutes of moderate intensity physical activity on most, preferably all, days.
- Older people who have stopped physical activity, or who are starting a new physical activity, should start at a level that is easily manageable and gradually build up the recommended amount, type and frequency of activity.
- Older people who continue to enjoy a lifetime of vigorous physical activity should carry on doing so in a manner suited to their capability into later life, provided recommended safety procedures and guidelines are adhered to.
Box 9: Defining physical activity levels

Within the HPSF, levels of physical activity are defined as follows:

- Sufficiently active: participates in physical activity at levels that meet or exceed the National Physical Activity Guidelines for their age group.
- Insufficiently active: participates in some physical activity but not at levels sufficient to meet the National Physical Activity Guidelines for their age group.
- Inactive: does not participate in physical activity.

2. Priorities for increasing active living in WA, 2012–2016

Increase the proportion of people who are active enough for good health

The proportion of Western Australians who are meeting recommended levels of physical activity is on the rise, but a substantial number of people are still not sufficiently active for good health. People of all ages need to be encouraged and supported to increase active living (Box 10). This can be achieved in a number of ways, through formal activities—such as by participating in sport or going to the gym, or informally—for example by walking or cycling to the shops instead of driving, and playing in the park. Increasing the duration and intensity of activity above the National Physical Activity Guidelines may result in additional health and fitness benefits.

Although everyone should be encouraged to be more active, the greatest population health gains will be achieved by increasing levels of physical activity in those who are insufficiently active. It is of particular importance in older people, as it helps to improve mobility and balance, and protect against falls.

Box 10: Active living

Active living is a way of life that incorporates activity into daily routines and gets people up and moving. It means increasing physical activity and reducing sedentary behaviour at all stages of life.

Everyday examples of active living include walking or cycling to the shops, school or work; taking public transport instead of driving; participating in an active class; playing sport; unstructured outdoor play for children; using the stairs instead of the lift; doing active tasks; and reducing recreational screen time.

Maintain the physical activity levels of those who are already active enough for good health

It is common for people’s activity levels to fluctuate over time. This may be due to a range of contributing factors, such as changes to personal circumstances, competing time pressures, injury, the weather or loss of personal motivation. Subsequently, there is a risk that those who are sufficiently active may relapse to insufficient levels of activity. Efforts need to be invested in maintaining the activity levels of those who are already sufficiently active for good health.

*The term “older people” primarily refers to those aged over 65 years, and over 55 years for Aboriginal people. For further detail refer to the National Physical Guidelines for Australians, available from: http://www.health.gov.au/internet/main/publishing.nsf/content/health-pubhlth-strateg-phys-act-guidelines
Reduce sedentary behaviour

Over past decades, lifestyles have changed for much of the population. The emergence of more passive forms of entertainment, labour saving devices, more sedentary occupations and increased car use have fundamentally changed how much time people spend being physically inactive at home, at work, during travel and in their leisure activities. It is more common to lead busy though often inactive lives, with prolonged sitting and insufficient physical activity a part of daily routine. For children, screen-based forms of entertainment and socialising via internet and mobile phone, in combination with negative parental perceptions of neighbourhood safety, have also contributed to less active lifestyles.

Recent evidence has shown that prolonged sedentary behaviour, particularly sitting, is associated with health risks, even in people who exercise regularly. It is essential that action is taken to reduce the amount of time people of all ages spend being sedentary.
3. Strategic directions for active living in WA, 2012–2016 (Table 4)

NOTE: Strategic directions for healthier eating (Table 3) and healthy weight (Table 5) complement and overlap with strategic directions for active living.

**Healthy policies**
- Explore and support the development and implementation of operational policies in childcare, school and workplace settings that increase active living.
- Encourage the prioritisation of active transport over private car use.
- In collaboration with other stakeholders, contribute to the development of new, and review of existing relevant Government policies to ensure that they support active living.
- Call for the ongoing implementation of a minimum of two hours’ physical activity per week in all schools.

**Legislation and regulation**
- Support State and Commonwealth Government regulatory initiatives that increase active living. These could include planning, transport and land use requirements that support active transport, and built environments which are conducive to active living.

**Economic interventions**
- Investigate and encourage the development of innovative tax and pricing interventions that facilitate active living.

**Supportive environments**
- Assist in the creation of childcare and school environments that increase opportunities for active play.
- Encourage employers to incorporate and support less sedentary workplace practices.
- Work with the planning and land development sector and advocate for the incorporation of healthy design principles in urban development to support active living, particularly active transport.

**Public awareness and engagement**
- Invest in sustained, high quality statewide public education campaigns that motivate and support adults and children to increase physical activity and reduce sedentary behaviour. Actively reinforce these messages through appropriate settings.
- Increase access to reliable, practical, culturally-appropriate information about the need for physical activity at all stages of life.
- Support communities and stakeholders to advocate for and change local environments and policies that increase active living.

**Community development**
- Work with communities and local governments to identify and prioritise actions which will support more active living; for example walking groups; planning for active neighbourhoods; and outdoor play and recreational areas.
- Advocate for the shared use of physical activity facilities; for example community access to school physical activity facilities outside school hours.

*continued on next page*
### Targeted interventions

- Support and strengthen initiatives that embed active living in childcare, school, workplace and community settings.
- Deliver parent and family-oriented initiatives that increase the ability of parents and carers to establish active lifestyles in children early in life.
- Facilitate the transition from school-based to community-based participation in physical activity in conjunction with other stakeholders.
- Develop programs to meet the needs of those who are less likely to engage in physical activity, or whose health is placed at greater risk through inactivity, such as older people.

### Strategic coordination, building partnerships and capacity building

- Continue to work collaboratively with existing partners, and develop new partnerships across all relevant sectors to ensure a coordinated approach to active living.
- Support capacity building initiatives for the health and non-health physical activity workforce to assist their delivery of best practice active living initiatives.
- Ensure that research, evaluation and surveillance structures are in place to monitor initiatives and key issues impacting on active living.
Maintaining a healthy weight

Overweight and obesity are a major concern for the health system. High body mass increases the risk of a number of serious health conditions, particularly type 2 diabetes, coronary heart disease, stroke, certain cancers, sleep apnoea and osteoarthritis. Children with high body mass have a greater risk of psychosocial problems in childhood, and of being overweight in adulthood.\(^{100}\)

1. A snapshot of overweight and obesity in Western Australia

- In 2011, 66% of Western Australian adults aged 16 and over were either overweight or obese, based on self-reported body mass index (BMI) (see Box 11—How healthy weight is assessed). Males were more likely to be overweight or obese than females (74% compared with 59%).\(^6\)
- Males aged 45–64 had the highest rates of overweight and obesity in the community (85%).\(^6\) In women, the highest prevalence of overweight and obesity occurred in those aged 65 and older (70%).\(^6\)
- Rates of adult overweight and obesity have increased in Australia over the past three decades and show no signs of abating.\(^49\) Between 2002–2011, the proportion of WA adults who were overweight and obese increased from 61% to 66%.\(^6\)
- In 2011, almost one in five (19%) Western Australian children aged 5–15 were classified as overweight or obese (based on BMI).\(^40\) WA research indicates that children who speak a language other than English in their home have a slightly higher BMI.\(^101\)
- Conversely, in 2011, one in twenty (5%) Western Australian children aged 5–15 were underweight.\(^8\) While the vast majority of harm is caused by overweight, being underweight also increases the risk of a range of health and psychosocial issues.\(^102\)
- National data show that Aboriginal people are almost twice as likely to be obese, and more than three times more likely to be extremely obese compared with non-Aboriginal people.\(^103\)
- Rates of overweight and obesity are also significantly higher among lower socioeconomic and disadvantaged groups,\(^104\) people with disabilities,\(^105-107\) people living in rural or remote areas,\(^104\) and some overseas-born populations.\(^104,108,109\)
**Box 11: How healthy weight is assessed**

The following information is taken from the *Draft Australian Dietary Guidelines* (Draft; 2011).81

Healthy weight in adults is assessed through **Body Mass Index (BMI)** or **waist circumference**.

**BMI** is calculated by dividing a person’s weight in kilograms by their height in metres squared (kg/m²). In adults:
- a BMI of less than 18.5 kg/m² is classified as underweight;
- a BMI of 18.5–25.0 is in the healthy weight range;
- a BMI of 25.0 or more is overweight; and
- a BMI of 30.0 or more is obese.

These classifications may not be suitable for all ethnic groups. Some groups may have equivalent levels of risk at a lower BMI (eg people of Asian origin) or higher BMI (eg people of Polynesian origin). BMI ranges have not been developed for Aboriginal people.

Classifications may also vary with increasing age. A higher BMI (23–28 kg/m²) may be desirable for people aged over 70.

**Waist circumference** is another way of assessing health risk due to excess weight in adults. A waist circumference of above 94 cm in males, and above 80 cm in females indicates being overweight. Measurements above 102 cm in males and or 88 cm in females signify obesity.

Assessing healthy weight is more complex in children. Because of individual patterns of growth and development, it is not appropriate to have a standard set of BMI values that apply to all ages and both sexes. In infants, children and adolescents, growth patterns and healthy weight are assessed on the basis of growth charts and reference tables.

For more information, see the *Australian Dietary Guidelines* (Draft; 2011)81 (summarised in Box 7).

The priorities presented in this section overlap with and complement those outlined in the earlier sections on Eating for better health and A more active WA. Approaches to preventing overweight and obesity also need to address and integrate the closely related issues of poor nutrition and insufficient physical activity.

Prevent overweight and obesity

WA shares the growing problem of obesity with the rest of Australia and other parts of the world. Preventing obesity in the first place offers the most potential for reversing current trends, as it is difficult and expensive to treat once established, particularly over the long term. To date, no country which has experienced an upswing in obesity has been able to reverse the trend. Although successful interventions from other areas of public health provide some guidance, tackling obesity is, to some extent, uncharted territory.

Given this, the recommended approach is to “learn by doing”, in which staged interventions are closely monitored, researched and evaluated. Turning the tide of obesity will depend on a willingness to try innovative approaches, and to set a priority-driven agenda for research (see Informing future planning in Part 4).

Increase awareness of and positive attitudes towards maintaining a healthy weight

Increasing numbers of Australians perceive being overweight as normal. There is an urgent need to address these attitudes and beliefs, and to emphasise the importance of maintaining a healthy weight at all stages of life. This will require a mixture of approaches, including public education to inform and motivate, and provision of practical information and support to help bring about behavioural change.

There also needs to be a greater focus on addressing obesity-related risk factors during pregnancy and in early childhood. A healthy weight is essential for appropriate growth and the early establishment of healthy behaviours that can continue throughout life.

Programs for children should focus on the promotion of appropriate growth and development, nutritious diet and physical activity rather than on weight or obesity. Interventions must be designed to minimise any risk of increasing eating disorders, body image problems or stigmatisation of those who are overweight or obese. These conditions can be associated with a significant burden of disease, particularly for adolescents.

Address the obesogenic environment

The “obesogenic environment” includes the physical environment; economic factors; laws; policies; and the social and cultural attitudes which influence how much exercise we get and the types and quantities of foods we eat. It also includes the ways in which foods are grown, processed, packaged, marketed and served; and the relative accessibility and affordability of quality nutritious foods compared to less healthy options.

Public opinion in WA supports stronger restrictions on advertising and promotion of unhealthy food and drink which is directed at children, including television advertising, sponsorship of children’s sporting activities, and advertising in children’s magazines and on the internet.

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w The management of adult obesity, severe (or morbid) obesity in adults and children, underweight and eating disorders is outside the scope of this framework.
The complexity and multitude of influences on eating behaviours and patterns of physical activity means that there is no single or simple solution to the problem. A multisectoral approach will be needed to create environments which support healthier eating and increased physical activity. The health sector needs to lead debate and the development and implementation of healthy policy on these issues, in partnership with the community, government, non-government organisations, and industry bodies.

3. Strategic directions for healthy weight in WA, 2012–2016 (Table 5)

NOTE: Strategic directions for healthier eating (Table 3) and active living (Table 4) complement and overlap with strategic directions for healthy weight.

<table>
<thead>
<tr>
<th>Healthy policies</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Advocate for and actively contribute to the development of government policies at all levels that have a positive impact on overweight and obesity and its determinants.</td>
</tr>
<tr>
<td>■ Support the development and implementation of organisational policies in child and adult settings that support a healthy diet and active living.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Legislation and regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Advocate for stricter controls to restrict the marketing of unhealthy food and drinks, particularly where children are exposed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Economic interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Support research to identify appropriate fiscal policies to reduce obesity.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supportive environments</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Encourage food industry initiatives to increase the production and promotion of healthier foods and drinks; for example with reduced added sugars and saturated fats; and to offer smaller portion sizes.</td>
</tr>
<tr>
<td>■ Implement initiatives to create environments and settings that promote and support a healthy diet, active living and a healthy weight.</td>
</tr>
<tr>
<td>■ Implement initiatives to limit children’s exposure to inducements to consume energy dense, nutrient poor foods and drinks.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Public awareness and engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Invest in sustained, high quality statewide public education campaigns to motivate and support the adoption and maintenance of behaviours that ensure healthy weight in adults and children.</td>
</tr>
<tr>
<td>■ Increase access to reliable, practical, culturally-appropriate information about healthy weight and appropriation nutrition and physical activity levels at all stages of life.</td>
</tr>
<tr>
<td>■ Support communities, key stakeholders and parents to advocate for and change local environments and policies to address overweight and obesity.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community development</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Work with local communities and local governments to identify and prioritise actions that will support healthier food choices and physical activity; for example community gardens; walking groups; active planning for healthier neighbourhoods.</td>
</tr>
</tbody>
</table>
Targeted interventions

- Support and strengthen programs and policies that embed healthy lifestyles in everyday settings, particularly at home and in childcare, school, workplace and community settings.
- Deliver parent and family-oriented initiatives that increase the ability of parents and carers to establish healthy lifestyles and maintain healthy weight in children early in life.
- Invest in locally driven, whole-of-community initiatives to address the factors influencing obesity levels, particularly in low socioeconomic and regional and remote communities.

Strategic coordination, building partnerships and capacity building

- Continue to work with existing partners, and develop new partnerships across all sectors to ensure a coordinated approach to addressing overweight and obesity.
- Strengthen skills among health professionals to identify weight-related health risks and undertake appropriate interventions and referral.
- Build capacity of the non-health workforce to ensure that their programs, policy and plans support healthy eating, active living and a healthy weight.
- Work with the eating disorder sector to minimise any potential for unintended consequences of obesity prevention programs.
- Investigate and monitor effectiveness of policies and interventions targeting overweight and obesity and monitor key environmental and individual factors impacting on, or with potential to impact on obesity rates.
Making smoking history

Smoking rates continue to decline in WA, and more of us live, work and relax in smoke-free environments than ever before, but there is still much to be done to make tobacco use a thing of the past.

1. A snapshot of smoking in Western Australia

- In 2011, 11% of the Western Australian population aged 16 and over were daily smokers, and a further 3% were occasional smokers.\(^6\)
- Men were more likely to be daily smokers than women (13% compared to 9%).\(^6\)
- About six percent of Western Australian secondary school students aged 12–17 reported that they were regular smokers in 2011. Prevalence was similar between boys (5.9%) and girls (5.6%).\(^43\)
- Between 1984 and 2011, weekly smoking rates among 12–17 year olds fell from 18%\(^114\) to 6%.\(^43\)
- 44% of Aboriginal people in WA were smokers in 2008, lower than the national rate for Aboriginal people of 48%.\(^115\)
- Lower socioeconomic groups, people who live outside major cities, people with mental illness, prison inmates, gay, lesbian and bisexual people, and some overseas-born communities also have a higher prevalence of smoking than the general population.
- In WA in 2009, 15% of mothers reported smoking during pregnancy. Prevalence of smoking during pregnancy is higher in some groups, including Aboriginal women, younger women, and women who are disadvantaged.\(^119\)
- Most homes in WA are smoke-free. In 2011, only 5% of adults reported smoking in their home on a frequent basis, and 98% of children aged 15 and under lived in a smoke-free home.\(^40\)
- Tobacco was responsible for 7% of the total burden of disease in 2006 and was estimated to have caused 1,295 deaths, or about 11% of all deaths in WA for that year. Most of the disease burden was due to lung cancer and chronic obstructive pulmonary disease (emphysema).\(^5\)
- In 2004–05, the social costs of tobacco use in WA (including costs to government, business and individuals) were estimated at $2.4 billion. Hospital costs accounted for $60 million of this total.\(^121\)


Continue the efforts to drive down smoking rates in the community

Although smoking is in decline, tobacco use continues to have a major impact on public health and will continue to do so for many years to come.\(^121\)

There is no safe cigarette, and there is no risk-free level of exposure to tobacco smoke.\(^122\) The only way to bring an end to the damage caused by smoking is to encourage people to stop smoking and to discourage children from starting to smoke.
Decades of experience gained from tobacco control in Australia and internationally have provided clear direction about best practice in reducing the prevalence of smoking. This has most recently been articulated by the National Preventative Health Taskforce\textsuperscript{49} and in the *National Tobacco Strategy 2012–2018*.\textsuperscript{123}

Of the range of possible preventive strategies to reduce tobacco use, the two most effective are fiscal policies which result in increases in the real price of tobacco products, and well-designed mass media campaigns that are properly funded in order to maximise frequency, reach and intensity. In combination, these strategies have great potential to further reduce smoking in the community.\textsuperscript{124}

**Eliminate exposure to tobacco smoke in places where the health of others can be affected**

The harmful effects of secondhand tobacco smoke\textsuperscript{125} underpin the importance of ensuring smokefree public environments. While the primary goal of smokefree regulation is the immediate protection of others from tobacco smoke, restrictions on tobacco use in specific settings have a profound influence on smoking behaviour. There is good evidence that smoking restrictions help to reduce the uptake of smoking among young people,\textsuperscript{126, 127} reduce the amount of cigarettes consumed by smokers,\textsuperscript{128} and prompt quit attempts.\textsuperscript{129} They also have a flow-on effect of increasing the numbers of smokers who choose to keep their homes and cars smokefree, and to refrain from smoking in other people’s homes.\textsuperscript{129}

Artwork by Patrick Bayly, for the Quitline Aboriginal Liaison Team. © Department of Health, WA. Funded by the Australian Government Department of Health and Ageing.
### 3. Strategic directions for tobacco control in WA, 2012–2016 (Table 6)

<table>
<thead>
<tr>
<th><strong>Healthy policies</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Encourage implementation of smokefree policies, particularly in environments where children are exposed to tobacco smoke.</td>
</tr>
<tr>
<td>■ Integrate smoking cessation with other healthy lifestyle initiatives.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Legislation and regulation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Eliminate exposure to secondhand smoke in workplaces and public places, especially where children are present.</td>
</tr>
<tr>
<td>■ Effectively monitor and enforce legislative controls on the sale, supply, marketing and use of tobacco products.</td>
</tr>
<tr>
<td>■ Ensure that the legislative environment is responsive to changing market conditions and industry innovation.</td>
</tr>
<tr>
<td>■ Advocate for and support regulatory initiatives at the national level, and in other States and Territories.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Economic interventions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Support Commonwealth Government fiscal policies to discourage tobacco use.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Supportive environments</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Continue to build on strong public support for tobacco control measures.</td>
</tr>
<tr>
<td>■ Encourage the expansion of smokefree environments.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Public awareness and engagement</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Invest in sustained, high-quality statewide public education campaigns to encourage and support quitting, and discourage uptake of smoking.</td>
</tr>
<tr>
<td>■ Increase access to reliable, practical, culturally appropriate information to discourage uptake and to support quitting smoking</td>
</tr>
<tr>
<td>■ Adopt new technologies to enhance and extend public education activities.</td>
</tr>
<tr>
<td>■ Support communities, stakeholders and parents to advocate for and change local environments and policies which will reduce the prevalence of smoking, and exposure to tobacco smoke in places where the health of others can be affected.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Community development</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Work with local communities and local governments to identify and prioritise actions which will reduce exposure to secondhand tobacco smoke.</td>
</tr>
<tr>
<td>■ Encourage and sustain development of local government tobacco action plans.</td>
</tr>
</tbody>
</table>
### Targeted interventions

- Integrate successful, culturally appropriate program components, and collaborate on the range of initiatives implemented under the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes*.

- Develop programs to meet the needs of other groups with higher smoking prevalence (including those with mental illness and the prison population), or which are particularly vulnerable to the harmful effects of smoking (such as pregnant women) to reduce consumption and support cessation.

- Encourage and embed provision of quit services and information throughout workplaces, educational and community settings and health service providers.

### Strategic coordination, building partnerships and capacity building

- Continue to work with existing partners, and develop new partnerships across all sectors to ensure a coordinated approach to reducing the incidence of tobacco smoking in WA.

- Foster the development of skills, expertise and resources within the tobacco control workforce.

- Bolster the capacity of the wider health and allied workforce to provide reliable cessation information and support to smokers.

- Contribute to the evidence base on tobacco policy and health and ensure that policies and programs are based on best information available.

- Improve data collection on smoking behaviour in populations which may not be well-represented in existing data sets.
Reducing harmful alcohol use

All Australians have a role to play in reshaping our drinking culture, including our governments, law enforcement agencies, the health and welfare sector, the alcohol beverage and related industries, local communities, families and individuals.—National Preventative Health Taskforce.49

1. A snapshot of alcohol use in Western Australia

- In 2011, 76% of the WA population aged 16 and over reported that they consumed alcohol, and 24% reported that they were non-drinkers.6
- Of those who reported that they drank alcohol, half did so at levels that put their health at risk of alcohol-related disease or injury over their lifetime, and 23% consumed alcohol at levels that put their health at risk for an alcohol-related injury from a single occasion of drinking6 (based on National Health and Medical Research (NHMRC) Guidelines130—Box 12).
- Males who consumed alcohol were more likely to drink at levels which placed them at risk of lifetime harm than females who drank (61% compared with 38%). Male drinkers were also more likely to drink at levels which placed them at risk of harm on a single occasion than female drinkers (30% compared with 16%).6
- High-risk drinking behaviours decline with age for both men and women.6
- Based on adult drinking guidelines, in 2011, more than one third (36%) of Western Australian school students aged 12–17 who reported drinking in the last week consumed alcohol at risky levels (for single occasion harm).42
- Of students who drank in the last week, the most common sources of alcohol for WA school students in 2011 were parents (28%) and friends (26%). Twenty-three per cent of students asked someone else to buy alcohol for them.42
- For women who are pregnant or breastfeeding, the NHMRC Guidelines state that “not drinking is the safest option.”130 In Australia in 2010, 51% of women reported that they drank during pregnancy, and 66% had continued to consume alcohol while breastfeeding.116
- In a national study conducted in 2008, 27% of Aboriginal people aged 15 years and over had not consumed alcohol in the previous year. This study used 2001 NHMRC guidelinesx to estimate risky drinking and is not directly comparable to more recent data collection on risky drinking. About 17% of Aboriginal people aged 15 and over reported drinking at long-term risky or high-risk levels in the year prior to the survey, and 37% reported consuming short-term risky or high-risk levels of alcohol in the two weeks prior to the survey. Males were more likely to drink at risky levels than females.115
- National data from surveys conducted in 2004–05 showed that Aboriginal people were more likely than non-Aboriginal people to abstain from drinking, but that those who did drink, were more likely to do so at levels for risk or high risk of short-term risk.115x

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x In this report, the criteria for ‘at risk’ drinking were based on recommended adult daily limits according to the NHMRC guidelines for alcohol consumption (2001) which were current at the time. Short-term risky drinking was consumption in excess of six but less than 11 standard drinks on any one day for males, and in excess of four but less than seven standard drinks for females. Short-term high-risk drinking was consumption of 11 or more standard drinks on any 1 day for males, and in excess of seven standard drinks for females.
Between 2003–2007, rates of alcohol-related deaths were more than twice (2.4 times) as high among people living in very remote areas compared with those who lived in major cities, and the most socioeconomically disadvantaged populations in WA experienced 1.5 times the death rate due to alcohol than the least disadvantaged group.\textsuperscript{131}

Between 2003–2007 the cost of hospitalisations in WA associated with alcohol use was estimated at more than $379.7 million.\textsuperscript{131}

Australian\textsuperscript{130, 132} and international\textsuperscript{133} health authorities do not recommend drinking alcohol as a way of preventing or treating heart disease.

Box 12: Australian Guidelines to reduce health risks from drinking alcohol (2009)\textsuperscript{130}

The National Health and Medical Research Council recommends that:

- For healthy men and women, drinking no more than two standard drinks on any day reduces the lifetime risk of harm from alcohol-related disease or injury.
- For healthy men and women, drinking no more than four standard drinks on a single occasion reduces the risk of alcohol related injury arising from that occasion.
- Parents and carers should be advised that children under 15 years of age are at the greatest risk of harm from drinking and that for this age group, not drinking alcohol is especially important.
- For young people aged 15–17 years the safest option is to delay the initiation of drinking for as long as possible.
- For women who are pregnant or planning a pregnancy, not drinking is the safest option.
- For women who are breastfeeding, not drinking is the safest option.


Change community attitudes towards alcohol use

Alcohol use is embedded in national culture\textsuperscript{134} and the majority of Western Australians consume alcohol at some level.\textsuperscript{6} Research shows that the greatest number of alcohol-related problems occur in people who often drink moderately but occasionally drink to harmful levels, which accounts for a large proportion of the general drinking population.\textsuperscript{135}

Australian children are initiated into a culture of drinking at an early age.\textsuperscript{134} Among WA secondary school children in 2011, more than one third (36\%) of those who drank alcohol in the last week aged 12–15 and 43\% of those who drank in the last week aged 16–17 reported that they drank alcohol with the aim of getting drunk.\textsuperscript{136} Community attitudes to drinking, and availability, price, advertising and role-modelling all influence the drinking behaviour of young people.\textsuperscript{134}

The traditional Australian tolerance of harmful levels of drinking\textsuperscript{49} is increasingly being countered by community concern and awareness about the damage it causes. In a WA survey in 2011, 60\% of respondents thought that it was unacceptable to get drunk.\textsuperscript{137}
Influence the supply of alcohol

How alcohol is made available influences the extent to which alcohol related harm occurs. Risk can be reduced by controlling alcohol sales and supply through location, density and type of licensed outlets. Increasingly, communities are engaging in the decision-making process about how alcohol is managed in their localities. Some remote communities in WA have opted for a complete ban on alcohol. The most common source of alcohol for under-aged drinkers is their parents. There is a need for public education about the harms of under age drinking and the importance of delaying initiation to alcohol use, as well as increasing awareness about adult responsibilities and obligations to protect children and adolescents from alcohol use.

Reduce demand for alcohol

A range of options has been demonstrated to influence demand for alcohol products and can be employed to help shape lower-risk patterns of drinking behaviour or abstention for population groups for whom this is considered to be the safest option. These include changes to taxation and pricing; regulation of access and availability; drink-driving countermeasures; regulation of alcohol advertising and promotion; public education; and provision of appropriate treatment and rehabilitation options.

Alcohol is closely associated with injury. It is a contributing factor to almost one in five (19%) of injury deaths and more than one in ten (12%) of hospitalisations due to injury in the community. Introducing effective strategies to reduce harmful drinking in the community will also bring down the amount of injury caused by alcohol use.

### 3. Strategic directions for reducing harmful alcohol use in WA, 2012–2016 (Table 7)

<table>
<thead>
<tr>
<th>Healthy policies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promote the development and implementation of organisational policies on alcohol in workplaces and social settings, including sporting and social clubs, and particularly in schools and other environments in which children or young people are involved.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Legislation and regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectively monitor and enforce legislative controls on the sale, supply and use of alcohol.</td>
</tr>
<tr>
<td>Actively work towards reducing the exposure of children and adolescents to alcohol consumption and the promotion of alcohol.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Economic interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participate in the national debate about reform in alcohol taxation and pricing as a means of reducing harmful alcohol consumption.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supportive environments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support the development of settings that discourage harmful alcohol use and promote a lower risk drinking culture, and in particular, reduce exposure of children to alcohol consumption and influences which encourage consumption.</td>
</tr>
<tr>
<td>Consider evidence on the cumulative impact of high-risk licensed premises and options for balancing types and numbers of lower risk outlets.</td>
</tr>
</tbody>
</table>
Public awareness and engagement

- Support the development and implementation of evidence-based public education campaigns and other communications strategies to reduce short-term and long-term harmful alcohol use, and to influence cultural and social attitudes to alcohol.
- Raise public awareness about adult responsibilities and obligations to protect children and adolescents from alcohol use and related harms.
- Provide ongoing supportive education regarding patrons’ and licensees’ responsibility to act in accordance with current legislation, including the responsible service of alcohol.
- Increase access to reliable, practical, culturally-appropriate information about reducing harmful drinking.

Community development

- Work with communities and local governments to support them in contributing to evidence-based strategies to prevent alcohol-related harm.

Targeted interventions

- Advocate for the compulsory delivery of appropriate alcohol education in schools.
- Support implementation of evidence-based and innovative interventions for groups within the community who are particularly at risk for harmful drinking, or who are especially vulnerable to the harmful effects of alcohol use (such as women who are pregnant or breastfeeding).

Strategic coordination, building partnerships and capacity building

- Continue to work with existing partners and develop new partnerships across all sectors to ensure a coordinated approach to changing the drinking culture and promoting low risk drinking practices.
- Encourage all health professionals to address harmful alcohol consumption in their clients and patients.
- Increase the capacity and competency of health and other staff working in relevant sectors in the development of localised strategies and activities to reduce harmful alcohol use.
- Promote and facilitate improved monitoring, evaluation and research regarding alcohol-related interventions in all settings.
Creating safer communities

Most injuries have the potential to be anticipated, and could therefore be avoided.

1. A snapshot of injuries in Western Australia

Alcohol is a contributing factor to nearly one in five (19%) injury deaths, and almost one in eight (12%) hospitalisations due to injury. Alcohol use is a contributing factor in about 45% of hospitalisations and deaths due to injury caused by violence. Introducing effective strategies to reduce harmful drinking in the community will have a positive impact on the amount of injury caused by alcohol use. Priorities for addressing harmful use of alcohol are discussed in the previous section.

Detailed analysis of a range of data sources on injury in Western Australia has shown that between 2000–2008:

- Injuries were the leading cause of premature death in the State.
- Nearly one quarter (24%) of attendances at hospital emergency departments was due to injury.
- The leading causes of injury death were suicide (30%), transport injuries (26%), other unintentional injuries (18%) and falls (11%).

Policies for suicide prevention have been developed by the Mental Health Commission in its Western Australian Suicide Prevention Strategy 2009–2013, available from http://www.mentalhealth.wa.gov.au/Homepage.aspx

- The main causes of hospitalisation due to injury were other unintentional injuries (34%), falls (31%) and transport injuries (14%).
- Males were more than twice (2.4 times) as likely to die, and 1.5 times more likely to be hospitalised because of injury compared with females.
- Falls were the leading cause of hospitalisation due to injury in all age groups except for people aged 15–24, among whom transport injuries were the leading cause of hospitalisation due to injury. Falls accounted for 23% of deaths due to injury in people aged 65 and over.
- About half of all injury deaths in people aged between 5–24 were due to transport accidents.
- Twenty-three percent of injuries occurred in the home, and 9% took place on roads or highways. Specific activities during which injuries were most likely to occur were while playing sport (10%) and in the course of employment (8%).
- People living in the most disadvantaged circumstances had about double the risk of dying from injury compared with people who were least disadvantaged. Those living in regional or remote areas were also at greater risk.
- Aboriginal people were about three and half (3.6) times more likely to be hospitalised due to injury, and to die from injury, than non-Aboriginal people.
- Average annual hospital costs due to injury in WA were estimated at $173 million.

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\(^{7}\) Defined as deaths in people aged under 75, and measured by Potential Years of Life Lost.

\(^{7}\) Excludes injuries due to complications of medical and surgical care, as well as other unclassified injuries, which account for 2.5% of all injury deaths.

\(^{aa}\) “other unintentional injuries” are injuries other than those caused by transport, falls, poisoning or interpersonal violence.

WA Health works with a range of partners, including other government and non-government agencies, which share the goal of preventing injury and improving community safety in this State. In some areas WA Health takes a lead role, but in areas led by other agencies—such as road safety, occupational health and safety, product safety and crime prevention—WA Health provides support by offering a skills base, models of practice, and data provision and analysis.

Reduce road crashes and road trauma

Transport-related incidents are a leading cause of injury in all age groups and are a major public health problem in this State. Young people, especially males, Aboriginal people, residents of the most disadvantaged areas and people who live in remote and regional parts of the state are at greatest risk.

Reducing injuries and deaths on the roads requires a multisectoral approach, and the adoption of a comprehensive range of policies which address road safety from all angles. WA Health actively supports the Road Safety Council’s *Towards Zero Road Safety Strategy*, which is based on the four cornerstones of safe road use, safe roads and roadsides, safe vehicles and safe speeds.

Prevent falls in older people

Falls are an important cause of death from injury at all stages of life, but especially for the general population aged over 65, and for Aboriginal people aged 55 and over. Death rates from falls increased by about 9% per year between 2000–2007 in Western Australia, reflecting the ageing of the population.

A number of factors increase risk of injury from falls in older people, including medical conditions, some kinds of medication, environmental factors and alcohol use. Physical activity and good nutrition help protect against falls. Most falls occur in the home environment, especially among women. A significant number falls also occur in residential care settings and in hospitals.

Experiencing a fall can have a devastating impact on quality of life in older people, and may mark the transition between living independently to leading a more dependent lifestyle.

Falls prevention involves education and support for creating safer environments, encouraging and enabling active ageing in the community, and engaging health care professionals in helping to reduce modifiable risk factors for falling.

Protect children from injury

Children are at special risk of injury. Children aged four and under have the highest death rates in the community due to drowning, and the highest rates of hospitalisation due to burns and scalds. In children aged 14 and under, transport accidents and drownings are the leading cause of injury-related deaths. Most hospitalisations due to injury in this age group are caused by falls, transport-related injuries (particularly cycling injuries) and poisonings.

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Preventing injuries among infants and younger children involves ensuring that home and community environments (including the products to which they are exposed) are safe, and that the people who look after them are aware of and understand how to protect children from potential risks. Older children encounter a wider range of settings and begin to make their own judgements about matters of personal safety. For this group, injury prevention should focus on the avoidance of serious injury while still providing opportunities to learn positive risk management strategies.\textsuperscript{140}

**Improve water safety**

Fatal and non-fatal drowning are an important cause of death and hospitalisation, particularly in children, young adults, and people aged in their 60s and 70s.\textsuperscript{7} The risk of fatal and non-fatal drowning is higher for males, residents of more disadvantaged socioeconomic areas, and among people who live in rural and remote areas.\textsuperscript{7} Non-fatal drowning may result in serious brain damage.\textsuperscript{139} Other injuries associated with water-based activities include spinal injuries, fractures and major wounds.\textsuperscript{7}

Key factors contributing to fatal and non-fatal drowning in children are insufficient adult supervision and poor or no safety barriers around bodies of water.\textsuperscript{139} In adults, risk factors for fatal and non-fatal drowning include alcohol use,\textsuperscript{7} lack of familiarity with the location, inadequate swimming skills and knowledge, and having a pre-existing medical condition.\textsuperscript{141}

**Reduce interpersonal violence**

Interpersonal violence refers to family and intimate partner abuse, elder abuse and community violence.\textsuperscript{7} In the WA population, it ranks fourth as a cause of hospitalisation due to injury, and sixth as a cause of death due to injury. Males are almost twice as likely to be hospitalised for, or to die from injury due to interpersonal violence compared with females.\textsuperscript{7} Alcohol use is a contributing factor in about 45% of deaths and hospitalisations due to violence in WA.\textsuperscript{7}

Experience of interpersonal violence is much higher in the Aboriginal population. Aboriginal males are about 13 times more likely to be hospitalised due to interpersonal violence than non-Aboriginal males, and Aboriginal females are about 68 times more likely to be hospitalised because of violence compared with non-Aboriginal females.\textsuperscript{7}

WA Police leads the multisectoral Crime Prevention Council (CPC), of which WA Health is a member. The Crime Prevention Council is developing a *State Community Crime Prevention Plan*\textsuperscript{ac}, which brings together communities, local governments, State government departments and agencies and the non-government sector in an effort to identify grassroots solutions to local crime and safety issues, and set the foundations for long-term prevention of crime.

### 3. Strategic directions for injury prevention in WA, 2012–2016 (Table 8)

<table>
<thead>
<tr>
<th><strong>Healthy policies</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Advocate for and contribute to the development of policies across all sectors that have a positive impact on injury prevention and community safety.</td>
<td></td>
</tr>
<tr>
<td>■ Contribute to the development of planning, transport and land use policies that prioritise and promote injury prevention and community safety.</td>
<td></td>
</tr>
<tr>
<td>■ Advocate for policies that mitigate harmful use of alcohol in the context of injury prevention and community safety.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Legislation and regulation</strong></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>■ Support State and Commonwealth Government regulatory initiatives that reduce the risk of injury. These could include reducing harm from alcohol and other drug use, promoting water safety legislation and supporting child safety protocols.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Economic interventions</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Investigate potential economic interventions to address injury prevention.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Supportive environments</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Foster the development of environments and communities which reduce the risk of injury and promote safer behaviours.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Public awareness and engagement</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Raise awareness of injury risks and protective measures through public education campaigns. This includes promoting healthy lifestyles.</td>
<td></td>
</tr>
<tr>
<td>■ Educate and encourage individuals, families and communities to develop the knowledge, attitudes and skills to choose harm minimising activities and promote healthy environments.</td>
<td></td>
</tr>
<tr>
<td>■ Increase access to reliable, practical, culturally-appropriate information about injury prevention.</td>
<td></td>
</tr>
<tr>
<td>■ Where appropriate, incorporate alcohol-related prevention and minimisation strategies in injury prevention programs and policy initiatives.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Community development</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Work with local communities and local governments to identify and prioritise actions to support injury prevention and community safety.</td>
<td></td>
</tr>
<tr>
<td>■ Embed injury prevention and community safety into community healthy lifestyle initiatives.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Targeted interventions</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Promote injury prevention initiatives across the lifespan and develop programs appropriate to the needs of at-risk groups. These include; children, youth and young adults, adults, older people, rural and remote populations, Aboriginal people, people who are disadvantaged, and CaLD communities.</td>
<td></td>
</tr>
<tr>
<td>■ Incorporate messages about alcohol use and increased risk of injury in interventions for high risk populations.</td>
<td></td>
</tr>
</tbody>
</table>

*continued on next page*
Strategic coordination, building partnerships and capacity building

- Continue to work with existing partners, and develop new partnerships across all sectors to ensure a coordinated approach to injury prevention and community safety.
- Foster the development of skills, expertise and resources within the injury control workforce.
- Ensure that research, evaluation and surveillance structures are in place to monitor initiatives and key issues impacting on injury prevention and community safety.
Part 4 Putting policy into practice

Building partnerships
Building strong, cooperative partnerships is central to implementation of the HPSF. This accords with state, national, and international thinking about how to best to bring about improved, sustainable and equitable health outcomes. Effective partnerships share knowledge, skills, experience and networks; extend the reach of messages; help to make scarce resources go further; facilitate better understanding across sectors; and allow for constructive dialogue and wider consultation about the best ways of developing workable policy options and translating them into action. Successful partnerships also generate new energy and motivation; foster innovation and creativity; and pursue continuous improvement in methods and outcomes.

Working collaboratively is increasingly a hallmark of the development and delivery of effective health promoting initiatives, and it can be expected to become more critical in the future. As noted in Part 2, health outcomes are influenced by many different factors, most of which lie beyond the control of traditional health networks. The HPSF has identified a broad range of sectors which have an important role to play in supporting healthy living, including industry, education, the parks and recreation sectors, non-government organisations, and all levels of government.

As local governments are responsible for the planning and delivery of much of the infrastructure, building, recreational amenity and services which makes local environments more conducive to healthier ways of living, they are vital partners in promoting better health. Some local governments in WA have already undertaken a formal approach to planning for healthy communities, and there is an evolving base of Australian resources and literature which provides practical guidance on how local governments can plan and deliver healthier services and settings, and work collaboratively across sectors for the benefit of their communities.

Reporting on progress
WA Health sets targets for reduction in chronic disease and injury which are measured against Key Performance Indicators (KPIs) (Table 9). The Government of WA is also committed to meeting targets stipulated in National Agreements.

Progress in implementation and measuring effectiveness of interventions to reduce the incidence of chronic disease and injury will be assessed by:

- annual reporting of activity in support of implementation of the HPSF
- monitoring prevalence of lifestyle risk factors, and morbidity and mortality caused by preventable chronic disease and injury.

The extent to which existing State and national monitoring and surveillance systems meet current and emerging needs is a matter for ongoing review.
Western Australian benchmarks and indicators

**Annual Health and Wellbeing Surveillance System data collection**

WA Health collects data on the general wellbeing of the population, risk factors, chronic diseases, demographics and health service utilisation. These data are also available on a region-by-region basis. Health and Wellbeing Surveillance System (HWSS) data are reported annually and are available from the Epidemiology Branch within the Public Health Division.\(^\text{ad}\)

**Key performance indicators for WA Health Annual Reporting**

As a whole-of-system measure, WA Health reports annually on loss of life from premature death due to identifiable causes of preventable diseases or injury. The measure used is Person Years of Life Lost (PYLL).\(^\text{14}\) WA Health implements health promotion programs as one of its strategies to reduce preventable disease and injury. However, it is important to note that positive impacts of health promotion programs on health outcomes (as opposed to behaviours) can only be realised over the long term, since changes in risk factor prevalence do not translate into instant declines in disease outcomes.\(^\text{14}\)

Table 9 shows PYLL from selected preventable diseases since 2000, and the current targets. The overall trend shows that PYLL from these preventable diseases and injury due to falls are either improving or being maintained at the same level.\(^\text{14}\)

Table 9: **Key performance indicators for WA Annual Health Reporting: person years of life lost from selected preventable diseases and injury, WA, 2000–2009**

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung cancer</td>
<td>2.2</td>
<td>2.3</td>
<td>2.4</td>
<td>2.2</td>
<td>1.9</td>
<td>1.9</td>
<td>2.0</td>
<td>2.2</td>
<td>1.8</td>
<td>2.0</td>
<td>2.0</td>
</tr>
<tr>
<td>IHD*</td>
<td>3.8</td>
<td>4.2</td>
<td>3.7</td>
<td>3.1</td>
<td>3.2</td>
<td>3.3</td>
<td>3.3</td>
<td>3.6</td>
<td>3.3</td>
<td>3.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Falls</td>
<td>0.3</td>
<td>0.4</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
<td>0.4</td>
<td>0.5</td>
<td>0.6</td>
<td>0.4</td>
<td>0.2</td>
<td>0.2</td>
</tr>
</tbody>
</table>

\(^*\)Ischaemic heart disease

Source: WA Health\(^\text{14}\)

**National benchmarks and indicators**

**National Partnership Agreement on Preventive Health**

The Government of WA is a signatory to this Agreement, which came into force in January 2009,\(^\text{16}\) was due to expire in 2015, and has since been extended until mid-2018.\(^\text{23}\)

Specific performance benchmarks have been provided for slowing the increase in the proportion of the population at unhealthy weight, and increasing fruit and vegetable consumption and physical activity in children and adults. Performance benchmarks have been specified for smoking in the adult population (Table 10). The performance indicators included in the Agreement are consistent with those in the **National Healthcare Agreement** (see following section).

Although it is a stated intention of the Agreement to “reduce the harmful and hazardous consumption of alcohol”, no specific performance benchmarks have been stipulated for alcohol.

The baseline for the benchmarks other than for smoking is the last available data at June 2009. The baseline for smoking is national data from 2007. Performance against these benchmarks will be assessed using data for WA collected through a combination of State and National surveys, including the WA HWSS, the National Drug Strategy Household Survey, the Australian School Students’ Alcohol and Drugs (ASSAD) Survey, and the National Secondary Students’ Diet and Activity (NaSSDA) Survey.

Performance against benchmarks will be assessed in June 2016 and December 2017 and based on the most recent survey data available at the time.

Table 10: Performance benchmarks in the National Partnership Agreement on Preventive Health, 2009–2018

<table>
<thead>
<tr>
<th>Children</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slow and reverse the increase in children at unhealthy weight</td>
<td>Increase in proportion of children at unhealthy weight held at less than 5% from baseline for each state by 2016; proportion of children at healthy weight returned to baseline level by 2018.</td>
</tr>
<tr>
<td>Increase fruit and vegetable consumption</td>
<td>Increase in mean number of daily serves of fruits and vegetables consumed by children by at least 0.2 for fruits and 0.5 for vegetables from baseline for each State by 2016; 0.6 for fruits and 1.5 for vegetables by 2018.</td>
</tr>
<tr>
<td>Increase physical activity</td>
<td>Increase in proportion of children participating in at least 60 minutes of moderate physical activity every day from baseline for each State by 5% by 2016; by 15% by 2018.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adults</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slow and reverse the increase in adults at unhealthy weight</td>
<td>Increase in proportion of adults at unhealthy weight held at less than 5% from baseline for each State by 2016; proportion of adults at healthy weight returned to baseline level by 2018.</td>
</tr>
<tr>
<td>Increase fruit and vegetable consumption</td>
<td>Increase in mean number of daily serves of fruits and vegetables consumed by adults by at least 0.2 for fruits and 0.5 for vegetables from baseline for each State by 2016; 0.6 for fruits and 1.5 for vegetables from baseline by 2018.</td>
</tr>
<tr>
<td>Increase physical activity</td>
<td>Increase in proportion of adults participating in at least 30 minutes of moderate physical activity on five or more days of the week of 5% from baseline for each State by 2016;15% from baseline by 2018.</td>
</tr>
<tr>
<td>Reduce smoking</td>
<td>Reduction in state baseline from proportion of adults smoking daily commensurate with a 2% point reduction in smoking from 2007 national baseline by 2011; 3.5% reduction from 2007 national baseline by 2013.</td>
</tr>
<tr>
<td>Reduce the harmful consumption of alcohol</td>
<td>No target set.</td>
</tr>
</tbody>
</table>

Source: National Partnership Agreement on Preventive Health (Variation).23
National Healthcare Agreement

All Australian State and Territory governments are signatories to the National Healthcare Agreement 2012. Fundamental to the agreement are the principles that Australia’s health system should focus on the prevention of disease and injury and the maintenance of health, and support an integrated approach to the promotion of healthy lifestyles and injury prevention across the continuum of care. This Agreement sets specific performance benchmarks, including one for smoking prevalence in Aboriginal people (Table 11).

Table 11: Performance benchmarks* in the National Healthcare Agreement

<table>
<thead>
<tr>
<th>Performance Benchmark</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes in people aged 25 and over</td>
<td>Reduce the age-adjusted prevalence rate for Type 2 diabetes to 2000 levels (equivalent to a national prevalence rate of 7.1%) by 2023.</td>
</tr>
<tr>
<td>Smoking in the overall Australian population</td>
<td>Reduce the national smoking rate to 10% of the population by 2018, over the 2009 baseline.</td>
</tr>
<tr>
<td>Smoking in the Aboriginal population</td>
<td>Halve the Aboriginal smoking rate by 2018, over the 2009 baseline.</td>
</tr>
<tr>
<td>Increase proportion of the population with healthy bodyweight</td>
<td>Increase by five percentage points the proportion of Australian adults and Australian children at a healthy body weight by 2018, over the 2009 baseline.</td>
</tr>
</tbody>
</table>

These performance benchmarks were first agreed to by the Council of Australian Governments (COAG) in November 2008.
Source: National Healthcare Agreement

National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes

The Closing the Gap Agreement sets targets to improve health and educational outcomes for Aboriginal people. Health targets are shown in Table 12. This Agreement is in force from July 2009 until June 2013.

The WA Health reports annually against benchmarks and timelines which have been laid out in Implementation Plans for the agreement. Progress is assessed by qualitative or quantitative measures, or both.

Table 12: Targets in the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, 2009–2013

<table>
<thead>
<tr>
<th>Target</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy</td>
<td>Close the gap in life expectancy for Aboriginal Australians within a generation (by 2031).</td>
</tr>
<tr>
<td>Mortality in children aged under 5</td>
<td>Halve the gap in mortality rates for Aboriginal children under five by 2018.</td>
</tr>
</tbody>
</table>

Source: National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes
Informing future planning

Monitoring activities

Many different agencies and organisations around the State engage in health promotion and preventive work across chronic disease and injury. While some of this work is undertaken with the support of WA Health, other interventions—many of them excellent—have been initiated by other stakeholders. In order to inform future planning, WA Health will monitor activities in the State. This work will help to identify shortfalls and gaps in current programming, as well as areas in which there is the potential for duplication and overlap. It will also aid in identifying current and emerging priorities, and new opportunities.

Building the evidence base

Building an evidence base involves assembling relevant information to ensure that all considerations are taken into account in planning for future investment in health promotion and chronic disease and injury prevention.

Proper evaluation of programs and activities forms an important component of the evidence base. Robust evaluation will ensure that all aspects of programs can be properly assessed, lessons learnt, strengths built on, and future directions and policies properly informed. In the case of initiatives which are being funded by WA Health, evaluation is also vital to ensure that the Western Australian community is benefiting from the programs.

Importantly, building an evidence base also involves monitoring and critically reviewing strategies, programs and evidence originating from elsewhere in Australia and where relevant, internationally.

WA Health places priority on developing a strong evidence base, and on developing structured ways of sharing and building on knowledge with key partners and stakeholders.

Boosting research capability and setting an agenda for research

The value and importance of a collaborative and consultative approach to research priority setting is well-recognised. It allows for consensus on identifying essential and urgent research topics, establishes a unified research agenda, encourages maximisation of limited resources, and has potential to accelerate necessary policy changes and investment in appropriate interventions.

The National Health and Medical Research Council describes priority-driven research as work which “contributes directly, in the short to medium term, to population health and the effectiveness, efficiency and equity of the health system.” To ensure effective outcomes, the agenda requires the commitment of Government and other stakeholders, as well as the capacity to integrate research-based knowledge into policy and practice.149

Associated with this, there is also a need to develop and nurture a skilled, interdisciplinary workforce with the expertise to undertake research and evaluation of health policies and programs. This will require close engagement with tertiary educational institutions, and research organisations in this and other states.
While this State has a solid record in health promotion research, there is great scope for building interdisciplinary partnerships across Government, tertiary institutions and non-government organisations to develop and pursue a practical, priority-driven research agenda for health promotion and chronic disease and injury prevention, policy and control.

WA Health will seek ways of focussing the research agenda with a view to guiding future policy options, as well as capitalising and building on research capacity in this state.
Appendix: State and Commonwealth policies

General

State

Working together. WA Health Strategic Intent 2010–2015

Aboriginal Men’s Health Strategy 2012–2015

National


Taking Preventative Action – A response to Australia: the healthiest country by 2020—the report of the National Preventative Health Taskforce (2010)

National Aboriginal and Torres Strait Islander Health Plan (in development, December 2012)

National Chronic Disease Strategy (2006)


National Partnership Agreement on Preventive Health, and Variation (2012)

National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes (2008)

Eating for better health

National

Australian Dietary Guidelines (in development, December 2012)


Eat Well Australia: An agenda for action in public health nutrition, 2000–2010
Infant Feeding Guidelines for Health Workers (in development, December 2012)

National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000–2010


A more active WA

State
Active Living for All: A Framework for Physical Activity in Western Australia 2012–2016
www.beactive.wa.gov.au

An Age-friendly WA: the Seniors Strategic Planning Framework 2012–2017
http://www.communities.wa.gov.au/serviceareas/seniors/Pages/AgeFriendlyWA.aspx

Directions 2031 and Beyond: Metropolitan planning beyond the horizon (2010)

Liveable Neighbourhoods (2007)

Public Transport Plan for Perth (2011)

Walk WA: A Walking Strategy for Western Australia 2007–2020

Western Australian Bicycle Network Plan 2012–2021 (in development, December 2012)

Western Australian Sport and Recreation Industry Strategic Direction 2011–2015

National
National Cycling Strategy (2010)

National Physical Activity Recommendations for Australians (1999)

Our Cities Our Future—A National Urban Policy for a productive, sustainable and liveable future (2011)

Maintaining a healthy weight

National
Weighing it up: obesity in Australia (2009)
Making smoking history

National

National Tobacco Strategy 2012–2018

Reducing harmful alcohol use

State
Drug and Alcohol Interagency Strategic Framework for Western Australia 2011–2015

Strong Spirit Strong Mind—Aboriginal Drug and Alcohol Framework for Western Australia 2011–2015

National
National Alcohol Strategy 2006–2011


Australian Guidelines to Reduce Health Risks from Drinking Alcohol (2009)

Creating safer communities

State
State Community Crime Prevention Plan (in development, December 2012)

Towards Zero. Road Safety Strategy to Reduce Road Trauma in Western Australia 2008–2020

National
Australian Work Health and Safety Strategy 2012–2022


National Aboriginal and Torres Strait Islander Safety Promotion Strategy (2005)

National Falls Prevention for Older People Plan: 2004 Onwards

National Road Safety Strategy, 2011–2020
References


This document can be made available in alternative formats on request for a person with a disability.