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Acknowledgements

The Department of Health would like to thank the people and organisations who contributed time and expertise to the development of the First Interim State Public Health Plan.

Feedback

Any feedback related to this document should be emailed to publichealthact@health.wa.gov.au
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The WA Department of Health acknowledges the Aboriginal people of the many traditional lands and language groups of Western Australia.

We acknowledge the wisdom of Aboriginal Elders past and present and pay respect to Aboriginal communities of today.
Message from the Chief Health Officer of Western Australia

I am pleased to release the First Interim State Public Health Plan for the first stage of consultation across Western Australia (WA). This document includes:

**Part 1: A health status report for Western Australians** This section aims to examine public health trends in WA and identify areas of inequalities in particular population sub-groups.

**Part 2: Objectives and policy priorities 2017 - 2021** This section outlines the proposed public health objectives and policy priorities for WA for the next 5 years.

I would like to engage with interested stakeholders across WA and seek feedback on this document, as well as gather ideas on how the WA Department of Health can work with our many partners into the future. I will review and consider all feedback and may put out a Second Interim State Public Health Plan at a later stage.

Although the requirement for public health planning will not come into effect until Part 5 of the Public Health Act 2016 (Public Health Act) is implemented in approximately four years’ time, I am aware that a number of local governments advocated for public health planning and are producing local public health plans (Local PH Plans) in anticipation of the commencement of Part 5 of the Public Health Act. To support local governments that want to continue to be proactive in developing their Local PH Plans, I have published the First Interim State PH Plan as a guide for local governments that seek to be consistent with the current objectives and policy priorities of the WA Department of Health in the development of their Local PH Plans. I support this initiative and encourage local governments to commence or continue the process of developing their Local PH Plans if they wish to do so.

The First Interim State PH Plan can also be used to guide and support our many partners in public health including non-government organisations, State Government departments, industry and the general public.

Once Part 5 of the Public Health Act is enacted I will release the first State PH Plan. I commit to working closely with local government, the public and other key stakeholders in the development of this plan.

Prof Tarun Weeramanthri
Chief Health Officer
Public Health Division | Department of Health Western Australia
14 July 2017
Executive summary

Western Australia (WA) has a high standard of health compared with other countries. Life expectancy is increasing, infant mortality is low and trending downwards, and there have been sustained declines in the prevalence of smoking over the past decade.

However, while most Western Australians are doing well, there is evidence that health status varies considerably across different population groups.

For example, WA’s Aboriginal population have demonstrably poorer health outcomes than the non-Aboriginal population including a significantly higher prevalence of obesity and diabetes, an increased incidence of most infectious diseases, higher hospitalisation rates for assault and intentional self-harm and higher mortality rates, both overall and from specific chronic diseases.

Health outcomes are also significantly poorer in country WA, particularly in the remote regions, with a higher prevalence of risky behaviours including smoking and alcohol consumption as well as increased rates of sexually transmissible infections (STIs), youth suicide, potentially preventable hospitalisations and mortality.

Social and economic disadvantage is also associated with poorer health outcomes, with some social gradients emerging prior to birth. For example, smoking during pregnancy among mothers from the most disadvantaged socioeconomic quintile in WA is over four times the prevalence found among mothers from the least disadvantaged quintile. Social inequity continues throughout the life course with similar disparities evident for infant mortality, developmental delays and the prevalence of chronic disease in adulthood.

Obesity and chronic disease have also emerged as significant public health challenges for the population overall. The burden of chronic disease is likely to increase over the next decade, due to an ageing population and the lag time associated with chronic conditions which often reflect the cumulative influence of risk factors across the life course.

Part 1: A health status report for Western Australians presents a range of information about the health status of the WA population, examines trends over time and identifies inequalities in health for Aboriginal people and other high risk and vulnerable communities and population groups.

In developing this document, the Chief Health Officer provides evidence to support the need for public health programs across the three priority areas as identified in the First Interim State Public Health Plan:

1. Empowering and enabling people to make healthy lifestyle choices
2. Providing health protection for the community
3. Improving Aboriginal health.
Population of Western Australia

It is important to have an understanding of the population context of WA to help determine both current and future needs of the population, understand disparities in health between population groups, and ensure that health services are designed appropriately to meet these needs.

As at 30 June 2016 WA had an estimated resident population of approximately 2.6 million people.¹ The majority of the population (79%) reside in the Perth metropolitan region which is also experiencing the State’s largest population growth (1.3% from 2015 to 2016). The rest of WA has seen a small population decline (-0.1%) during the same period, with regional areas such as Leinster - Leonora (-6.1%) and Meekatharra (-5.1%) particularly affected.² Rural and remote WA has a population density of only 0.2 people per square kilometre which has implications for the number and range of health services that are available in these areas. Access to health services can be further limited by the long distances of travel required for the non-metropolitan population. Figure 1 demonstrates the total population distributions across WA.

Figure 1: Total population density by SA2, Western Australia 2016

In 2015, life expectancy at birth in WA was 80.5 years for males and 85.0 years for females. This compares well nationally, with males in WA having the third highest life expectancy and females in WA having the second highest life expectancy.  

While life expectancy has been increasing in WA, the fertility rate has been in decline. Since 1975, the total fertility rate in WA has decreased from 2.1 babies per woman to 1.8 babies per woman in 2015.

Sustained low fertility leading to proportionately fewer children and increasing life expectancy resulting in proportionately older people has changed the age structure of the population. In the past year, the proportion of the WA population aged 65 years and over increased by 4 per cent. By 2061, it is estimated that one in five Western Australians will be over 65 years of age. The anticipated increase in the population aged 65 years and over will have a significant impact on the demand for health services into the future.

Overseas migration also contributes to shifts in population structures, and in 2014-15, a little over 14,000 people from overseas arrived in WA. Overall, almost four in ten people in WA were born overseas. Residents born overseas are likely to have different health profiles and may also be less likely to access health services, factors which should be considered when determining the health needs of the population.

In general, Western Australians enjoy some of the highest incomes and levels of affluence in Australia. However, there are also pockets of social and economic disadvantage. It is important to look at a broad range of characteristics when identifying areas of socioeconomic disadvantage as income viewed in isolation can be misleading.

For example, East Pilbara has the fourth highest median income in Australia, driven largely by the high incomes of the local mining community, but it also contains a significant population with low education levels, unskilled occupations, and low incomes.

Aboriginal Western Australians

Aboriginal Western Australians comprise 3.1 per cent of the State’s population, and have a younger age structure than the non-Aboriginal population with almost half the population under the age of twenty.

The Aboriginal population of WA is projected to grow by 65 per cent by 2031, a rate of growth that exceeds estimates for the non-Aboriginal population and would see the proportion of Aboriginal people in the population increase to 5.2 per cent. At the same time, the age structure of the Aboriginal population is also expected to change due to the fall in infant and child mortality rates; subsequently there will be a shift to an older Aboriginal population and this has potential implications for the burden of chronic disease among this population.


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Socio-economic indexes for areas (SEIFA) are measures that summarise the characteristics of a population using a range of information collected during the Census and then rank areas across Australia. The 2011 Census identified that seven of the ten most disadvantaged areas in WA are located in the northern and remote regions, with the most disadvantaged places often containing a sizeable Aboriginal population. The most disadvantaged area in Western Australia is Halls Creek, which is also ranked in the bottom 0.1 per cent of Australia’s population for disadvantage.

This backdrop of social and economic disadvantage provides a unique challenge for public health service delivery in these regions.

### Empowering and enabling people to make healthy lifestyle choices

In 2011, Western Australians lost more than 435,000 years of healthy life due to premature death and living with disease and injury. Cancers, mental disorders and cardiovascular diseases together accounted for almost half (45%) of the total health loss in WA. It is estimated that almost one-third of the total burden of disease in Australia is potentially avoidable, either through preventing problems before they occur or finding problems early and treating them.

Over half of all deaths in Western Australians aged under 75 years could potentially have been avoided across 2011 to 2015, with chronic conditions and cancer the leading conditions contributing to avoidable deaths. Ischaemic heart disease was responsible for the highest proportion of deaths (19.6%), with chronic obstructive pulmonary disorder (5.8%) and type 2 diabetes (5.0%) also featuring in the top ten leading causes.

While the degree to which a condition can be prevented varies, chronic conditions have a number of modifiable behavioural risk factors in common, including dietary factors, obesity, physical activity, tobacco use and excess consumption of alcohol. A focus on prevention and the promotion of healthy lifestyle choices and the creation of health-promoting environments is therefore very important to reduce the future impact of chronic disease.

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11 WA Department of Health. Top fifteen causes of avoidable death for Western Australia State residents (aged 0-74 years). Epidemiology Branch in collaboration with the Cooperative Research Centre for Spatial Information. Perth: WA Department of Health, accessed 28 April 2017
Healthy eating

A balanced and nutritious diet is essential for the growth and development of children and contributes significantly to healthy weight, quality of life, optimal oral health, resistance to infection and protection against chronic disease and premature death throughout the life course.

Most Western Australians are not meeting the minimum recommended serves for the five major food groups – vegetables, fruit, grain (cereal) foods, milk and meat or their alternatives. Intake of fruit and vegetables has not changed over time and remain consistently lower than what national dietary guidelines recommend. Although consumption of fast food is declining, with four in ten WA adults reporting that they never eat meals from fast food outlets in 2015 compared with three in ten in 2009, dietary surveys found that foods high in saturated fat, salt, sugar or alcohol contributes more than a third of total energy intake among the WA adult population.

At a population level, it is essential to promote healthy food environments to help support people make better lifestyle and dietary choices.

A nutrition survey of adults aged 18 to 64 years in WA illustrated that three in ten adults will purchase at least one meal from a restaurant, lunch bar, canteen or other food outlet on any given day. However, around one-quarter of WA adults felt that there were not enough healthy choices when they last purchased a meal through one of these options.

When adults were asked about the variety of fresh fruit and vegetables available in their neighbourhood, adults in metropolitan Perth were significantly more likely to strongly agree that there was a large selection of fruit and vegetables available compared with adults in rural and remote regions (56.4% compared with 42.2%).

This correlates with the results from the 2013 Food Access Cost Survey which found that access to fresh, good quality, affordable food in WA was highly dependent on where people lived. The cost of food was substantially higher in remote areas, and this gap had increased from 20.8 per cent in 2010 to 26.1 per cent in 2013. In particular, fruit cost 37.9 per cent more in remote areas compared to Perth.

Food insecurity

Food insecurity, which relates to restricted food availability, access and use, can have a detrimental impact on a population’s health and contributes to the disadvantage experienced by Aboriginal Western Australians.

In 2012-13, over one-quarter (27%) of Aboriginal people aged 15 years or over in WA lived in a household that experienced food insecurity in the past 12 months. This compares with 3.5 per cent of the non-Aboriginal population.


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Families on low income or welfare were also identified as needing to spend a greater proportion of their disposable income to buy healthy food than families earning an average income.

A more active WA

Physical activity is an important modifiable risk factor that is associated with several potentially preventable chronic diseases including cardiovascular disease, cancer, stroke, hypertension and diabetes. Physical inactivity was responsible for 4.6 per cent of the total burden of disease and injury in WA in 2011, ranking fifth across all risk factors.\(^{16}\)

Almost two-thirds of Western Australian adults (63.8\%) were sufficiently active for good health in 2015 and this was a significant increase from 2007 (56.2\%).\(^{17}\) Unfortunately, the opposite trend was evident among children, with only 38.4 per cent meeting the physical activity recommendations, the lowest level observed in a decade.\(^{18}\)

As well as increasing participation in leisure time physical activity, it is important to decrease sedentary time during occupational and domestic activities. Research has suggested that there is an association between sitting and the risk of developing diabetes, heart disease and other conditions.\(^{19}\)

In 2015 around four in ten Western Australian adults reported that they spent most of their day sitting. Prevalence was significantly higher in the least disadvantaged SEIFA quintile (50.1\%) compared with the most disadvantaged quintile (35.5\%).\(^{20}\)

References:

\(^{16}\) Australian Institute of Health and Welfare (AIHW) analysis of the Australian Burden of Disease 2011 database (unpublished)


Curbing the rise in overweight and obesity

Obesity is associated with type 2 diabetes, cardiovascular disease, and some cancers. Excess body mass contributed to 5.3 per cent of all disease and injury in WA in 2011, ranking third across all risk factors. In particular, high body mass was responsible for 53 per cent of the diabetes burden, 39 per cent of the chronic kidney disease burden and 18 per cent of the stroke burden.\(^\text{21}\)

Approximately two-thirds of Western Australian adults (67.1\%) reported height and weight measurements in 2015 that classified them as overweight or obese. Prevalence was significantly higher in inner regional (73.2\%), remote (73.7\%) and very remote areas (80.3\%) of WA.\(^\text{22}\)

There has been a significant increase in the prevalence of obesity in Western Australian adults from 21.3 per cent in 2002 to 27.0 per cent in 2015, although there are signs that this trend is now plateauing.\(^\text{23}\) Approximately one in five children in WA were classified as overweight or obese in 2015.\(^\text{24}\)

In 2011 over 62,000 inpatient separations and 8,655 emergency department presentations in WA were attributed to excess body mass. This was estimated to cost the acute hospital system $241.0 million and, assuming obesity levels remain the same, projected hospital costs for acute hospitalisations in 2021 are estimated to be $488.4 million.\(^\text{25}\)

**Perceptions of weight**

The majority of people under-estimate their weight class which may contribute to a lack of participation in health promotion initiatives established to help people achieve a healthy weight. In 2015, over half (54.8\%) of Western Australian adults with a BMI that classified them as overweight perceived their weight to be normal and three-quarters (75.2\%) of people with a BMI that classified them as obese perceived their weight to be overweight instead.

Among children with a BMI that classified them as overweight or obese, the majority of parents (69.6\%) perceived their child’s weight to be normal.

**Obesity by Aboriginal status**

Aboriginal adults are 1.6 times more likely than non-Aboriginal Australians to be obese.

Aboriginal children aged 10 to 14 are twice as likely as non-Aboriginal children of the same age to be obese.


\(^\text{21}\) Australian Institute of Health and Welfare (AIHW) analysis of the Australian Burden of Disease 2011 database (unpublished)


\(^\text{23}\) Ibid


Drive down smoking rates in the community

Tobacco smoking is one of the largest preventable causes of death and disease in Australia. Tobacco use, including past and current use as well as exposure to second-hand smoke, was responsible for 7.9 per cent of the total burden of disease and injury in WA in 2011 making it the most burdensome risk factor. In particular, tobacco use was responsible for 79 per cent of the lung cancer burden and 73 per cent of the Chronic Obstructive Pulmonary Disorder (COPD) burden.

The rates of current daily smokers in WA have decreased from 17.7 per cent in 2011-12 to 14.3 per cent in 2014-15. However, the proportion of Aboriginal people in WA who were current daily smokers remained the same from 2008 to 2014-15 (41%).

Among Western Australian youth, smoking prevalence also continues to decline and is more than two-thirds less than that recorded in 1993 (4.8% in 2014 compared to 16.9% in 1993).

Smoking during pregnancy

Smoking during pregnancy is the most common preventable risk factor for pregnancy complications and adverse perinatal outcomes and is associated with poorer health outcomes for the baby throughout life especially cardiovascular disease.

In 2013 nearly half (48.7%) of Aboriginal women in WA reported smoking during pregnancy. This was more than five times the proportion of non-Aboriginal women (8.7%).

The prevalence of smoking during pregnancy was highest among women who lived in the country, both for Aboriginal women (51.2%) and non-Aboriginal women (13.7%).


Reducing harmful alcohol use

Harmful alcohol consumption contributes to disease risk such as cancer and cardiovascular disease which arises from lifetime drinking patterns, as well as to the risk of alcohol-related injury associated with excess consumption on a single occasion. In addition, there can be significant adverse economic and social effects of excessive alcohol consumption.

Alcohol use was the second leading risk factor causing disease burden in WA in 2011 (5.6%).

Alcohol use was responsible for 21 per cent of the burden from suicide and self-inflicted injuries and 27 per cent of the burden from motor vehicle road traffic injuries in WA. It was also responsible for 5 per cent of coronary heart disease burden and 12 per cent of stroke burden in WA.  

Approximately one-third of people aged 16 to 44 years drink at levels considered to be risky for long-term harm, and males are significantly more likely than females to report drinking at risky levels across all age groups.  

Across Australia, WA had the highest proportion of adults who consumed more than two standard drinks per day on average.


Alcohol consumption among Western Australian youth has declined over the past three decades with 13.9 per cent of students reporting drinking in the past week in 2014 compared with 33.5 per cent of students in 1984. The proportion of students reporting that they have never drunk alcohol has more than tripled across the same time period, increasing from 9.0 per cent to 31.5 per cent. However, of those students who did report drinking in the past week, there has been an increase in the proportion who consumed more than four standard drinks on any one day (16.1% in 1984 compared with 29.8% in 2014).  

Reference:
Prevent injuries and promote safer communities

Injury is one of the leading causes of total burden of disease in WA ranking fifth overall. It is responsible for 14 per cent of the burden among males and 6 per cent of the burden among females.\textsuperscript{33} Notably, 82 per cent of the burden from injuries is due to early death.

Leading causes of injury deaths and hospitalisations in WA include injury from falls, interpersonal violence, suicide, transport accidents, poisoning, burns and drowning.

Males had a higher rate of injury events than females and were more likely to die or be hospitalised for all injury types except falls. Areas of high socioeconomic disadvantage also have higher rates of injuries, with deaths 2.3 times more likely and hospitalisation 1.6 times more likely compared to areas of low socioeconomic disadvantage. Aboriginal people are three times more likely than non-Aboriginal people to be hospitalised for an injury and two times more likely to die due to an injury.\textsuperscript{34}

Injuries incur a significant cost on the health system including both the acute sector as well as costs related to longer-term care needs, but there are also substantial costs to the economy due to loss of paid productivity as well as the quality of life costs borne mainly by the individual and their family. In 2012, the cost of injury in WA was estimated at $9.6 billion.\textsuperscript{35}

Suicide in Western Australia

More than 300 people take their own life each year in WA and over 2,500 more people are admitted to hospital from deliberate self-harm. Rates of death from suicide are highest among adults aged 25 to 29 years. Males are three times more likely than females to die due to suicide and Aboriginal people in WA are 2.8 times more likely than non-Aboriginal people to die due to suicide. Residents of very remote WA have a 40 per cent increased risk of suicide.


\textsuperscript{33} Epidemiology Branch, Public Health Division, 2016. Overview of the burden of disease in Western Australia, 2011. Perth: Department of Health

\textsuperscript{34} Hendrie D, Miller TR, Randall S, Brameld K, Moorin RE, 2015. Incidence and costs of injury in Western Australia 2012. Report prepared for the Chronic Disease Prevention Directorate, WA Department of Health

\textsuperscript{35} Ibid
Providing health protection for the community

Public health aims to improve community health through the delivery of a suite of essential services and regulatory programs including organised immunisation programs, regulation of food safety, waste-water management, infectious disease surveillance and outbreak response, control of disease vectors such as mosquitoes and disaster management.

Administer and enforce public health regulatory regimes

Since 1881, life expectancy at birth for Western Australians has increased by over 30 years.\(^{36}\) Much of this increase has been driven by public health actions to improve and regulate living conditions including the provision of clean drinking water and safe food, and the elimination of occupational, environmental and worksite hazards.

The success of an effective public health regulatory system which supports public health legislation is evident in the low burden of disease attributed to these hazards now. In 2011 it was estimated that 2.4 per cent of the total burden of disease and injury in WA was due to occupational exposures and hazards.\(^{37}\)

Example of public health regulation

The *Food Act 2008* is a key piece of legislation intended to govern the production and sale of food in WA and provides important powers to government bodies to investigate suspected or known food-borne disease outbreaks.

Food-borne illness is an example of a common yet largely preventable public health problem which is caused by the consumption of contaminated foods. It often results in gastroenteritis (symptoms of which can include diarrhoea, fever, nausea and vomiting). There are significant economic costs associated with food-borne illnesses including loss of productivity and medical expenses.

Campylobacteriosis and salmonellosis are two of the most common causes of bacterial gastroenteritis, with 3,424 and 1,961 notifications respectively in WA in 2016. This represented an increase of 78 per cent and 67.5 per cent from 2012 although this may be partially due to the introduction of more sensitive testing.


\(^{37}\) Australian Institute of Health and Welfare (AIHW) analysis of the Australian Burden of Disease 2011 database (unpublished)
**Mitigate the impact of public health emergencies on the community**

It is important that governments and communities are prepared to prevent, respond to, and rapidly recover from public health emergencies which will likely involve multiple casualties or cause significant disruption to patient care. These can include severe weather events, natural disasters such as floods and bushfires, infectious disease epidemics or pandemics, man-made emergencies such as a major transport accidents, and chemical or radiation emergencies.

**Support immunisation**

Immunisation is widely recognised as one of the most successful and cost effective public health interventions available. A comprehensive immunisation program, with high levels of uptake, can protect both individuals and the community from a range of infectious diseases which can cause hospitalisation, serious ongoing health conditions and sometimes death.38

WA has high rates of childhood immunisation, with coverage rates among one and five-year olds consistently above 90 per cent since 2014.39 However, there is still room for improvement with these rates somewhat lower than most other jurisdictions in Australia.

The national human papillomavirus (HPV) vaccination program was introduced on 1 April 2007 to reduce the mortality and morbidity related to infection with this virus. The vaccine protects against the two high-risk HPV types (types 16 and 18), which cause 70 per cent of cervical cancers in women and 90 per cent of all HPV-related cancers in men. It also protects against two low-risk HPV types (types 6 and 11), which cause 90 per cent of genital warts.40 Research studies have demonstrated early signs of the vaccine’s success including a 77 per cent reduction in the two HPV types and a 90 per cent reduction in genital warts in heterosexual men and women less than 21 years of age.41

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40 National HPV Vaccination Program Register 2016, National (Australia) HPV 3 dose vaccination coverage for females turning 15 years of age in 2015
In WA, approximately three-quarters (74.4%) of females turning 15 years of age in 2015 are fully vaccinated against HPV, which is slightly lower than the national average (77.4%). Among males, 63.4 per cent are fully vaccinated, which again is slightly lower than the national average (67.1%).

### Vaccination during pregnancy

Pertussis vaccination during pregnancy helps protect the mother and newborn from catching whooping cough, a highly contagious bacterial disease which can cause breathing problems, pneumonia and sometimes death. In 2015 just over 70 per cent of pregnant women in WA reported being immunised with pertussis vaccine.

Pregnant women are also encouraged to get vaccinated against the flu (influenza). In 2015 it was estimated that 56 per cent of pregnant women in WA were immunised against seasonal influenza. This is 2.5 times the rate observed in 2012 (22%).


### Prevention and control of communicable diseases

Communicable diseases are a significant public health priority for WA with a particular focus on preventing and responding to new or emerging infectious diseases.

State-wide surveillance is therefore essential to facilitate effective and appropriate identification of and responses to sporadic cases and outbreaks of communicable diseases and minimise further transmission in the community. In WA, medical practitioners, nurse practitioners and pathologists are required to report around 70 communicable diseases to the WA Department of Health. Some examples of these notifiable diseases include chlamydia, cryptosporidiosis, measles, meningococcal disease, Ross River virus infection, Salmonella gastroenteritis and viral hepatitides.

Sexually transmitted infections (STIs) and blood-borne viruses (BBVs) represent a significant burden of disease in WA, particularly among specific population cohorts such as young people and Aboriginal people.

Unsafe sex accounted for 0.4 per cent of the total burden of disease and injury in WA in 2011. However it was responsible for the entire disease burden due to cervical cancer and STIs, and 90 per cent of the burden due to HIV/AIDS.

High levels of STIs continue to occur in WA. Chlamydia was the most commonly notified disease in WA in 2015 with 11,220 notifications. The crude notification rate was 41 per cent

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42 National HPV Vaccination Program Register 2016, National (Australia) HPV 3 dose vaccination coverage for males turning 15 years of age in 2015
43 Australian Institute of Health and Welfare (AIHW) analysis of the Australian Burden of Disease 2011 database (unpublished)
higher than the national rate and was the second highest in Australia. The notification rate among Aboriginal people was almost four times higher than that of non-Aboriginal people.\textsuperscript{44}

Gonorrhoea was the second most commonly notified STI in WA with 2,266 notifications in 2015. This represented a ten-year high in notifications; however this is partially attributed to an increase in testing. The notification rate among Aboriginal people was 13 times higher than non-Aboriginal people.\textsuperscript{45}

While AIDS notifications and deaths among HIV-infected persons have remained low since the late 1990s, the annual number of HIV notifications in WA has increased by 71 per cent in the last decade.\textsuperscript{46}

Hepatitis is a blood-borne virus which can lead to serious liver disease. In 2015, there were 576 notifications of hepatitis B and 1,110 notifications of hepatitis C in WA.

Hepatitis B is vaccine preventable and WA has had high rates of childhood vaccination against the disease through the national childhood vaccination program.\textsuperscript{47} Rates of hepatitis B have also generally been decreasing among Aboriginal people.\textsuperscript{48}

There is no vaccine against hepatitis C and at-risk populations include people who inject drugs and people in, or who have recently exited, custodial settings. Notification rates for newly acquired (within 24 months prior to diagnosis) and unspecified (infections of unknown duration) hepatitis C were highest in the 20 to 24 and 35 to 39 year age groups respectively.\textsuperscript{49}

\begin{flushright}
Mosquito-borne disease
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Ross River virus and Barmah Forest virus are the two most common mosquito-borne viruses in WA. No vaccine or specific antiviral treatment is available for these viruses; therefore prevention and control is the best strategy. Both infectious conditions are notifiable to ensure that appropriate public health actions can be taken, including the implementation of mosquito control programs and issuing public warnings. The number and rate of Ross River virus notifications has been decreasing since 2012, with 476 notifications recorded in 2016 at a rate of 18.0 per 100,000.


\textsuperscript{44} Communicable Disease Control Directorate, 2016. The Epidemiology of Notifiable Sexually Transmitted Infections and Blood-Borne Viruses in Western Australia 2015. Perth: WA Department of Health
\textsuperscript{45} Ibid
\textsuperscript{46} Ibid
\textsuperscript{47} Immunise Australia Program, 2017. Childhood immunisation 12-<15 months by State. Canberra: Commonwealth Department of Health
\textsuperscript{48} Communicable Disease Control Directorate, 2016. The Epidemiology of Notifiable Sexually Transmitted Infections and Blood-Borne Viruses in Western Australia 2015. Perth: WA Department of Health
\textsuperscript{49} Ibid
Promote oral health improvement

Good oral health is important for general health and wellbeing. Tooth decay, gum disease and oral cancers are the major oral diseases, but are mostly preventable.

While there have been substantial improvements in oral health over the past 20-30 years, more than three in ten children in WA experience tooth decay\textsuperscript{50} and one in four adults have untreated tooth decay.\textsuperscript{51}

Oral disease shares a number of risk factors with other chronic diseases including poor nutrition and consumption of alcohol and tobacco; and public health interventions around these lifestyle behaviours will also contribute to improved oral health. In addition, fluoridation of community water supplies is recognised by the National Health and Medical Research Council as one of the most cost-effective and equitable public health strategies to prevent dental caries.\textsuperscript{52} In WA, approximately 92 per cent of the population has access to fluoridated drinking water.

\begin{quote}
Higher rates of untreated tooth decay are experienced by Aboriginal people, regional and remote residents and people on lower incomes
\end{quote}


\textsuperscript{52} National Health and Medical Research Council, 2007. A systematic review of the efficacy and safety of fluoridation. Canberra: NHMRC, Australian Government
Improving Aboriginal health

The greatest relative difference in health status in WA is between Aboriginal and non-Aboriginal Western Australians, culminating in a life expectancy that is 15.1 years lower for Aboriginal men and 13.5 years lower for Aboriginal women compared with non-Aboriginal Western Australians.\(^{53}\)

Reduce the incidence of chronic disease and injuries for Aboriginal people

A major contributor to this gap is chronic disease, which is estimated to account for around two-thirds of all premature deaths among Aboriginal Australians.\(^{54}\) When compared with the non-Aboriginal population, Aboriginal Australians are more than three times as likely to have diabetes, twice as likely to have signs of chronic kidney disease and more likely to have more than one chronic condition.\(^{55}\) In addition, Aboriginal adults are more likely to experience chronic conditions at an earlier age, with a recent study suggesting that they experience diabetes 20 years earlier than non-Aboriginal Australians.\(^{56}\)

Injury, including suicide and self-inflicted injuries, is the leading cause of the total disease burden among Aboriginal Western Australians, accounting for 19 per cent. In addition, it is the second leading contributor to the gap in total burden between Aboriginal and non-Aboriginal people in WA, contributing 17 per cent.\(^{57}\)

Improve environmental health conditions in remote communities

Poor environmental health conditions in some remote Aboriginal communities also contribute to ill-health among this population group.

It is widely acknowledged that poor environmental health conditions, including overcrowding, passive smoking and poor sanitation, are linked to a number of adverse health outcomes, including respiratory infections, gastroenteritis, trachoma, hearing loss, and skin diseases.

Infectious disease prevalence is disproportionately high among Aboriginal children, particularly in remote regions. In WA, respiratory and gastrointestinal infections accounted for the majority of all hospital admissions among children under the age of fifteen and were

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\(^{55}\) Australian Bureau of Statistics 2014. Australian Aboriginal and Torres Strait Islander Health Survey: Biomedical Results, 2012-13. Cat no. 4727.0.55.003. Canberra: ABS
\(^{56}\) Ibid
Overcrowding

The effects of overcrowding occur in combination with other environmental health factors such as poor water quality and sanitation, which are associated with increased risk of transferring infectious diseases, and the recurrence or exacerbation of chronic infections such as otitis media.

Aboriginal Western Australians were over eight times more likely to live in overcrowded households compared with non-Aboriginals.


significantly higher than in non-Aboriginal children, with the rate of hospitalisation for influenza and pneumonia almost 5 times the rate in non-Aboriginal children.\(^{58}\)

In 2014-15, the National Aboriginal and Torres Strait Islander Social Survey found that 13 per cent of Aboriginal children aged 4-14 years had eye or sight problems, up from 9 per cent in 2008.\(^ {59}\) Trachoma is an infectious eye disease caused by poor environmental conditions that can lead to blindness if it is not detected and treated. Australia is the only developed country in the world where trachoma is endemic, with several known at-risk regions located in northern Western Australia. The WA Trachoma Program has successfully reduced rates of trachoma infection in rural and remote Aboriginal communities from 15 per cent in 2007 to 2.6 per cent in 2015.\(^ {60}\) This indicates that targeted public health programs have the potential to improve health conditions in specific communities of need.

Otitis media is the predominant ear disease among Aboriginal children and repeated occurrences can lead to hearing loss, and consequently poorer educational outcomes and employment opportunities.\(^ {61}\) Prevalence of the disease varies widely between communities in WA, with some studies observing estimates between 20 and 55 per cent\(^ {62}\), rates that far exceed the 4 per cent prevalence defined by the World Health Organization as a major public health problem.\(^ {63}\)

\(^{58}\) WA Department of Health. Aboriginal and non-Aboriginal comparisons. Epidemiology Branch in collaboration with the Cooperative Research Centre for Spatial Information. Perth: WA Department of Health, accessed 27 April 2017


24
Reduce the incidence and prevalence of STIs and BBVs among Aboriginal people

Rates of notifiable STIs and BBVs are noticeably higher among Aboriginal people in WA compared with non-Aboriginal people.

Rates of chlamydia are almost four times higher, those for gonorrhoea 13 times and infectious syphilis are 10 times higher. A syphilis outbreak among Aboriginal people in Northern Australia and increasing syphilis notifications among ‘men who have sex with men’ contributed to a 75 per cent increase in infectious syphilis notifications in 2015 (n=166) compared to 2014 (n=95).

New diagnoses of hepatitis C have also increased among Aboriginal people in WA over the past ten years. In comparison, there has been a decrease in diagnoses among non-Aboriginal people over the same time period resulting in rates among Aboriginal people that are almost 25 times those seen in non-Aboriginal people in 2015.  

Reduce the incidence of vaccine preventable diseases among Aboriginal people

Data from the Australian Childhood Immunisation Register indicates that there is a disparity in immunisation coverage for Aboriginal children in WA in the early years of life with coverage approximately seven per cent lower than that for non-Aboriginal children at one year of age, and four per cent lower at two years of age.

Aboriginal children in WA under the age of five years also continue to have higher rates of vaccine preventable disease including influenza (3.4 times higher), invasive pneumococcal disease (9.5 times higher) and pertussis (2 times higher).  

By five years of age immunisation coverage among Aboriginal children exceeds that of their non-Aboriginal counterparts, however the challenge for public health agencies is to boost coverage at the earlier time points.

64 Communicable Disease Control Directorate, 2016. The Epidemiology of Notifiable Sexually Transmitted Infections and Blood-Borne Viruses in Western Australia 2015. Perth: WA Department of Health

Part 2: Objectives and policy priorities 2017 – 2021
Requirements of the *Public Health Act 2016*

Part 5 of the Public Health Act requires the preparation of two types of public health plans:

1. A State PH Plan prepared by the Chief Health Officer (CHO) and
2. A Local PH Plan prepared by each local government.

The purpose of public health planning is to identify the public health needs of the State and each local government district by examining data on the health status and health determinants of the population. This information is used to establish objectives and public health priorities for:

- the promotion, improvement and protection of public health and
- the development and delivery of public health services for the State and each local government district.

The relationship between the State PH Plan and Local PH Plans and some key elements of public health planning required under the Public Health Act are summarised below:

<table>
<thead>
<tr>
<th>Public Health Planning</th>
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<tbody>
<tr>
<td><strong>State public health plan</strong></td>
</tr>
<tr>
<td>- Identifies public health needs</td>
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<tr>
<td>- Examines health status and health determinants</td>
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<tr>
<td>- Establishes objectives and policy priorities for:</td>
</tr>
<tr>
<td>- Promotion, improvement and protection of public health</td>
</tr>
<tr>
<td>- Development and delivery of public health services</td>
</tr>
<tr>
<td>- Establishes a framework for identifying and responding to public health risks</td>
</tr>
<tr>
<td>- Ensures continuous review, replacement and reporting of the plan</td>
</tr>
<tr>
<td><strong>Local public health plans</strong></td>
</tr>
</tbody>
</table>

The Public Health Act states that a Local PH Plan must be *consistent* with the State PH Plan. This provides an opportunity for local government to align with the State Government and establish locally based objectives and policy priorities that are consistent with those of the State, whenever they may be applicable and relevant to their local government district.

The Public Health Act also enables Local PH Plans to be prepared in conjunction with the plan for the future required under section 5.56 (1) of the *Local Government Act 1995* to minimise the number of strategic planning processes required by local government.

The first State PH Plan is not required to be produced until one year after Part 5 of the Public Health Act is enacted, which is still 4 years away. Local governments are not required to produce their Local PH Plans until two years after Part 5 is enacted. This means that the development of the State or a Local PH Plan is not yet legally required. The Chief Health Officer has decided to publish this document as an interim measure until Part 5 comes into effect.
This First Interim State PH Plan has been developed by the Chief Health Officer and the Public Health Division of the WA Department of Health, by assessing the health status and health determinants data summarised in Part 1: A health status report for Western Australians. The information from the health status report, which examines the public health trends in WA and identifies areas of inequalities in particular population sub-groups, such as Aboriginal people, has been invaluable in affirming the current objectives and policy priorities documented in this First Interim State PH Plan.

It is important to note that this First Interim State PH Plan does not adhere to all the requirements specified in Part 5, section 43 of the Public Health Act. In particular it does not address:

Section 43(e) describe how the Chief Health Officer proposes to work with local governments and other bodies undertaking public health initiatives, projects and programmes to achieve the objectives and policy priorities referred to in paragraph (c)

Section 43(f) include a strategic framework for the identification, evaluation and management of public health risks in the State and any other matters relating to public health risks in the State —

(i) that the Chief Health Officer considers appropriate to include in the plan; or

(ii) that are required to be included in the plan by the regulations.

Section 43(3) The Chief Health Officer must review the State public health plan each year and may amend or replace it at any time.

Due to the significant amount of work that is currently being undertaken by the Department to prepare for the various stages of implementation of the Public Health Act, the Chief Health Officer would like to ensure that the Department’s resources are focused on meeting this work demand. Accordingly, the First Interim State PH Plan is the first step towards complying with section 43 of the Public Health Act.

The Chief Health Officer acknowledges that governments at all levels can work more effectively together to help to influence many of the determinants of health, the conditions that influence a person’s opportunity to be healthy, their risk of illness and life expectancy. The Department has already partnered with numerous agencies that deliver a range of health programs and services required to maintain and improve the health of the community, and who provide invaluable support for the acute public health care sector. There is now an opportunity to strengthen our partnerships with the many other agencies that play a role in influencing the determinants of health in some way.
## Vision, mission, goals

### Vision

| In WA, it is easy to be healthy |

### Mission

| To protect, promote and improve the health and wellbeing of the public of Western Australia and to reduce the incidence of preventable illness. |

### Goals

| Promote and improve public health |
| Protect against public health risks |
| Promote information about public health risks |
| Encourage healthy environments |
| Provide for prevention or early detection of public health risks |
| Support public health programs |
| Facilitate information flow to decision makers |
| Ensure certain public health information is collected and used effectively |
| Reduce public health inequalities |
| Ensure State and local governments perform public health functions |
We want the people of WA to experience the best possible health, wellbeing and quality of life because they are empowered as individuals and within their communities to make healthy decisions.

It is important that Western Australians can actively participate in community life and that the places and spaces where they live, learn, work and play are safe, clean, green and accessible.
Public health objectives for Western Australians 2017 – 2021

The following objectives represent the State’s public health priorities. By focusing action and investing resources on these priority areas, we can aim to achieve the biggest gains in minimising deaths, burden of disease and improving the quality of life for people living in WA.

1. Empowering and enabling people to make healthy lifestyle choices
2. Providing health protection for the community
3. Improving Aboriginal health
Objective 1: Empowering and enabling people to make healthy lifestyle choices

Western Australians need to feel empowered and enabled to make healthy choices in their daily lives, from eating the right foods and taking action to keep active. Our responsibility is to educate Western Australians to make healthy lifestyle choices and ensure that individuals and families have access to the right information and services to stay healthy. An important part of this is fostering health-promoting environments.

<table>
<thead>
<tr>
<th>Policy priorities</th>
<th>How we aim to achieve this</th>
</tr>
</thead>
</table>
| **1.1 Healthy eating*** | 1. Foster environments that promote and support healthy eating patterns  
2. Increase availability and accessibility of quality, affordable, nutritious food  
3. Increase the knowledge and skills necessary to choose a healthy diet |
| **1.2 A more active WA*** | 1. Promote environments that support physical activity and reduced sedentary behaviour  
2. Reduce barriers and increase opportunities for physical activity across all populations  
3. Increase understanding of the benefits of physical activity and encourage increased activity at all stages of life  
4. Motivate lifestyle changes to reduce sedentary behaviour |
| **1.3 Curbing the rise in overweight and obesity*** | 1. Promote environments that support people to achieve and maintain a healthy weight  
2. Prevent and reverse childhood overweight and obesity  
3. Motivate behaviour to achieve and maintain a healthy weight among adults |
| **1.4 Making smoking history*** | 1. Continue efforts to lower smoking rates  
2. Eliminate exposure to second-hand smoke in places where the health of others can be affected  
3. Reduce smoking in groups with higher smoking rates  
4. Improve regulation of contents, product disclosure and supply  
5. Monitor emerging products and trends |
| **1.5 Reducing harmful alcohol use** | 1. Change community attitudes towards alcohol use  
2. Influence the supply of alcohol in accordance with the *Liquor Control Act 1998*  
3. Reduce demand for alcohol |
<table>
<thead>
<tr>
<th>Policy priorities</th>
<th>How we aim to achieve this</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.6 Prevent injuries and promote safer communities*</td>
<td>1. Protect children from injury</td>
</tr>
<tr>
<td></td>
<td>2. Prevent falls in older people</td>
</tr>
<tr>
<td></td>
<td>3. Reduce road crashes and road trauma</td>
</tr>
<tr>
<td></td>
<td>4. Improve safety in, on and around water</td>
</tr>
<tr>
<td></td>
<td>5. Reduce interpersonal violence</td>
</tr>
<tr>
<td></td>
<td>6. Develop the injury prevention and safe communities sector</td>
</tr>
<tr>
<td></td>
<td>7. Monitor emerging issues in injury prevention</td>
</tr>
</tbody>
</table>

*Refer to the [Western Australian Health Promotion Strategic Framework 2017-2021](#) for a detailed examination of Objective 1.
Objective 2: Providing health protection for the community

As WA’s population grows across the State it is important that we not only manage traditional public health risks, but are ready to respond to new and emerging risks that may pose harmful impacts on the community.

Although public health has had numerous successes over the previous decades in helping to prevent, reduce or even eliminate the prevalence of many diseases and health risks, it is important that we do not become complacent in the areas we manage well. The enforcement of regulatory programs continues to be an important priority for the State.

<table>
<thead>
<tr>
<th>Policy priorities</th>
<th>How we aim to achieve this</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2 Mitigate the impact of public health emergencies on the community</td>
<td>1. Ensure public health emergencies are included in emergency and disaster planning 2. Continuous improvement in the response to public health emergencies 1. Improve immunisation rates among children entering school and in geographic areas with low vaccination rates 2. Improve immunisation rates among Aboriginal populations 3. Expand access to immunisation services by increasing the capacity of existing health care providers to vaccinate 4. Improve the immunisation education and consent process throughout WA 5. Sustain mechanisms to ensure robust surveillance and follow-up of suspected adverse events following immunisation 6. Enhance surveillance for vaccine-preventable diseases 7. Ensure stakeholder involvement in immunisation planning 8. Coordinate school-based immunisation programs</td>
</tr>
</tbody>
</table>
**Refer to the WA Immunisation Strategy 2016-2020 for a detailed examination of immunisation priorities**

**Refer to the WA Sexual Health and Blood-borne Virus Strategies 2015-2018**

**Refer to the State Oral Health Plan 2016-2020**

### 2.4 Prevention and control of communicable diseases***

1. Undertake state-wide surveillance and disease control response to sporadic cases and outbreaks of communicable diseases
2. Maximise ongoing community engagement with health programs by eliminating stigma and discrimination amongst priority populations
3. Continue to enhance access to needle and syringe programs and safe disposal of used injecting equipment
4. Continue to support and enhance STI and BBV prevention and education programs and access to health hardware for priority populations
5. Enable access to HIV pre-exposure prophylaxis for populations vulnerable to HIV
6. Improve access to STI testing, treatment and management in primary health care
7. Support workforce development to enable HIV, hepatitis C and B testing and management in primary health care settings
8. Support and enable the delivery of sexual health and relationship education in school-based settings

### 2.5 Promote oral health improvement****

1. Support the promotion of the public health initiatives outlined in the Oral Health Plan 2016 - 2020
**Objective 3: Improving Aboriginal health**

We have a responsibility to work closely with other agencies across the State to manage a range of projects and programs to address public health issues for Aboriginal people.

<table>
<thead>
<tr>
<th>Policy Priorities</th>
<th>How we aim to achieve this</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3.1 Improve environmental health conditions in remote communities</strong></td>
<td>1. Ensure Aboriginal people living in remote communities have access to quality environmental health programs</td>
</tr>
</tbody>
</table>
| **3.2 Reduce the incidence of chronic disease and injuries for Aboriginal people** | 1. Complement population approaches with targeted programs that are culturally-secure and meet the needs of Aboriginal people  
2. Support communities and stakeholders to adopt local policies that will support healthier lifestyle behaviours  
3. Provide guidance to Local Governments to develop Local Public Health Plans that support healthier lifestyle behaviours |
| **3.3 Reduce the incidence and prevalence of STIs and BBVs among Aboriginal people living in WA** | 1. Increase awareness and knowledge of STIs and BBV prevention, testing and treatment  
2. Increase access to health-hardware such as condoms and lubricant, needles and syringes and safe disposal of used equipment  
3. Increase testing, treatment and management of STI and BBVs in primary care settings  
4. Enhance the capacity Aboriginal health workers, nurses and general practitioners through workforce development and culturally secure service delivery |
| **3.4 Reduce the incidence of vaccine preventable diseases among Aboriginal people** | 1. Assess vaccination rates among Aboriginal populations to identify potential subsets which may benefit from additional immunisations services  
2. Develop and implement systems to follow-up Aboriginal children identified as overdue for vaccinations  
3. Work closely with Aboriginal community controlled health services, Area Health Services, WA Primary Health Alliance (WAPHA) and other stakeholders to develop culturally appropriate, community-based programs in areas needing improvement  
4. Resolve legal barriers to vaccination by Aboriginal health workers (AHWs) and train and empower AHWs to vaccinate through expansion of the current AHW Immunisation Competency Training Program  
5. Support efforts by WA Health to recruit and retain more AHWs in the government workforce |
Supporting strategies

This Interim State PH Plan is not designed to incorporate every public health issue or concern, or to replace already existing plans, strategies, policies or programs designed to protect or improve public health. Rather, this Interim State PH Plan highlights areas of most public health significance for WA.

This Interim State PH Plan complements and links with existing plans. Other strategies produced by the WA Department of Health that support this strategy include:

- WA Health Promotion Strategic Framework 2017 - 2021
- WA Sexually Transmissible Infections Strategy 2015–2018
- WA Hepatitis B Strategy 2015-2018
- WA Hepatitis C Strategy 2015-2018
- WA Human Immunodeficiency Virus Strategy 2015-2018
- WA Aboriginal Sexual Health and Blood-borne Viruses Strategy 2015-2018
- WA Immunisation Strategy 2016-2020
- WA Health Strategic Intent 2015-2020
- WA Aboriginal Health and Wellbeing Framework 2015-2030
- State Oral Health Plan 2016–2020

Partnerships

The Chief Health Officer recognises that health and wellbeing is a shared responsibility, and that partnerships must be strengthened with the many bodies undertaking public health initiatives, projects and programs to achieve the objectives and policy priorities of this plan.

Although the key focus of this Interim State PH Plan is to support local governments in the development of their Local PH Plans, this plan may also be used by all agencies and organisations with an interest in protecting, promoting and improving the health and wellbeing of Western Australians and helping to reduce the incidence of preventable illness.

Making it easy to be healthy in WA will require the involvement of many partners, including:

- State government departments and agencies
- local government
- non-government organisations
- health professionals
- industry groups
- educational bodies
- community groups and
- the general public.

Each of these groups has the opportunity to initiate public health initiatives, projects and programs to help to achieve the objectives and policy priorities outlined in this Interim State PH Plan. In particular, local governments, a major partner in public health, already provide a number of services that have public health benefits for their local community.

Although it may not be possible to address all the objectives and policy priorities, this Interim State PH Plan will help to identify areas of need for a local government district.