

# Victorian public health and wellbeing plan 2015–2019





# Victorian public health and wellbeing plan 2015–2019

Please note:

Where the term 'Aboriginal' is used it refers to both Aboriginal and Torres Strait Islander people.

Indigenous is retained when it is part of the title of a report, program or quotation.

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Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

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ISBN 978-0-7311-6791-3 (pdf)

Available at [www.health.vic.gov.au/prevention](http://www.health.vic.gov.au/prevention)

(1507012)

# Foreword

I am delighted to release the *Victorian public health and wellbeing plan 2015–2019*.

This plan sets out the Andrews Labor Government's priorities and vision to improve the health and wellbeing of Victorians over the long term, and particularly over the next four years.

There are many aspects that contribute to an individual's health and wellbeing, including access to quality education, stable employment and good working conditions, secure housing, freedom from violence, safe and sustainable natural and built environments, food affordability, respectful relationships, supportive social networks and services and opportunities to participate in community life.

As a government we play a key role in protecting and supporting the public health and wellbeing of all Victorians, and this plan sets out a number of priorities to be achieved by 2019.

These include: promoting healthier eating and active living; reducing the harm caused by smoking, alcohol and drug use; improving mental health; preventing violence and injury; and improving sexual and reproductive health.

The plan addresses the importance of reducing inequalities in health and wellbeing among our community, because we know that people suffering social disadvantage tend to have poorer health outcomes than others.

In developing this plan the Victorian Government has consulted extensively with the leading health organisations and experts, local governments and health care providers. I want to thank everyone who has taken the time to contribute to this important work.

Victorians have one of the highest life expectancies in the world, however, there are a number of challenges that need to be addressed to improve health and social outcomes in Victoria.

Of particular concern is the growing burden of chronic disease. Chronic disease can lead to many people living with illness, pain and restrictions in activity over many years, and can reduce a person's ability to engage in work and in the community. Yet a considerable proportion of chronic disease is known to be preventable and unfortunately we know that chronic conditions are experienced at higher rates and often have poorer outcomes, among those who experience disadvantage. Addressing the risks and determinants of avoidable chronic disease is therefore a major focus of this plan.

Further, it is estimated that around 10 per cent of Victorian patients with chronic diseases contribute to 55 per cent of hospital inpatient days. During 2014–15 there were around 60,000 avoidable admissions in Victorian hospitals and it is estimated that avoidable hospital admissions will grow to nearly 80,000 by 2025–26 if things don't change. We must do more to reduce the number of people who are being admitted to hospital for conditions that could have been avoided.

The Victorian Government is also very concerned about family violence, which is a leading cause of ill health, disability and premature death in women aged 15–44. Yet it is preventable. Research shows that women with a history of intimate partner violence are more likely to smoke and have alcohol or drug problems, have contracted a sexually transmitted infection, be diagnosed with a mental illness, suffer from a chronic lung condition, heart disease, hypertension, stroke and experience chronic pain and fatigue. It is absolutely critical that we address this national emergency.

The Andrews Labor Government is committed to initiating, supporting and enabling health-focused initiatives, and strongly encourages close collaboration across sectors, all levels of government, professional organisations and the wider community.

It is only by working together that we will break the cycle of poor health and social disadvantage and be able to improve the health and wellbeing of all Victorians.

A handwritten signature in black ink, reading "Jill Hennessy". The signature is fluid and cursive, with a long, sweeping underline that extends to the right.

**The Hon Jill Hennessy MP**  
Minister for Health  
Minister for Ambulance Services

# Executive summary

This second public health and wellbeing plan establishes a new and ambitious population health vision for the state: a Victoria free of the avoidable burden of disease and injury, so that all Victorians can enjoy the highest attainable standards of health, wellbeing, and participation at every age.

Consistent with this vision, and with the objective of the *Public Health and Wellbeing Act 2008*, the overarching aim of the plan is to reduce inequalities in health and wellbeing.

The plan sets out a long term agenda for improving health and social outcomes in Victoria. Many of the actions needed lie beyond the remit of the health system. Individuals, families, communities, the voluntary sector, the private sector, the education system, and all levels of government share responsibility for improving health and wellbeing and will share the benefits of preventing and tackling the causes of avoidable health problems.

## Scope and design

The plan builds on the first *Victorian public health and wellbeing plan 2011–2015*, and takes account of feedback from consultations, policy changes in Victoria and Australia, new evidence, recent international developments and examples of best practice, as well as opportunities to align with wider government policies.

It sets high level strategic directions for change and improvement, but also introduces a stronger focus on outcomes, targets and accountability.

These strategic directions are focused on prevention, health promotion and health protection. The plan recognises and seeks to complement the range of other existing, or currently in development, health plans, strategies and policies. Together, these will address the spectrum of actions needed under a comprehensive response to priority health challenges.

A process of wider community, government and sectoral engagement will continue over the time of the plan to help strengthen and sustain the prevention effort in Victoria. An action plan will be developed that will capture more detail of the commitments and particular initiatives of government and its partners that will contribute to achieving the vision of this plan.

The plan recognises the need to ensure limited prevention resources are used to best effect over the course of its implementation.

## Health and wellbeing in Victoria

The health and wellbeing of Victorians is high by international standards and significant gains have been made in recent years. Despite good progress, such as reductions in smoking rates and motor vehicle fatalities, further improvements can be made, particularly in reducing inequalities.

**a Victoria free of the avoidable burden of disease and injury, so that all Victorians can enjoy the highest attainable standards of health, wellbeing, and participation at every age**

The plan sets out the challenges that we will face in achieving the vision, including:

- **increases in some risks to health and only limited or no improvement in others:** over the past two decades adult obesity has increased by about 40 per cent, with more than 2.3 million Victorians now overweight or obese; Victoria has also seen increases in the number of people reporting physical abuse associated with alcohol and in alcohol-related hospitalisations, despite an overall decline in alcohol consumption
- **the increasing impact of chronic disease:** chronic diseases, such as cardiovascular disease, type 2 diabetes, cancers, musculoskeletal conditions, mental disorders, injuries and chronic respiratory disease, are now the largest causes of poor health and disability and more Victorians are living with one or more chronic conditions
- **persistent inequalities in health status:** Aboriginal people have a life expectancy 10 years lower than non-Aboriginal people and life expectancy varies by up to seven years between local government areas in Victoria; rates of adult obesity vary almost five-fold across Victoria; the smoking rate for people experiencing psychological distress is more than double that of the rate for Victoria overall
- **demographic trends require new approaches:** population ageing requires a stronger emphasis on prevention efforts in later years of life; at the same time rapid population growth requires maintaining a focus on the health and wellbeing of children and families
- **environmental sustainability and health protection:** the impact of climate change presents environmental, economic and health challenges; communicable diseases are spreading faster and new diseases emerging more quickly, reinforcing the importance of communicable disease planning and preparedness.

aim to reduce  
inequalities in health  
and wellbeing

In addition to the analysis in this plan, the companion document – *Health and wellbeing status of Victoria* – provides more detailed health and wellbeing data across the life course.

### Meeting the challenges: setting priorities

In developing a response to these challenges, the plan sets six priorities to guide action over the next four years. These comprise important stepping stones towards achieving the state's vision, with measureable progress in outcomes to be achieved by 2025.

The priorities are:

- healthier eating and active living
- tobacco free living
- reducing harmful alcohol and drug use
- improving mental health
- preventing violence and injury
- improving sexual and reproductive health.



The selection of these priorities recognises that many diseases and conditions share common risks, determinants and protective factors. Focusing on these leading causes of poor health and wellbeing offers an opportunity to improve outcomes across a wide range of mental and physical health problems and the potential to engage a wide range of partners. The impact on specific diseases and conditions will be tracked through an outcomes framework to be developed under this plan.

There are also important relationships between the priority areas, offering opportunities for synergies across preventive strategies, for example, between: mental health and alcohol and drug use; sexual health and mental health; alcohol and violence; and healthy eating and mental health.

### **A life course approach**

Actions to respond to priorities identified in the plan will take account of the needs of different population groups at different stages of life. Preventive and supportive action taken early at each stage and transition point in the life course can provide multiple benefits. The plan includes a focus on health and wellbeing from the pre-natal period, the early years, through adolescence and youth, the adult years and into older age.

### **Delivering change**

Improving and sustaining health and wellbeing across the life course will require consideration of the wider determinants and action on many levels. The plan recognises the role of the state in providing safe, healthy and sustainable environments to protect and secure the health and wellbeing of Victorians, as well as the role individuals and families play in looking after their own health and wellbeing.

The plan outlines three major 'platforms' through which much of the implementation of the plan will occur. Many areas identified as priorities have or will have program-specific implementation strategies, for example, HIV/AIDS, the *Ice action plan*, and ongoing measures in areas such as tobacco control, skin cancer prevention and immunisation.

The delivery platforms are as follows.

#### *Healthy and sustainable environments*

This platform is concerned with the continued protection of health and wellbeing by ensuring: high standards of air, soil and water quality; a safe food supply; and control of physical, chemical, biological and radiological hazards as key underpinnings of a healthy society. It also includes actions to mitigate the impacts of climate change.

**climate change presents serious environmental, economic and health challenges**

### *Place-based approaches*

This platform provides a focus on all of the key settings where people live, learn, work and play. These include early childhood care settings and schools, workplaces, communities, liveable neighbourhoods, health and human services and residential and custodial care. The plan recognises the importance of local integrated action and the key role played by local government in community health and wellbeing. A particular focus is on reducing gaps in health and wellbeing between more and less advantaged areas and between rural/regional and metropolitan Victoria.

### *Person-centred approaches*

This platform includes the opportunities to strengthen the provision of integrated, preventive health services to individuals and families at all levels of the health care system. It encompasses many approaches that can empower individuals to gain the skills, knowledge and confidence needed for better health and wellbeing.

### **Accountability: measuring progress and outcomes**

To ensure accountability and measurement of progress against the priorities in the plan, a range of appropriate targets will be developed, supported by a comprehensive public health and wellbeing outcomes framework. The framework will include specific measures of chronic disease, risk and protective factors and social variables such as social capital.

Establishing targets for this plan will take into consideration the targets adopted for the World Health Organization's *Global action plan for the prevention and control of noncommunicable diseases 2013–2020* and other national and current Victorian targets and indicators.

Ongoing monitoring will enable progress to be evaluated and adjustments made where needed. The Department of Health and Human Services will provide an update of Victoria's health and wellbeing status every two years to monitor progress.

### *Governance*

In giving effect to all of the actions above, a shared understanding of problems and a joint approach to addressing them will be necessary across state and local government and partners. This will take account of the health and wellbeing responsibilities of local government under the Public Health and Wellbeing Act.

Governance of the plan's implementation will occur through:

- a yearly forum held by government with key stakeholders to review the *Health and wellbeing status of Victoria*, report on priorities and enlist commitments to future work
- the Victorian Secretaries Board, which will provide oversight on state government contributions to achieving the priorities of this plan.

health and wellbeing is  
everyone's responsibility

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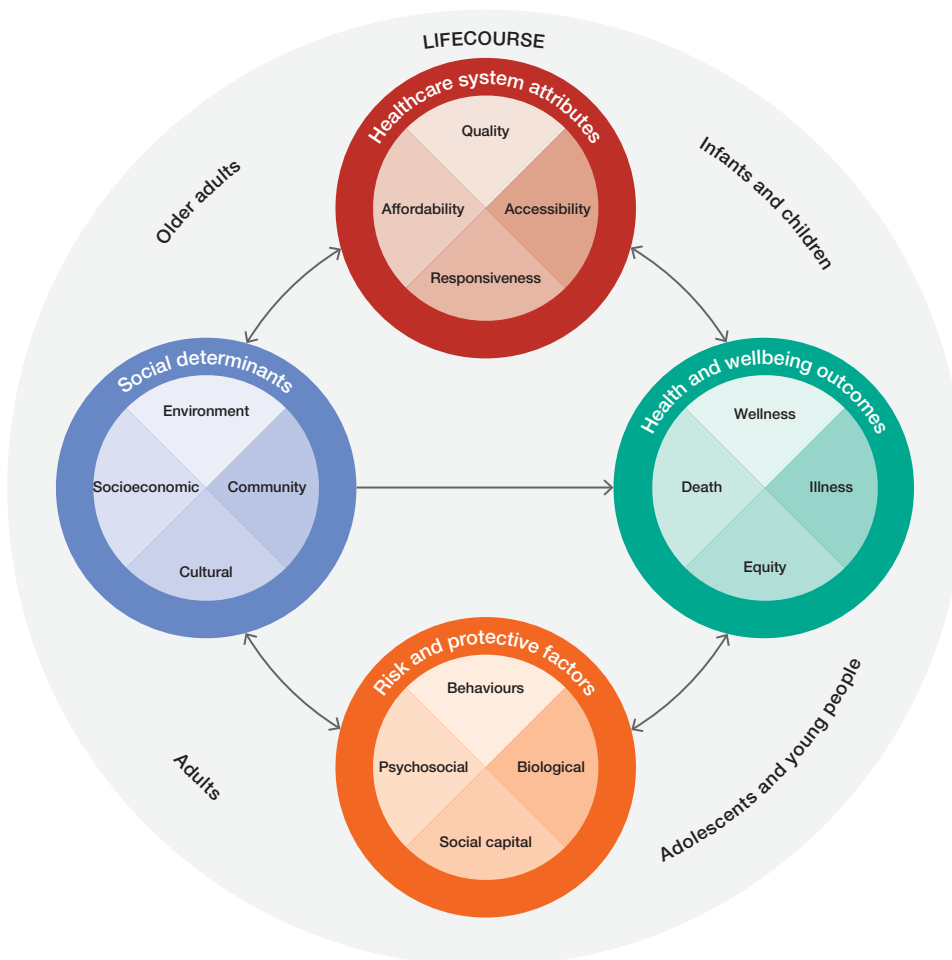
# Introduction

Good health and wellbeing is important to everyone and enables people to more fully participate in communities, education and employment opportunities. Good health and wellbeing is also essential for a strong economy.

This plan establishes a vision for the state: a Victoria free of the avoidable burden of disease and injury so that all Victorians can enjoy the highest attainable standards of health, wellbeing and participation at every age.

While the majority of Victorians experience good health and wellbeing, this is not shared by all. The relationships between the multiple contributions to health and wellbeing over the lifecourse are illustrated below (Ansari et al. 2003; National Health Information Standards and Statistics Committee 2009). Inequalities in health can lead to, or result from, inequalities in various other areas of life – housing, education, employment and transport accessibility among others. The link between poor health and poverty is clear: those with the least resources suffer more from avoidable illness and reduced life expectancy, often across generations. These inequalities are particularly evident for Aboriginal Victorians.

Relationships between determinants of health and wellbeing across the lifecourse



Such concerns informed the development of the Victorian *Public Health and Wellbeing Act 2008* (see the appendix for other relevant public health and wellbeing legislation), which has as its primary objective the achievement of the highest attainable standard of public health and wellbeing for Victoria. This objective is to be achieved by: protecting public health; preventing disease, illness, injury, disability and premature death; promoting conditions in which people can be healthy; and reducing inequalities in the state of public health and wellbeing.

One of the major requirements of the Act is the preparation, every four years, of a state public health and wellbeing plan. Victoria's first plan was released on 1 September 2011. Each plan is required to: identify Victoria's public health and wellbeing needs based on an examination of data relating to health status and health determinants; establish objectives and policy priorities for the promotion and protection of public health and wellbeing based on available evidence; and specify how the state is to work with other bodies undertaking the public health initiatives, projects and programs needed to achieve the objectives.

The Act also recognises that local government is a major partner to the state government in the effort to protect public health and wellbeing in Victoria. Each council is required to prepare a municipal public health and wellbeing plan every four years. When preparing this plan a council must have regard to the state public health and wellbeing plan.

**local government  
is a major partner**

This second plan sets out a new long-term agenda for improving all Victorians' health and wellbeing. This plan gives special attention to ensuring that the greatest improvements are realised among those whose health is poorest, including those who often have fewer financial and social resources than the rest of the population. These groups include but are not limited to some Aboriginal people, some groups of Victorians from culturally and linguistically diverse backgrounds, residents of rural Victoria, people with disabilities, refugees, asylum seekers, people who identify as lesbian, gay, bisexual, transgender or intersex, people who are homeless, and children in out-of-home care. While there are complex social and cultural factors that impact on identity this plan draws on available categories to demonstrate where inequalities exist or are improving. It is acknowledged that these categories do not always reflect the complexities of people's lives.

In seeking to address disadvantage, the plan applies a gender lens throughout, recognising that women's gendered experience, including of violence and sexism, can affect their life experiences and subsequently their health and wellbeing.

While building on the first plan, this plan sets priorities as a guide to action across all sectors. It establishes a vision to garner collective effort, collaboration and cooperation to achieve improvement in the health and wellbeing of Victorians.

Recognising the fact that health and wellbeing is everyone's responsibility, a wider process of engagement will be used to develop an action plan. The action plan will outline comprehensive actions, strategies, timeframes and deliverables based on commitments and opportunities across government and the health sector and with non-government organisations and other relevant stakeholders. A comprehensive outcomes framework will be developed to enable monitoring and reporting on progress.

A public health and wellbeing outcomes framework will be developed to guide regular reporting on health and wellbeing outcomes and their determinants.

The *Victorian public health and wellbeing plan 2015–2019* is consistent with other government plans and strategies that impact on the wellbeing and health of Victorians. While this plan focuses on high-level strategic directions, more detailed actions are included in topic specific plans, strategies and policies, including those in development such as the *10-year mental health plan and Victoria's cancer plan*.

The governance for this plan will include new mechanisms for coordinating, monitoring and reporting on health and wellbeing, particularly among disadvantaged populations. This plan should be seen as a 'living document' that will be built on and actioned according to progress, lessons learnt and feedback over the next four years.

ensuring that the  
greatest improvements  
are realised among those  
whose health is poorest

## Scope of this plan

This plan includes a focus on many of the same health issues and approaches as the 2011–2015 plan as their importance has not changed. In most cases change in any one area of public health requires a long timeframe for any improvement to be realised.

Taking into account new evidence, recent international developments, best practice, feedback from consultations, policy changes in Victoria and Australia, and opportunities for alignment with wider government policies, the scope and design of this plan includes a:

- stronger focus on inequalities in health and wellbeing and the determinants that contribute to inequalities
- more explicit focus on improving health and wellbeing across the life course
- recognition of the need for greater flexibility in responding to local priorities and context – the plan identifies priorities for which there is good evidence for their benefits on health and wellbeing
- stronger focus on outcomes, targets and accountability
- more explicit emphasis on the benefits to be achieved through a whole-of-government, whole-of-community and whole-of-system response.

The scope of the plan bridges the responsibilities of the health system and those of other sectors that influence the wider determinants of health such as planning, education, employment, transport and housing. It shares the objectives of the

World Health Organization's (WHO) *Global action plan on prevention and control of noncommunicable disease*: to reduce modifiable risk factors and underlying social determinants by creating equitable health-promoting environments while aiming to strengthen and orient health systems for disease prevention and control through people-centred healthcare.

The plan's approach is built on a strong 'systems thinking' perspective. Many public health problems have complex and multiple causes. It is therefore important to see health problems in the context of the total system of which they are part, and consider the interactions and relationships among the elements that characterise the entire system. Multiple interventions may be needed to tackle different dimensions of the problem. This requires coordinated and 'joined-up' action, beyond disciplinary, programmatic or sectoral silos. This is particularly important in cases of entrenched social disadvantage.

A systems approach to public health and wellbeing is applicable to efforts to both protect and promote health. Protecting health is focused on ensuring the community is safe from hazards resulting from or associated with communicable diseases, food, water or the environment. Health promotion is focused on achieving population-level health improvement through interventions aimed at individuals, and at a community or societal level, including supportive public policies (National Public Health Partnership 2006). In order to ensure that vulnerable groups are not left behind and existing inequalities not inadvertently exacerbated in the improvement of population health, public health approaches generally need to include a mix of universal and targeted approaches.

Many of the most successful approaches to public health to date have been multifaceted and involved sustained and concurrent action across different levels – for example, a comprehensive mix of educational, regulatory, fiscal and service delivery measures in the case of tobacco control.

The plan's ambition is to achieve system-wide and enduring changes to support Victorians to stay healthy and well, prevent the onset of disease and intervene early to help people to manage their own health needs. Actions focused on improving the priorities of this plan have potential benefits across multiple health and social outcomes. National and international studies have demonstrated the potential cost effectiveness and cost benefits of such preventive interventions (World Health Organization Regional Office for Europe 2014a).

The plan is divided into three main parts outlined below.

**Part A: Understanding health and wellbeing** provides an overview of the factors that contribute to the health and wellbeing of Victorians, including the determinants of health and the impact of inequalities, risk and protective factors and broader trends and challenges.

**Part B: Strategic directions** outlines priority health conditions and essential public health approaches needed to improve the health and wellbeing of Victorians, with particular attention to the need to ensure action is taken across the life course.





**Part C: Accountability** describes governance arrangements, the scope of the action plan and monitoring and reporting commitments, including the development of an outcomes framework.

These various components of the plan are summarised in Figure 1.

Figure 1: Summary of the *Victorian public health and wellbeing plan 2015–2019*

<p><b>Vision</b></p> <p>This plan establishes a vision for the state: a Victoria free of the avoidable burden of disease and injury so that all Victorians can enjoy the highest attainable standards of health, wellbeing and participation at every age.</p>																																										
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## Achievements

The 2011–2015 Victorian public health and wellbeing plan elevated the significance of public health and wellbeing across government and with agencies and organisations that contribute to the health and wellbeing of Victorians. It also brought to prominence the importance of health and wellbeing for organisations that were not from within the health sector and/or had little if any contact with the sector previously.

The first plan emphasised the need to develop an integrated and multilevel approach to public health and wellbeing. It has been referenced and considered in local government plans and a substantial number of cross-government strategies and frameworks. The majority of council plans and municipal public health and wellbeing plans adopted a large number of the priorities of the plan and committed to specific actions and measures. Many councils noted that their contributions to the health and wellbeing of their communities go beyond the priorities listed in the first plan. Additional areas included in some council plans were problem gambling, community safety, immunisation, land-use planning and family violence.

Achievements over the period of the first plan include the following.

- The implementation of a complex systems approach to improve diet and physical activity, reduce obesity and related preventable chronic diseases in Victoria. This approach, which received international recognition, began a process of high-level statewide policy and leadership for change through multiple partnerships and strong community engagement and by empowering local governments, health services, statewide non-government organisations, business, industry and communities. This initiative was delivered as part of the implementation of the *National Partnership Agreement on Preventive Health*, which the Commonwealth Government ended in 2014.
- The Healthy Together Achievement Program has helped foster a whole-of-organisation approach to health and wellbeing by creating healthy environments in early childhood care and education settings, schools and workplaces.
- Children's services, hospitals and workplaces now have better access to information about healthy food and drink options through advice from the Healthy Together Healthy Eating Advisory Service. Healthy eating policies have been expanded in workplaces, parks and sport and recreation centres.
- In 2014 Melbourne hosted the 20th International AIDS Conference, which resulted in the co-development of the *AIDS 2014 legacy statement* committing all states and territories to the goal of the virtual elimination of new HIV transmissions in Australia by 2020.
- There is now improved cancer screening program participation for under-screened groups including Aboriginal communities, culturally and linguistically diverse communities, people from low socioeconomic groups and adults with a disability.

the first plan elevated the significance of public health and wellbeing across government

- The *Skin cancer prevention framework 2013–2017*, an evidence-based, comprehensive, community-wide approach to reducing the burden of skin cancer in Victoria, has been developed.
- The *Action plan for oral health promotion 2013–2017* was developed to improve the oral health of all Victorians including population groups at higher risk.
- The *Victorian health management plan for pandemic influenza* provides operational guidance for health services and primary care to minimise the impact of an influenza pandemic and includes planning considerations for residential aged and disability services, schools, children's services, custodial facilities, local government, laboratories and emergency services.
- The regulatory requirements for food-related businesses have been reduced and new food safety enforcement tools for councils have been developed. These measures allow council officers to better focus on food safety issues that pose a threat to the public.
- The *State heat plan*, a whole-of-state and local government approach to heatwave emergencies, was developed. New resources supported local governments to enhance their heat health plans to protect their communities. The collective efforts of local and state governments have contributed to a reduction in the severity of impacts of the 2014 heatwave (Victorian Auditor-General 2014; Department of Health 2014b).
- Victoria's 'healthy parks healthy people' approach has built on evidence that demonstrates the many human health benefits of contact with nature. These benefits include recreational opportunities, amenity, opportunities for cultural connection, social cohesion and a sense of place.
- Victoria's WorkHealth initiative was delivered by WorkSafe Victoria between 2009 and 2013. This initiative broke new ground in developing partnerships and communicating with employers and employees about the relevance and benefits of preventive health in the workplace.

## Work underway

The Victorian Government has committed to significant work that will contribute to the health and wellbeing of Victorians. This includes the following key policies and plans.

- The 10-year mental health plan will set a long-term vision for mental health in Victoria. A mental health workforce plan will support mental health workers and peer support workers.
- The *Ice action plan* (State Government of Victoria 2015a) represents a concerted effort to reduce the supply, demand and harm of the drug 'ice'. It includes the expansion of rehabilitation services for ice users, especially in regional Victoria, additional support for families, training and supervision of workers, and an increase in police and forensic resources.



- The *Victorian dementia action plan 2015–2019* identifies priority areas for action to support Victorians with dementia and their families and carers.
- The *Improving Cancer Outcomes Act 2014* (Parliament of Victoria 2014) aims to improve efforts to reduce cancer incidence, morbidity and mortality and to enhance the wellbeing of those affected by cancer.
- Continued commitment to *Closing the Gap* (Council of Australian Governments 2008) is combining the efforts of Commonwealth, state and territory governments to address the disadvantage faced by Aboriginal Australians in life expectancy, child mortality, education and employment.
- The *Koolin Balit 2012–2022* (Department of Health 2012) objectives include closing the gap in health outcomes for Aboriginal people living in Victoria and improving access to services and outcomes for Aboriginal people.
- Australia's first *Royal Commission into Family Violence* (Royal Commission into Family Violence 2015) has been tasked with finding the most effective ways to prevent family violence and improve early intervention to identify and protect those at risk.
- The government is supporting the rollout of the National Disability Insurance Scheme (National Disability Insurance Agency 2014). Victoria's transition to the National Disability Insurance Scheme will commence in 2016 and will be fully operational from 2019–20.
- The appointment of Victoria's first Gender and Sexuality Commissioner will help champion the rights of lesbian, gay, bisexual, transgender and intersex Victorians.
- The Victorian Code of Conduct for Community Sport (Department of Health and Human Services 2015e) supports environments in which every person in Victoria has the right to participate in community sport that is safe, welcoming and inclusive.

- The Community Sports Infrastructure Fund (Department of Health and Human Services 2015a) will support new and redeveloped sport and recreation facilities that will enable increased participation, with a focus on females and addressing disadvantage.
- The Inquiry into Women and Girls in Sport and Recreation aims to develop a strategy that will increase representation of women in governance and leadership roles and enhance accessibility, choice and pathways for women and girls.
- Safer Cyclists and Pedestrians Fund will improve safety for Victorian cyclists and pedestrians with the development of new dedicated pathways and routes for cyclists and walkers.
- Keeping up with the new skills that industry requires, the Victorian Government is developing a clear plan for an Education State, focusing on education across all stages of life in order to ensure that it is a positive force.
- The Back to work plan includes the *Back to Work Act 2015* that has established a new payment to employers hiring unemployed youth, the long-term unemployed and retrenched workers.
- A new ministerial advisory group will develop a major strategy to build on the success of the former WorkHealth program to improve the health of all Victorian workers.
- The Regional Jobs and Infrastructure Fund will support major projects, create jobs and industries and build stronger regional communities.
- The commitment to refresh *Plan Melbourne* (State Government of Victoria 2015b) will ensure it accurately reflects community and expert priorities and advice.
- The *Metropolitan open space strategy* will ensure the people of Melbourne are able to enjoy the environmental and physical and mental health benefits of open space into the future.
- Investing in major transport projects such as the Melbourne Metro Rail Project (Melbourne Metro Rail Authority 2015) will help to relieve road and rail congestion, enhance pedestrian and cycling accessibility and thus contribute to the health and wellbeing of Victorians.
- Victoria's new Road Safety Strategy and Action Plan are being developed with public consultation in order to reduce death and serious injury on Victorian roads.
- Hazelwood Mine Fire Inquiry reopened in May 2015 to address concerns following the fire and options of mine rehabilitation at the three coalmines in the LaTrobe Valley.
- The Victorian Government has committed to position Victoria as a leader in climate change action. The independent review of the *Climate Change Act 2010* in 2015 is one of the first steps in achieving this goal.
- The development of the second *Victorian climate change adaptation plan*, to be completed in 2016, will set out the risks and impacts of climate change across Victoria including those relating to health and government priorities for adaptation.



# Part A: Understanding health and wellbeing





# Health and wellbeing in Victoria

Under the Act a major requirement of the Victorian public health and wellbeing plan is to identify the public health and wellbeing needs of the people of the state, including an examination of data relating to health status and its determinants; and establish priorities for the state.

The priorities identified in this plan are based on the most significant causes of poor health and wellbeing that are most amenable to preventive action and cause the greatest inequalities in outcomes across the population.

The plan recognises that ‘wellbeing’ has two dimensions: subjective wellbeing (or personal wellbeing) which includes considerations such as life satisfaction, resilience, feeling one’s life has meaning; and objective wellbeing which includes more objective measures such as having adequate housing, physical health, education, sufficient resources, adequate food, appropriate care, and a healthy and safe environment (Department of Health England 2013). Wellbeing is therefore the outcome of many factors, both internal to an individual and of their wider social experience and conditions of living.

By setting priorities for improving physical and mental health, the plan complements other initiatives of government that aim to improve the overall social and economic wellbeing of the Victorian community.

While the plan draws on a wide range of data and evidence, the starting point for this analysis is a consideration of the most recent studies of the burden of disease and injury. Burden of disease studies measure and rank the contributions of diseases, injuries, health conditions and risk factors to premature deaths and years lived with disability. Burden of disease studies also calculate a combined measure of years lost due to premature mortality and years lost due to living with a disability, disability adjusted life years (DALYs). Together these provide an estimate of a society’s total health loss and disease burden and the leading, modifiable causes of the burden of disease and injury. Alongside other considerations such as the health and wider social costs associated with particular conditions and risk factors, these studies provide an important basis for planning, policy development and priority setting.

However, burden of disease studies have limitations in what can and can’t be included in their calculations. They are less able to take account of social and ‘upstream’ factors and therefore do not tell the whole story about causes and the responses needed. Consideration of the wider determinants of health and the impact of protective social factors, such as the strength of social and community networks (or ‘social capital’) are also needed to provide a full picture of health and wellbeing and inform priority setting.

The plan’s companion document, *Health and wellbeing status of Victoria*, provides a detailed analysis of the current prevalence and incidence of the various conditions and risk factors that cause the greatest burden of disease and disability, and the distribution of these risks and conditions over time at each key life stage (Department of Health and Human Services 2015b).

the health and wellbeing of Victorians is high by national and international standards



It is important to note that this plan takes account of noncommunicable chronic diseases and their risk factors, as well as communicable diseases. Over the past 60 years Australia and Victoria have achieved historically low rates of infectious or communicable diseases. Therefore these do not figure prominently in burden of disease analyses. This is largely the result of the effective protective measures in place, including strict environmental controls on food and water quality and sanitation, and the availability of universal immunisation. Nevertheless, new disease epidemics can quickly emerge and the potential for significant impacts from an infectious disease outbreak on Victoria's health is always present, so the importance of effective control efforts and preparedness remains a high priority.

In this chapter some key statistics and considerations on health status and health needs are highlighted, which provide the overarching rationale for the priorities in this plan.

## Leading causes of poor health

The health and wellbeing of Victorians is high by national and international standards. Significant gains have been made in recent years, including in life expectancy. However, these gains are not shared equally across Victoria. Socioeconomic disadvantage is the greatest cause of health inequality in Victoria.

Of the leading causes of premature death and disability for the population overall, recent burden of disease studies have found that, for Australia<sup>1</sup>:

- noncommunicable, chronic diseases accounted for about 85 per cent of the total burden of disease in 2010, while injuries accounted for 10 per cent and communicable, maternal, neonatal and nutritional disorders accounted for 5 per cent (Australian Institute of Health and Welfare 2014a)
- the largest contributors to the total burden were cancer (16 per cent), musculoskeletal disorders (15 per cent), cardiovascular diseases (14 per cent) and mental and behavioural disorders (13 per cent) (Australian Institute of Health and Welfare 2014a)
- cancer contributed 33 per cent and cardiovascular diseases 26 per cent of the fatal burden (premature death) in 2010 (Australian Institute of Health and Welfare 2014a)
- musculoskeletal disorders contributed 26 per cent and mental and behavioural disorders 23 per cent, of the non-fatal burden (disability) in 2010 (Australian Institute of Health and Welfare 2014a)
- between 1990 and 2010 the burden due to Alzheimer's disease has more than doubled in Australia, a substantially larger increase than any of the other top 25 conditions (Institute for Health Metrics and Evaluation 2013).

**the priorities identified in this plan are based on the most significant causes of poor health and wellbeing that are most amenable to preventive action and cause the greatest inequalities in outcomes across the population**

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<sup>1</sup> The median age of Victoria's population is similar to that of Australia. The standardised death rate is slightly lower. While state estimates for burden of disease are not yet available, the burden for Victoria will be expected to match very closely that of Australia.



Chronic diseases and injuries are the most costly conditions to treat, with cardiovascular diseases, oral health, mental disorders, musculoskeletal conditions, injuries, cancers and respiratory conditions being the disease groups attracting the highest direct health care costs nationally in 2008–09 (Australian Institute of Health and Welfare 2014a).

Chronic diseases are therefore the most significant health challenge for the population overall, not only due to the scale of the problem and their health care costs but also the personal, social and economic impacts of these diseases. As premature mortality declines, more people are living longer with and managing the impact of one or more chronic conditions. Worse outcomes and increased costs are associated with co-existing, multiple chronic conditions.

Nearly a quarter of those people leaving their job prior to reaching retirement age report that they have done so as a result of poor health, injury or disability. This proportion has increased over time (Australian Bureau of Statistics 2013g). The likelihood of being employed is reduced for people with one chronic condition, but those with four or more conditions participate in employment at less than 20 per cent of the rate of those with no conditions (Schofield et al. 2013).

Population health and wellbeing data including burden of disease studies, mask considerable variations and inequalities, and some conditions disproportionately affect particular population groups.

- The greatest relative difference in health status is between Aboriginal and non-Aboriginal Victorians (Department of Health 2012)
- Chronic diseases and injuries show the largest differentials in prevalence for both men and women and between those in the most and least disadvantaged areas. They make the major contribution to inequalities in outcomes.

**chronic diseases are the most significant health challenge for the population overall**

the greatest relative difference in health status is between Aboriginal and non-Aboriginal Victorians

- Intimate partner violence was the second largest cause of the burden of disease for Australian females aged 20–34 years in 2010, and the 14th highest risk factor for all Australians (Institute for Health Metrics and Evaluation 2013).
- Poor oral health is a high-burden condition for particular populations, with people living in regional areas, those on lower incomes and Aboriginal people experiencing the worst oral health (Australian Institute of Health and Welfare 2014d). Dental conditions are the highest cause of all preventable hospitalisations for Victorians under 25 years of age and the second highest for all ages (Department of Health 2014c).
- For the leading causes of death in adult males between 2009 and 2011, the largest relative inequalities in rates between the lowest and highest socioeconomic areas were associated with transport accidents, cirrhosis of the liver, diabetes and chronic lung disease; and for adult females, diabetes, cirrhosis of the liver and chronic lung disease (Australian Institute of Health and Welfare 2014b).
- Cardiovascular disease prevalence varies significantly across regions of Victoria from a low of 14 per cent in inner Melbourne to 25 per cent and higher in outer Melbourne and in the most disadvantaged regional areas (Heart Foundation Victoria 2014).

The combined impact of the unequal distribution of disease and injury between population groups and areas of the state explains a large part of the up to seven-year difference in life expectancy observed between local government areas.

While communicable diseases account for a relatively small share of the total burden of disease and disability, some communicable diseases, such as HIV, have a relatively high prevalence in particular population cohorts, and may exert a considerable burden in these populations. For example, some groups of people from refugee backgrounds have higher rates of hepatitis B and tuberculosis than other Victorians; the prison population experiences very high rates of hepatitis C.

Improvements and reduced inequalities in the major categories of disease and disability identified above represent important outcomes for this plan. However, the contribution of the risk and protective factors identified as priorities in the plan will have variable impacts on these conditions.

Some high-prevalence and high-burden conditions are less amenable to preventive actions. This includes certain cancers, severe mental illness, certain disabilities, some musculoskeletal conditions, and dementias, particularly Alzheimer's disease, where the causes are not yet well understood. There is emerging and promising evidence of an association between a number of these conditions and physical activity and diet (Alzheimer's Association 2015), as well as other behaviours identified in this plan. Early intervention can provide opportunities to ameliorate conditions, or to address additional risks such as smoking or poor diet.

## Risk factors

Estimates suggest that around one-third of the total burden of disease and injury is potentially avoidable, whether through preventing problems before they occur or finding problems early and treating them (Jardine et al. 2010). For example, WHO has estimated that up to 80 per cent of all heart disease, stroke and diabetes cases, and up to 40 per cent of all cancers, are potentially avoidable through preventive interventions (World Health Organization 2005). Consistent with this, in 2003 32 per cent of the total burden of disease in Australia was due to the joint effect of 14 modifiable risk factors (Begg et al. 2007).

While the degree to which a condition can be prevented varies, many share common risk factors. These include poor diet, physical inactivity, smoking, alcohol and drug use, overweight and obesity, high blood pressure, high blood glucose and high cholesterol. The majority of these have been identified in the WHO *Global action plan for the prevention and control of noncommunicable diseases*.

Dietary risks alone were estimated to account for 10.5 per cent of the total burden of disease in Australia, followed by high body mass (8.5 per cent) and smoking (8.3 per cent) (Institute for Health Metrics and Evaluation 2013). Globally, it is estimated that dietary risk factors and physical inactivity accounted for the largest disease burden in 2010 (Lim et al. 2012). A significant proportion of the combined effect is associated with the contribution of these factors to obesity, which is now ranked above smoking as a cause of disease burden.

The significant and growing impact of obesity has been highlighted in many recent national and international studies. Some estimates suggest that the cost of obesity to health care systems in developed economies could approach up to 20 per cent of all health care spending and point to growing evidence of the impact of obesity on productivity (McKinsey Global Institute 2014).

In Victoria adult obesity rates, but not overweight, are strongly associated with socioeconomic disadvantage. Self-reported obesity prevalence ranges from seven to above 30 per cent across local government areas (Department of Health 2014d).

Tobacco use remains the next highest modifiable factor contributing to disease burden. While significant reductions have been achieved, smoking rates remain high in disadvantaged populations (Department of Health 2014d).

Harmful alcohol and drug use continues to be a major cause of both disease and injury and is associated with high social and economic costs. Excessive alcohol and drug use can contribute to the likelihood and frequency of being involved in violence. Mental health and substance use disorders were the second largest cause of disability or non-fatal disease burden in Australia in 2010, causing 22 per cent of the disability burden (Australian Institute of Health and Welfare 2013).

**around one-third of the total burden of disease and injury is potentially avoidable**

**dietary risks are the largest cause of disease burden**



## Protective factors

Protective factors can reduce the likelihood of a person suffering a disease or experiencing an injury and/or enhance their response to the disease or injury should it occur. They enhance life opportunities, promote good health and wellbeing, build resilience and moderate the impact of stress on social and emotional wellbeing across all stages of life. Protective factors include optimal growth and development in the prenatal period and early childhood, positive early childhood experiences, strong family connections, education and access to quality health and social services.

Further examples of protective factors are: strong cultural identity; social inclusion and respect for diversity across society; safe, affordable and accessible housing and employment; safe and healthy food, water and air; and accessible and affordable transport. For Aboriginal people, connection to land, family, ancestry, culture and spirituality are protective factors that can provide a source of strength, resilience and empowerment (Kelly et al. 2009).

Protective factors can support transitions across the life course, such as social support networks for young people upon leaving home, and supportive family networks and workplaces in the event of birth, illness or bereavement. Protective factors also have a direct impact on health outcomes. The strength of social and community networks (or 'social capital') provides a protective safety net and is associated with better health, where the higher the degree of social connectedness generally means a lower death rate (Stephens et al. 2013). Eating a variety of vegetables and fruit everyday can help protect against certain cancers, type 2 diabetes, coronary heart disease and overweight and obesity (Australian Bureau of Statistics 2012).

## The social determinants of health and wellbeing

Understanding health and wellbeing requires more than an understanding of burden of disease as such studies do not take into account the social determinants of health which influence health and wellbeing outcomes in multiple ways, including through their impact on risk behaviours.

There are well documented complex causal pathways between the wider conditions in which people live their lives and their health outcomes. These include the influences of social circumstances on behavioural risk factors, which are the more 'proximal' causes of many health problems. For example, poor socioeconomic circumstances can lead to psychological distress, which is a major risk factor both for depressive and anxiety disorders, and is associated with risk behaviours such as substance abuse, smoking and unhealthy diet. There is evidence that addressing psychological distress and its causes may have a number of important health and wellbeing outcomes that may be missed in a focus only on the 'linear' analysis in burden of disease studies.

The differences in health status do not happen by chance, nor, in most cases, are they the result of natural biological variation between individuals. They are socially patterned, and generally follow a social gradient in which a person's overall health tends to improve at each step up the economic and social hierarchy. It has been argued that socioeconomic factors have the largest impact on health, accounting for up to an estimated 40 per cent of all influences compared with health behaviours (30 per cent), clinical care (20 per cent) and the physical environment (10 per cent) (The British Academy 2014).

The determinants of health include the social and economic environment, the physical environment and individual characteristics and behaviours. Examples include: early childhood experiences, education, employment, income, social and economic status, housing and geography, social support networks, access and use of health services and the quality of air, soil and water (World Health Organization Regional Office for Europe 2014b).

Increasingly, sex and gender are recognised as determinants of health and wellbeing: gender roles, norms, expectations and behaviour significantly impact on people's ability to protect and promote their health, how people respond to their needs, and how people access health and other services (Commission on Social Determinants of Health 2008). Determinants of health can also include cultural and spiritual health.

The determinants of health are shaped by the distribution of money, power and resources at the global, national and local levels (World Health Organization 2011). The circumstances that affect health, and the impacts experienced, are accumulated during a lifetime, alter health across the life course, and can be transferred across generations.

Poor health itself can in turn be an amplifier of disadvantage; for example, if poor health affects a person's capacity to work, this may have further negative effects on health and wellbeing, including through its impact on income and social contact. Poor health therefore does not only cause pain and suffering to individuals and place pressures on the health care system, it can be a major barrier to full social and economic participation. Conversely having a satisfying job with good working conditions, strong and supportive social networks, and living in safe and healthy communities can help maintain and improve mental and physical health and foster resilience, even in the light of other adverse circumstances.

The plan identifies healthy and sustainable environments, place-based and people-centred approaches as the platforms needed to complement the focus on the more specific risks to health identified in the burden of disease analysis.

## Broader trends and challenges

The factors shaping health and wellbeing are not static, and the nature of determinants may change significantly over time as a result of wider trends and social changes. Global demographic, social, economic and political

**gender roles, norms and expectations affect people's ability to protect and promote their health and wellbeing**

conditions and relationships impact on people's health and wellbeing. Consideration of this wider context helps inform public health responses and identify where to focus efforts.

## Population growth and changing demographics

In 1970 there were roughly half as many people in the world as there are now (United Nations Population Fund 2015). Given the rate of population growth and the associated demand on natural resources, environmental sustainability will have far-reaching implications for generations to come as demand for food, water, energy, services, housing and employment continues to rise.

The Victorian population is projected to reach 10 million by 2051, with 80 per cent of the growth in the outer areas of Melbourne and the inner city, and a significant proportion of the population reaching retirement age. Projections suggest that by 2063 people aged 65 years or over will represent approximately 23 per cent of the population compared with 14 per cent in 2013. The proportion of people aged 85 years or over will account for five per cent of the population compared with two per cent in 2013 (Australian Bureau of Statistics 2014b). Projected population increases and an ageing population, particularly in many rural areas, will present substantial challenges to planning for public health and wellbeing.

The Aboriginal population in Victoria is growing at a faster rate and is much younger than the total Victorian population. The median age of non-Aboriginal people in Victoria is 37 years of age and the median age of Aboriginal people in Victoria is 22 (Australian Bureau of Statistics 2013d). The difference in demographics is due to a range of factors including higher birth rates and migration from other states. The fastest growing group is the elderly, who form a small but rapidly growing percentage of the Aboriginal population.

The 2011 census shows that of the total Victorian population, 26 per cent were born overseas in more than 200 countries, and 23 per cent speak a language other than English at home, with 260 languages spoken across the state (Australian Bureau of Statistics 2013a). About 47 per cent of all Victorians were either born overseas or have a parent who was born overseas.

The number of refugees settling in Victoria is currently around 4,000 per annum in addition to asylum seekers on bridging visas settling in the Victorian community, estimated at around 10,000 people (Department of Health and Human Services 2015d).

## Changes in lifestyle and work patterns

WHO (World Health Organization 2015b) attributes current levels of physical inactivity to increasing sedentariness of domestic and occupational activities, insufficient leisure-time physical activity, increasing use of passive modes of transport and increased urbanisation.

Changing work patterns such as shifts from permanent to casual employment and increased job insecurity over the past few decades have also impacted on the lives of an increasing number of casual employees. Those who have insecure

the social, economic and physical environments and individual characteristics and behaviours determine health

poor health can amplify disadvantage



employment have lower incomes, fewer rights and entitlements and face high risks of injury and illness. Insecure employment can also affect the living standards and financial independence of employees and their families, and can increase the likelihood of developing mental health issues (Independent Inquiry into Insecure Work in Australia 2012).

### **Food safety, food security and changing eating patterns**

Food production has been industrialised and its trade and distribution have been globalised. These changes introduce multiple new opportunities for food to become contaminated with harmful bacteria, viruses, parasites or chemical substances (World Health Organization 2015d).

Food security exists when all people at all times have access to sufficient, safe and nutritious food to maintain a healthy and active life (World Health Organization 2015a). Food security is likely to deteriorate for some, given the projected global population growth, existing and emerging food production constraints, changing consumption patterns, interruptions to sustainable agriculture production and water supplies and the anticipated impact of climate change.

Healthy eating at each life stage affects subsequent stages in a cumulative manner and is fundamental for healthy ageing. A shortage of food and lack of variety of food causes malnutrition and deficiency diseases. Excess intake contributes to the risk of obesity, cardiovascular diseases, type 2 diabetes, some cancers and dental caries.

**the effects of healthy eating accumulate over the lifetime**

### **Communicable disease**

Communicable diseases are spreading faster and emerging more quickly than ever before. Currently there are nearly 40 diseases that were unknown a generation ago (World Health Organization 2007). These developments reinforce the importance of communicable disease planning and preparedness.

Pandemic influenza is unpredictable. When the next pandemic will occur, how rapidly it will emerge and how severe the illness will be are all unknown. What is known is that even when the clinical severity of the disease is low, such as experienced in 2009, a pandemic can cause significant morbidity and mortality. It can overwhelm health systems and, in more severe scenarios, cause significant disruption to society (Department of Health 2014a).

### **Forced displacement**

According to the United Nations' High Commission for Refugees, the level of human displacement is the highest on record, with 51.2 million people counted as refugees, asylum seekers or internally displaced people in 2013 (UNHCR 2014). Forced displacement is primarily a result of persecution, conflict, and generalised violence, including sexual violence and/or human rights violations (UNHCR 2014). Prolonged periods in refugee camps, experiences of war, the effects of torture and trauma, loss of or separation from family members, and dangerous journeys to Australia are among the highly traumatic experiences that differentiate refugees from most other migrants to Australia and impact greatly on their health and wellbeing.

The predicted rise in natural disasters such as floods, droughts and landslides is also likely to increase displacement. Those displaced by climatic events may cross international borders but are not protected by the United Nations' *Refugee convention* nor by its *Guiding principles on internal displacement*, and are therefore a particularly vulnerable group.

# Part B: Strategic directions



# Improvements at every stage of life

It is now well established that preventive and supportive action taken early at each stage and transition point in the life course can provide multiple benefits. Rather than a static view of health and disease, the life course approach recognises that both biological and social risks accumulate and interact over the life cycle. Individual behaviours, the various environments in which people live and work, and the opportunities available throughout life, have cumulative impacts on health and wellbeing.

At each life stage there are critical periods of susceptibility and vulnerability, as well as opportunities to build resilience and capabilities. For example, investing in the early years establishes good health and resilience that will have benefits throughout life. The life course perspective is also valuable in understanding the factors that best ensure good health into older age.

Key transition points are times when people may be more vulnerable, but they may also be times of receptiveness to change. These transition points can include the birth of a child, the transition between childhood and adolescence, forming a relationship, experiencing gaps in employment, moving from good health to sickness or disability and from employment to retirement.

While a focus on each life stage enables interventions to be designed and targeted to meet needs at that point in the life cycle, there are important reasons for initiatives that are cross-generational. There is also a stronger likelihood of change when family members of different age groups are exposed to similar health messages. For example, adopting healthier eating at home is more likely when similar health messages are conveyed by schools and health care providers.

Many community groups, including sports and recreation clubs, provide opportunities for people of all ages to be involved, as participants, organisers and volunteers. Equally, a community environment where people feel safe and secure can encourage everyone to be more active and connected. For this reason, it is often the case that targeted life stage interventions can be best complemented by a 'whole of community' approach.

## Starting well

Every child's early experiences have a significant impact on their learning, development, health and future prospects. A person's health and wellbeing is influenced before conception – a woman's health before she becomes pregnant can affect the pregnancy and birth outcomes. Low birthweight and breastfeeding are also important markers of longer term health outcomes.

The support that children and young people receive early in life is critical for their long-term health and wellbeing, educational, social and economic outcomes as adults (Schweinhart et al. 2005; Shonkoff, Boyce & McEwen 2009). Child abuse and neglect are major contributors to poorer outcomes later in life, and therefore an important focus of government intervention.

**investing in the early years establishes good health and wellbeing**

Preventive efforts focused on developing children's and young people's knowledge, skills, physical literacy and behaviour for lifelong health and wellbeing are likely to achieve lasting benefits for individuals, families and communities. Immunisation is critically important for the individual and the community at large. School dental programs ensure that all that children and young people have every opportunity to optimise oral health.

Key transitions during a child's life can include beginning child care, the start of kindergarten and primary school, and the beginning of puberty and secondary school.

## Resilient adolescence and youth

Adolescence and young adulthood is a significant period of transition. Many of the physical, emotional and neural changes and development that occur can impact on health and wellbeing (Australian Institute of Health and Welfare 2014a). Youth is a critical time for developing modifiable risk factors (such as smoking) and protective factors (such as sports participation and healthy eating) because the patterns that develop when people are young often continue into adulthood. These factors can determine whether a person becomes a healthy adult, develops chronic illnesses or experiences the consequences of injury.

The education system provides important opportunities to address bullying, including physical, verbal and cyber bullying, at every level of the school curriculum, to improve the health and safety of same-sex attracted and gender-questioning students and address gender norms that negatively impact on the health behaviours of males and females.

Key transition points in adolescence and young adulthood include: puberty; starting and leaving secondary school; starting work or being unemployed; negotiating romantic and sexual relationships; driving; drinking alcohol and using drugs; starting higher education; and leaving home.



## Healthy adulthood

Adulthood, for many, comes with significant changes in responsibility in terms of work, housing, and relationships.

A healthy and productive workforce is important for economic wellbeing; equally, being in work can contribute to good health and wellbeing and to family security. Those who experience long-term unemployment face significant disadvantage. Unemployment and an inability to work due to ill health or disability can in turn contribute to further mental and physical health problems.

During adulthood, careers may grow, families may be formed and parenting responsibilities often begin. A range of services provide support to parents during this time including perinatal mental health services, healthy mother healthy baby programs, maternal and child health services and positive parenting programs.

Major life transitions during adulthood include: establishing or ending intimate relationships; the birth of children; changes in housing, employment, income and physical and mental capacity; and the death of parents, family members or partners.

## Active and healthy ageing

Health and social trends are changing the circumstances of Victoria's older population, redefining what it means to be 'old'. Ageing well is about more than the absence of disability or disease (Australian Institute of Health and Welfare 2014a). Healthy ageing enables older Victorians to remain active and to participate in and contribute socially and economically to their community. Ensuring wellness and independence in the older years requires attention to and investment in the earlier years and throughout adult life.

Participating in leisure, social, cultural and spiritual activities with family or in the community enables older adults to continue to use their skills, enjoy respect and esteem, and to maintain or establish supportive and caring relationships. This in turn contributes to better health and wellbeing.

There is increasing evidence that, with the right supports and services, people experiencing poor physical or mental health can make gains in their physical, social and emotional wellbeing and can continue to live autonomously and independently in the community.

Low intensity and low cost interventions focused on wellness can lead to improvements in wellbeing and morale for older adults and may reduce the number of hospital admissions. They may also delay any need for residential care.

These strategies can include low-intensity exercise, improving nutrition, using aids and equipment, linking people with support networks and developing new ways of coping with depressed mood or stress.

Key transition points for older adults include changes in employment circumstances, taking on a grandparent or carer role, ceasing driving, deterioration of mental or physical health and the impact on carers, death of partners or family members and changes in housing circumstances.



**ensuring wellness and independence in the older years requires investment in the earlier years and throughout adult life**





# Promoting health and wellbeing

The following priorities have been identified based on the analysis of the multiple contributions to health and wellbeing outlined in Part A. While they are described separately, there are important relationships between all the priorities – creating opportunities for action that will improve health and wellbeing in many areas.

This section also lists possible outcome measures or indicators of improvement for each of the priorities. A comprehensive public health and wellbeing outcomes framework will be developed that will outline agreed measures.

## 1 Healthier eating and active living

### Why this is important

This priority includes promoting a diet of healthy, sustainable and safe food consistent with the *Australian dietary guidelines*, and measures to support healthy food systems and settings.

A nutritious diet and adequate food supply are central for promoting health and wellbeing. Excess intake contributes to the risk of obesity, cardiovascular diseases, diabetes, some cancers and dental caries. Increased consumption of fruit and vegetables helps reduce the risk of overweight and obesity, heart disease and certain cancers.

Low levels of physical activity and high levels of sedentariness are major risk factors for ill health and mortality from all causes. People who do not do sufficient physical activity have a greater risk of cardiovascular disease, colon and breast cancers, type 2 diabetes and osteoporosis. Being physically active improves mental and musculoskeletal health and reduces other risk factors such as overweight, high blood pressure and high blood cholesterol (Australian Institute of Health and Welfare 2015).

Over the past two decades adult obesity has increased by about 40 per cent in Victoria with over two million Victorians now overweight or obese (Australian Bureau of Statistics 2013f). Unless effective population-level interventions to reduce obesity are developed and implemented, the steady rise in life expectancy that has been observed may soon come to an end, followed by a reversal that may see the youth of today having shorter lives than their parents (Olshansky et al. 2005).

Interaction with nature in Victoria's parks and open spaces and participation in sport and recreation make an important contribution to reducing chronic disease risk factors, increasing social inclusion and building strong communities.

Other key issues related to healthier eating and active living are oral health and ultraviolet radiation exposure and skin cancer.



## Oral health

The costs and burden associated with poor oral health are well known. Oral disease is a key marker of disadvantage, with greater levels experienced by people on low income, dependent older people, Aboriginal people, people in rural areas, people with a disability, and immigrant groups from culturally and linguistically diverse backgrounds (particularly refugees). Poor diet and consumption of sugar-sweetened drinks are important contributors to poor oral health. In addition to addressing the broader determinants of health, improving oral health requires access to fluoride (in water and toothpaste), good dental hygiene and regular access to preventive dental care.

## Ultraviolet radiation exposure and skin cancer

Outdoor activity, both recreational and work-related, increases a person's risk of over-exposure to ultraviolet radiation (UVR). It is important to balance the risks of developing skin cancer with spending time outdoors and maintaining an active lifestyle. It is also important to balance the risks of skin cancer from too much sun exposure with maintaining adequate vitamin D levels, which is essential for bone and muscle health in all age groups. Well planned and designed spaces that provide UVR protective shade, coupled with the community adopting sun protective behaviours, will provide the best protection from skin cancer.

## Key statistics

### Burden of disease

- 10.5 per cent of Australia's burden of disease is due to dietary risks, 8.5 per cent is due to high body mass (excess weight for height) and 4.6 per cent is due to physical inactivity (Institute for Health Metrics and Evaluation 2013).
- 22 per cent of the diabetes national burden and 79 per cent of the coronary heart disease burden is due to dietary risks.
- 71 per cent of the diabetes burden and 33 per cent of the coronary heart disease burden is due to high body mass (Institute for Health Metrics and Evaluation 2013).

## Nutrition, physical activity and overweight and obesity

### Children

- 39 per cent of children's total energy comes from discretionary foods, 12 per cent of Victorian children consume sufficient vegetables and 75 per cent eat enough fruit (Australian Bureau of Statistics 2014a).
- 24 per cent of children are overweight or obese – 18 per cent are overweight and 6 per cent are obese (Australian Bureau of Statistics 2013c).
- 62 per cent of 5–12 year olds meet guidelines for sufficient physical activity (Department of Education and Training 2015b), but only 26 per cent of children in Years 5, 8 and 11 meet the guidelines (Department of Education and Training 2015a).

one in four children and two in three adults are overweight or obese

more than a third of children's total kilojoules come from discretionary food



#### Adults

- 35 per cent of total energy comes from discretionary foods, 7 per cent of adults consume sufficient vegetables and 47 per cent consume enough fruit (Australian Bureau of Statistics 2015)
- 61 per cent of adults are overweight or obese – 35 per cent are overweight and 26 per cent are obese (Australian Bureau of Statistics 2013c).
- 64 per cent of adults met guidelines for sufficient physical activity (Department of Health 2014d).

#### What are the benefits of action?

Halting and reversing the rise in obesity and other preventable diet-related conditions such as diabetes will improve the health and wellbeing of Victorians and will reduce the major burden on the healthcare system and lost productivity.

Improving levels of physical activity will not only contribute to physical health, it will also contribute to mental health, social connectedness and reducing the risk of osteoporosis, and may assist in reducing or delaying dementia.

In addition, healthy eating and active living will support the optimum growth and development of children and young people.

#### Strategic directions

- Promote consumption of healthy, sustainable and safe food consistent with the *Australian dietary guidelines*.
- Support healthy food choices to be the easier choices for all Victorians by working across the entire food system.

- Encourage and support people to be as physically active as often as possible throughout their lives. Strategies may include active transport (such as walking or cycling to work), neighbourhood design that promotes activity and social connectedness and participation in sport and recreation.
- Encourage interaction with nature in Victoria’s parks and open spaces.

### Possible outcome measures

- Proportion who consume sufficient fruit and vegetables
- Proportion who consume sugar sweetened drinks
- Prevalence of insufficient physical activity
- Obesity prevalence
- Overweight prevalence

## 2 Tobacco-free living

### Why this is important

While smoking rates have significantly decreased over the past 30 years, 12 per cent of Victorian adults still smoke on a daily basis (Department of Health 2014d; 2013). The rate of decline has not been experienced equally across the whole population – smoking disproportionately affects disadvantaged population groups, with smoking rates higher among Aboriginal people, people who experience psychological distress, people with a lower level of education, people who live in rural areas and people on low incomes or who are unemployed.

**one in eight adults  
still smoke daily**

One in eight women continues to smoke while pregnant, with rates three times higher for Aboriginal women. After 20 weeks gestation one in 20 pregnant women smoke, with the rate four times higher for teenagers and more than double in rural areas compared with metropolitan areas (Consultative Council on Obstetric and Paediatric Mortality and Morbidity 2014).

Approximately one in five Victorian children aged 5–12 years live in a household with a smoker. Children in areas of least disadvantage are about three times less likely to live in a household with a smoker than those in most disadvantaged areas. In 2008 two-thirds of Aboriginal children lived in households with a daily smoker, more than twice that for non-Aboriginal children.

Smoking rates vary by up to about 40 per cent across the state. Smoking rates were about double for those with psychological distress; homosexual and bisexual Australians aged 14 years and older were twice as likely to be current smokers in 2010.

### Key statistics

#### Burden of disease

- 8.5 per cent of Australia’s burden of disease is due to smoking (Institute for Health Metrics and Evaluation 2013).

- 22 per cent of the national coronary heart disease burden, 79 per cent of the lung cancer burden and 65 per cent of the chronic obstructive pulmonary disease burden is due to smoking (Institute for Health Metrics and Evaluation 2013).

### Smoking

- 12 per cent of 16-year-old and 16 per cent of 17-year-old Victorian school students smoked in the last week (Department of Health 2013).
- 12 per cent of Victorian adults smoke daily (Department of Health 2014d).
- 41 per cent of Aboriginal people smoke daily (Australian Bureau of Statistics 2013b).

### What are the benefits of action?

Tobacco still accounts for 25 per cent of all deaths and is strongly linked to stroke and cardiovascular disease. In Victoria, smoking costs approximately 4,000 lives and \$2.4 billion in direct healthcare costs and lost productivity annually (Collins & Lapsley 2011).

International evidence shows that stopping smoking before the age of 40 avoids more than 90 per cent of later risk (Doll 2004). Death rates in adults can be reduced by preventing young people beginning to smoke and enabling adults to quit smoking.

### Strategic directions

- Continue to further reduce smoking rates with the ultimate aim of achieving a tobacco-free Victoria.
- Continue legislative and non-legislative approaches to tobacco reform, such as smoking cessation support, in order to continue the downward trend in smoking rates.
- Focus on smoking cessation support at the community level (via hospitals, GPs and community health services).
- Target smoking cessation measures for those groups with disproportionately high smoking prevalence, particularly Aboriginal Victorians.

### Possible outcome measure

- Proportion of people in Victoria who smoke tobacco.

tobacco causes a quarter of all deaths

## 3 Reducing harmful alcohol and drug use

### Why this is important

The health and social impacts of harmful and hazardous consumption of alcohol and drugs are considerable. One study estimated costs including crime, loss of life, loss of production, road accidents and health care are about \$24.6 billion per year in Australia (Collins & Lapsley 2008).

## regular drinking can cause disease

Although alcohol and other drug dependency can be viewed and treated as a chronic illness, many of the harms associated with alcohol are not about addiction but long-term regular drinking or single occasion risky (binge) drinking.

Research shows that long-term and regular alcohol consumption, not only binge drinking, is linked to disease, including some cancers and even cardiac illness. Long-term and frequent alcohol use is also a risk factor for alcohol-related dementia and other acquired brain injuries (Gao, Ogeil & Lloyd 2014).

Some drugs can trigger the onset of a pre-existing mental illness. Using frequent or large quantities of some drugs such as crystal methamphetamine ('ice') can cause drug induced psychosis. Alcohol and drug use is also closely associated with a range of mental health issues, and particularly anxiety and depression (Friel & Clarke 2011).

Suicide Prevention Australia has found that people who abuse alcohol may be at up to six times greater risk of suicide than the general population, while cannabis users may be at 10 times greater risk of suicide. Alcohol disorders are the second most commonly diagnosed disorder among those who die by suicide (Suicide Prevention Australia 2011).

A risk factor for problematic alcohol and drug use is the experience of trauma and in particular sexual violence (Kilpatrick et al. 2000).

Excessive alcohol and drug use can contribute to the frequency and likelihood of being involved in violence. Recent research has attributed the excessive use of alcohol as a preventable risk factor in some family violence incidents (Foundation for Alcohol Research and Education 2015).

### Key statistics

#### Burden of disease

- 2.8 per cent of Australia's burden of disease is due to alcohol use and 2.6 per cent to drug use.
- 20 per cent of the national self-harm burden, 14 per cent of the interpersonal violence burden and 7.5 per cent of the unintentional injury burden (other than road transport) is due to alcohol use (Institute for Health Metrics and Evaluation 2013).

#### Alcohol and drug use

- 25 per cent of 16-year-old and 37 per cent of 17 year old Victorian school students drink alcohol (Department of Health 2013).
- 9 per cent of adults drink at risky or high-risk levels for short-term harm at least weekly (Department of Health 2014d).
- 15 per cent of Victorian 18–24 year olds drink alcohol at risky or high-risk levels for short-term harm at least weekly (Department of Health 2014d).
- 14 per cent of people in Victoria used an illicit drug in the previous 12 months (Australian Institute of Health and Welfare 2014c).

## What are the benefits of action?

Alcohol and drug dependency is a treatable, although relapsing, condition. Continuing to work with community based services to ensure effective and evidence-based alcohol and drug treatment services will support people's longer-term recovery from addiction. Continuing to work with family, friends and other support people about what to expect from treatment and how best to help a loved one will also help people on their road to recovery.

While alcohol and illicit drug use at a population wide level have experienced slight declines over the past 20 years, some people are coming to greater harm from their alcohol and drug use. Young people are more likely to come to harm from single occasion (binge) drinking even though the proportion of those aged 18–29 consuming alcohol at risky levels declined in 2013 (Australian Institute of Health and Welfare 2014c). People in their 40s are now more likely to drink at lifetime risky levels than any other age group, and there has been little change in lifetime risky drinking patterns of people aged 40–69 since 2004 (Australian Institute of Health and Welfare 2014c).

People aged 20–29 were most likely and those aged 50 year or older least likely to have used illicit drugs in the past 12 months. Illicit drug use has increased in recent years for those aged 50 or older, the only age group to show a statistically significant increase in use (Australian Institute of Health and Welfare 2014c).

Continuing to reduce the amount of alcohol and drugs consumed at a population level overall will reduce the burden on individuals, families and communities. This will result in less alcohol and drug-related health risks, injuries and violence. Benefits can be achieved by focussing on population wide health promotion and easy access to early intervention for those people who are coming to the most harm from their alcohol and drug use.

**excessive alcohol and drug use can contribute to the frequency and likelihood of being involved in violence**

## Strategic directions

- Develop strategies across government to reduce the risk of short-term harms due to the misuse of alcohol, and minimise the chronic health problems associated with long term unhealthy drinking patterns.
- Continue to address the impacts of illicit drug use, for example, through the *Ice action plan*.
- Develop a Victorian pharmaceutical misuse strategy and education program to reduce problematic use of prescription medications.
- Improve alcohol and drug education in schools and access to early intervention services for people with alcohol and drug use issues.

## Possible outcome measures

- Harmful use of alcohol
- Harmful use of illicit drugs

## 4 Improving mental health

### Why this is important

Feeling connected to and valued by others, being able to cope with the usual stresses of life, having the opportunity and capacity to contribute to community and being productive are all critical to mental health. Mental health is an essential ingredient of individual and community wellbeing and significantly contributes to the social, cultural and economic life of Victoria.

Each year, one in five Victorians will experience a mental health condition, with 45 per cent of Victorians experiencing that in a lifetime (Australian Bureau of Statistics 2008). Certain population groups are at higher risk of poor mental health and mental illness because of greater exposure and vulnerability to unfavourable social, economic and environmental circumstances.

Mental disorders are a significant cause of disability or non-fatal disease burden in Australia. Major depressive disorders and anxiety disorders are specific causes of disability. About one in eight Victorian adults reported high or very high levels of psychological distress in 2011–12, which is unchanged since 2003 (Department of Health 2014d). The rate of this high level of distress was about two times greater for unemployed adults or those not in the labour force than employed adults. In the 2012–13 National Aboriginal and Torres Strait Islander Health Survey, 30 per cent of Aboriginal respondents reported high or very high psychological distress levels in the four weeks before the survey interview, which was nearly three times that of the non-Aboriginal rate (Australian Bureau of Statistics 2013b). Compared with others lesbian, gay, bisexual and transgender people have higher rates of mental health disorders. The most common disorders experienced by refugees and asylum seekers include depression, anxiety and post-traumatic stress disorder (Department of Health and Human Services 2015d). Adults who do not feel valued by society or do not trust other people are more likely to report psychological distress, low income and poor or fair self-reported health.

each year, one in five  
Victorians will experience  
a mental health condition

### Key statistics

#### Burden of disease

- 13 per cent of Australia's disease burden is due to mental and behavioural disorders, with most of the burden being non-fatal (disability) burden (Institute for Health Metrics and Evaluation 2013).

#### Psychological distress

- 16 per cent of Victorian students in Years 5, 8 and 11 experience psychological distress; for Year 11 students only, 23 per cent experience psychological distress (Department of Education and Training 2015a).
- 11 per cent of adults experience psychological distress (Department of Health 2014d).

23 per cent of Year 11  
students experience  
psychological distress



### **Social and civic trust**

- 71 per cent of students in Years 5, 8 and 11 reported having a trusted adult in their lives (Department of Education and Training 2015a).
- 39 per cent of adults feel most people can be trusted (Department of Health and Human Services 2015f).
- 53 per cent adults definitely feel valued by society, with 12 per cent not feeling valued (Department of Health and Human Services 2015f).

### **What are the benefits of action?**

Building healthy and resilient communities that promote social inclusion and economic participation is the fundamental building block of social and emotional wellbeing. Good mental health is also important to a thriving Victorian community. As all people experience varying levels of need related to mental health at different times during their lives, the protective factors for good mental health need to be enhanced and supported. Protective factors include positive early childhood experiences and attachments, healthy families, education, financial security, accessible health and human services, liveable and safe cities, and a society that is accepting of diversity. Actively addressing inequality, disadvantage and discrimination also opens up greater possibilities and opportunities for optimal mental health.

### **Strategic directions**

- Enhance and develop strategies to promote mental health and wellbeing and reduce current high levels of psychological distress. Examples include addressing discrimination, encouraging interaction with the natural environment, promoting positive body image, reducing disordered eating, preventing violence against women, tackling stress in the workplace, increasing physical activity and sporting participation and promoting acceptance of diversity and social inclusion to build resilient and connected communities.
- Increase the intensity of targeted action for those who experience greater social and economic disadvantage.
- Specifically consider and support the social and emotional wellbeing of Aboriginal Victorians.
- Invest in early identification and intervention with vulnerable children and families.
- Focus on promoting wellbeing and preventing suicide in at-risk populations including Aboriginal Victorians, young Victorians and those living in low socioeconomic areas.

### **Possible outcome measures**

- Proportion of the population experiencing psychological distress
- Harmful use of alcohol



## 5 Preventing violence and injury

### Why this is important

Preventing family violence is a major priority for the Victorian government. Violence and the fear of violence influence health and wellbeing. There is a strong relationship between the consumption of alcohol and violence.

The effects of family violence are profound and disproportionately impact on women and children. For Australian females aged 20–34 years in 2010, intimate partner violence was the second largest cause of burden of disease (Institute for Health Metrics and Evaluation 2013). The Royal Commission into Family Violence has been tasked with finding the most effective ways to prevent family violence and improve early intervention to identify and protect those at risk. The commission will also investigate how victims can be better supported, perpetrators made accountable and how government, legal, police and community sectors can more effectively integrate and coordinate efforts.

Street and community violence by contrast impacts primarily on men. In 2012, Victorian men were around 90 per cent more likely than women to have experienced physical assault in the previous 12 months (Australian Bureau of Statistics 2013e). Males are also substantially more likely to be victims of assault, robbery and homicide. In most cases perpetrators are other males. Tolerance of violence between men is conveyed through social attitudes held by some men and women, and through popular media and film.

In relation to injury, the leading causes of death in Victoria are falls, suicide, transport and poisoning, while the leading cause of morbidity is falls. About 60 per cent of premature deaths are potentially avoidable; of that about half are fully or partially preventable, including those due to falls and transport-related injury.

In Australia about one third of community-dwelling older adults experience at least one fall in a year (Australian Institute of Health and Welfare: Bradley 2013). Falls can cause joint fractures, dislocations, bruises, sprains, head injuries and abrasions and can result in a lack of confidence and a restriction of activities due to a fear of falling.

### Key statistics

#### Burden of disease

- 10 per cent of Australia's disease burden is due to injury and 13 per cent is due to mental and behavioural disorders (Institute for Health Metrics and Evaluation 2013).
- 18 per cent of the national self-harm burden, 17 per cent of the major depressive disorders burden and 14 per cent of the alcohol use disorders burden is due to sexual abuse and violence (Institute for Health Metrics and Evaluation 2013).
- 7 per cent of the national burden for children 0–14 years is due to injury (Institute for Health Metrics and Evaluation 2013).

family violence was the second largest cause of ill health and early death for women aged 20–34

about one-third of older adults have at least one fall a year



## Falls

- About 45,000 hospitalisations per year are due to falls in adults aged 65 years or older (Productivity Commission 2015).

### What are the benefits of action?

Preventing family violence will reduce the immediate and long term impacts experienced by women and children, families and the community at large.

Reducing violence in the community will create greater safety and reduce the pain and suffering experienced by those involved in violence, particularly young men.

Effective injury prevention measures provide savings in both the health and non-health related costs of injury such as property damage, fire and the cost of ambulance, hospital, police and judicial services.

### Strategic directions

- Prioritise strategies that support Victoria to be a respectful society that does not tolerate family or sexual violence, community violence or violence associated with abuse, racism, discrimination or bullying.
- Implement strategies to reduce family and sexual violence consistent with the recommendations of the Royal Commission into Family Violence.
- Continue to reduce the injury-related mortality and morbidity from transport-related injury, workplace hazards, falls (particularly for older Victorians) and sports.

## Possible outcome measures

- Incidence of family and community violence
- Harmful use of alcohol
- Proportion of the population experiencing psychological distress
- Hospitalisation rate due to falls in older adults and children

## 6 Improving sexual and reproductive health

### Why this is important

Sexual health is an important element of health and wellbeing. Sexual health requires respect, safety and freedom from discrimination and violence. It is critically influenced by power dynamics, gender norms and expectations and is expressed through diverse sexualities (World Health Organization 2015c). Ensuring individuals and couples have the freedom to decide if and when to have a child requires access to information and to the means to manage fertility.

Sexually transmissible infections and blood-borne viruses place a significant burden on the Victorian community. Rising rates of infection and rapid developments in prevention, testing and treatment, as well as advances in research, all pose challenges and opportunities to improve the public health response to communicable infections.

The past five years have seen significant advances in prevention, testing, treatment and management of HIV and hepatitis B and C, making the virtual elimination of new transmissions in Victoria a possibility. These advances have resulted in many affected people enjoying better health and living more engaged and productive lives than in the past.

These developments present an important opportunity to significantly reduce the impact of sexually transmissible infections and blood-borne viruses in the Victorian community, particularly for identified priority populations.

### Key statistics

- Chlamydia is the most commonly notified infectious disease and sexually transmissible infection in Victoria with 19,591 cases in 2013.
- Of the 12,607 notifications for sexually transmitted infections among Victorian 15–24 year olds in 2014, 90 per cent were for chlamydia.
- There were 306 notifications of diagnosis of HIV in 2013, with the highest rates being for 25–29 year olds. The rate was stable for a decade, with increases in 2013 and 2014.
- 660 cases of infectious syphilis were notified in 2013, the highest since 1991. In 94 per cent of cases the route of transmission was males (mostly 40–44 years), with 76 per cent due to male-to-male sex.
- There were 139 cases of newly acquired hepatitis C infections in 2013, which has decreased since 2009. Injecting drug use was the main risk factor, causing 81 per cent of infections.

(Department of Health and Human Services 2015c)

**sexual health requires  
respect, safety  
and freedom from  
discrimination and  
violence**



### **What are the benefits of action?**

With a reduction in stigma and discrimination, improved health literacy and sexuality education in schools the burden of disease on populations most at risk of sexual ill health and viral hepatitis will be significantly reduced.

Transmission of sexually transmissible infections and blood-borne viruses will be reduced with improved prevention, increased early detection, early access to treatment and care and support.

### **Strategic directions**

- Promote and support positive, respectful, non-coercive and safe sexual relationships and reproductive choice (including planned, safe and healthy pregnancy and childbirth).
- Actions to reduce sexually transmissible infections and blood-borne viruses will focus on prevention, testing, management, care and support, surveillance, research and evaluation, in line with national strategies.
- Work towards eliminating HIV and viral hepatitis transmission and significantly increase treatment rates.

### **Possible outcomes measures**

- Proportion of HIV acquired through sexual transmission
- Incidence of sexually transmissible infections



# Platforms for change

As a general rule, sustainable improvements in health and wellbeing are best achieved when change is guided and owned by affected communities, interventions are tailored to particular needs and local circumstances, and people are empowered to make the changes needed. Many of the actions under this plan need to occur in the communities and settings where people live, learn, work and play. State level policies and programs are important to support these actions.

On this basis, place-based and people-centred approaches provide key implementation platforms through which the aims of the plan can be given effect. Particular attention to regional and rural communities is needed as people living in regional and rural Victoria do not enjoy the same level of health and wellbeing as other Victorians.

## 7 Healthy and sustainable environments

Healthy environments are critical to the health and wellbeing of the current and future generations. All levels of government, industry and the community across Victoria have a responsibility to support and maintain sustainable, diverse and safe natural and built environments.

Environmental justice recognises that the access to environmental goods (clean air, water, parks) and the imposition of environmental harms (odour, noise and contamination of air, land and water) are shared unequally as a result of social, economic and political inequality.

Protecting health through robust, evidence-based standards that support clean air, soil quality, clean water, a safe food supply and management of physical, chemical, biological and radiological hazards are fundamental for a safe and healthy society.

It is important that Victoria maintains the capacity to swiftly and effectively take action when emergencies occur. Equally, investment needs to be made in building resilient communities and supporting disaster recovery.

### Climate change adaptation

The impact of climate change presents serious environmental, economic and health challenges. Some people will be at higher risk of health problems related to weather and climate change impacts. This includes children, older adults, people with existing medical conditions, people who work outdoors and those who live in areas most likely to be affected, such as rural and coastal communities.

Climate change impacts on both the built and natural environment. Improved understanding, preparedness for and mitigation of the effects of climate change are needed.

Investment in adaptation strategies will contribute to building resilient communities that are less affected by major climatic events such as storms and floods.

**local government has a key role in leading health for the local community**



### **Air, soil, water, noise and food quality**

The safety and quality of air, soil, water, noise and food has significant impact on health and wellbeing. Protecting health requires robust, evidence-based standards and controls to prevent or minimise pollution and ensure safe food supply, such as the *Australia New Zealand Food Standards Code* (Food Standards Australia New Zealand 2015). Physical, chemical, biological and radiological hazards also need to be managed.

## **8 Place-based approaches**

Place-based and 'whole of community' approaches recognise the fundamental role location plays in health and wellbeing. These approaches can respond to the geographic concentration of disadvantage and address multiple and interrelated forms of disadvantage simultaneously. A place-based approach can target an entire community and focus on the multiple determinants of health and wellbeing in a particular area, such as poor housing, social isolation, transport and neighbourhood safety as well as the particular health risks the community is experiencing such as high smoking rates or unhealthy diets. It can also focus on community strengths and enhancing protective factors. A place-based approach provides a platform to connect community engagement and empowerment with joined up action across government and the provision of integrated services and supports.

A place-based approach also enables comprehensive action within and across the range of settings in a particular location to promote health and wellbeing. State-level policies and strategies are required to enable and complement many of these activities, and may themselves arise from more central policies and strategies. The settings below expand on those detailed in the first plan by including liveable neighbourhoods and residential and custodial care.



## Early childhood care settings and schools

There is a positive relationship between health and wellbeing and education. Early childhood care settings and schools are integral parts of the community and can directly and indirectly contribute to the health and wellbeing of families and the community.

Preventive efforts that focus on developing children's and young people's knowledge, skills, physical literacy and behaviour for lifelong health and wellbeing are likely to achieve lasting benefits for individuals, families and communities. Interventions encompass a range of actions such as healthy eating, family support, oral health, sport and recreation, mental health promotion and immunisation across the early years, the school years and during adolescence.

Settings include maternal and child health services, perinatal mental health services, early childhood services and primary and secondary schools.

## Healthy workplaces

A healthy population is needed to drive a healthy economy. Working Victorians spend around one-third of their waking hours in workplaces. It is estimated that the loss to the labour force from people suffering from chronic disease (or their carers) is 537,000 full-time person years and 47,000 part-time person years (Business Council of Australia 2011). Many jobs today involve long sedentary hours, with workers often having inactive lifestyles (WorkSafe Victoria 2012). Valuing and supporting the good health and wellbeing of Victoria's working population will deliver benefits for the economy and society, as well as for individuals and their families. Health-promoting workplaces and industries also contribute to healthy and active ageing, helping people to maintain good health into their later working years and potentially prolonging their working lives.

While WorkSafe is responsible for workplace health and safety, employers and industry have an important role to play in promoting and supporting healthy lifestyles and work environments. Workplaces can encourage healthy eating, active travel, physical activity and reduce sedentary behaviour. Workplaces also have influence in the broader community, and many can support prevention through the programs, products and services they deliver, and the partnerships they undertake.

There is potential for employers, workplaces and industries to increasingly invest in promoting the safety, health and productivity of their workforces and there are significant opportunities for partnerships between the employment sector and health. This will have a flow-on effect to workers' families and communities and build on significant progress already underway in Victoria.

## Communities

Communities can be local (neighbourhoods or other geographic areas), activity-based (sport and volunteering, among others) or identity-based (faith-based, sexuality or cultural, among others). They can be self-organised or supported

**a healthy population  
is needed to drive  
a healthy economy**

by government agencies or non-government organisations. Consultation and public participation provide communities with opportunities to have input into their local environment, neighbourhood, and/or programs and policies that affect them. To be effective, community engagement needs to ensure all voices are heard, in particular the voices of the marginalised or excluded.

Local government has a key role in leading improvements in health and wellbeing for the local community. The Act requires the involvement of the community in the development, implementation and evaluation of municipal public health and wellbeing plans. For health services, community engagement can promote health literacy and encourage communities and individuals to be actively engaged in their healthcare.

Participating in sport, active recreation or cultural and community groups contributes to improving health and wellbeing outcomes. In many communities, particularly in regional and rural areas, a sporting club or recreation group provides a hub for community members to come together to engage with and support each other as players, volunteers, coaches or spectators.

### **Liveable neighbourhoods**

Liveability refers to the degree to which communities are safe, attractive, environmentally stable and socially cohesive and inclusive. This requires affordable and diverse housing, convenient public transport, walking and cycling infrastructure, access to education and employment, public open space, local shops, health and community services, and leisure and cultural opportunities (Lowe et al. 2013).

Land use, land use planning and urban and neighbourhood design can ensure areas are developed to maximise social connectedness and participation, support safe, socially cohesive and inclusive communities, and promote active living. This includes design of pedestrian-friendly neighbourhoods, accessible open spaces for recreation and leisure, and food environments that encourage healthy diets.

Land use planning also needs to consider the proximity of residential development to industry to prevent or minimise potential impacts on amenity and the impacts from odour, dust and noise.

Transport planning, conveniently located public transport and active transport options, offer multiple benefits not only for active living and injury prevention, but also for equity of access to education, services and employment. Examples include networks of safe high-quality cycling links and pedestrian-friendly streets.

Improved access to parks and green and open spaces can support a range of activities. There is good evidence linking the natural environment with good physical health and psychological wellbeing (Australian Institute of Health and Welfare 2011). Four key principles of Victoria's 'healthy parks healthy people' (Parks Victoria 2015) approach are:



- the wellbeing of all societies depends on healthy ecosystems
- parks nurture healthy ecosystems
- contact with nature is essential for improving emotional, physical and spiritual health and wellbeing
- parks are fundamental to economic growth and to vibrant and healthy communities.

contact with nature  
is essential for improving  
emotional, physical and  
spiritual health  
and wellbeing

Local government, community engagement and leadership are integral to achieving liveability aims. Engaged communities are key to building social support networks, cohesion and resilience and in sustaining measures to improve health and wellbeing.

Initiatives such as the *WHO Global Network of Age-friendly Cities and Communities*, which are developed in collaboration with older adults, deliver infrastructure, urban design and accessibility benefits for the whole community (World Health Organization 2014). A number of local councils in Victoria already use this approach.

Resources are available to support local councils to plan for liveable, active, inclusive and sustainable communities. These include *Environments for health* (Department of Human Services 2001) and *Healthy by design: a planners' guide to environments for active living* (Heart Foundation Victoria 2012).

### Healthcare and human services

A well-functioning health system responds in a balanced way to the needs and expectations of the population it serves by: improving the health status of individuals, families and communities; defending the population against what threatens its health; protecting people against the financial consequences of ill-health; and providing equitable access to people-centred care (World Health Organization 2010).

In Victoria health and human care services are provided through hospitals, primary care, community health centres, women's health services, ambulance services, disability services, dental services, mental health services, social housing, drug and alcohol services and community aged care services.

Health services are large employers and have significant influence on their employees and clients/patients, particularly in rural communities. They can influence health through broader policies (for example, food available to staff and clients/patients) and systematic support to individuals, both employees and patients (for example, brief interventions on smoking cessation). They can provide authoritative and credible voices for prevention and act as good corporate citizens and health champions in their communities.



### Residential and custodial care

While not a large number of Victorians live in residential or custodial care, many of those who do are particularly vulnerable. These settings include residential aged care facilities, hostels, prisons and non-private dwellings such as group homes. People reside in residential or custodial settings for a variety of reasons



including frailty associated with old age, disability, ill health, homelessness, economic hardship, rehabilitation, family breakdown or dysfunction, detention, imprisonment, study, employment and religious observance (Australian Bureau of Statistics 2001).

### **Aged and disability care settings**

Most older Australians live in their own homes, with only six per cent living in non-private dwellings such as aged care homes and hospitals (Australian Institute of Health and Welfare 2013). The proportion of older people living in non-private dwellings does, however, increase with age. In Victoria, an estimated one per cent of people with a disability live in a non-private dwelling, such as a group home (Department of Human Services 2012). Community service organisations support group homes and community residential units for people with a disability and, unlike other state governments, the Victorian Government remains a major provider of residential care services usually targeted to small rural communities and those with specialist care needs that are not being met. Residents of these facilities often have higher health needs than the general population, which require responses tailored to their specific needs. There are also supported residential services for people of any age who need residential but not nursing care and support. The National Disability Insurance Scheme will create major changes to the way people with ongoing, severe disabilities are supported and present opportunities to further protect and promote health and wellbeing.

### **Prisons**

The number of adult prisoners in Victoria in 2014 was 6,112, an increase of 14 per cent from 2013 and 69 per cent from 2004. Half of all Victorian prisoners had been imprisoned under sentence previously (Australian Bureau

of Statistics 2014c). In Victoria the Aboriginal (and Torres Strait Islander) age-standardised imprisonment rate was 11 times the non-Aboriginal age-standardised imprisonment rate (Australian Bureau of Statistics 2014c). Aboriginal prisoners have higher rates of diagnosed mental illness, substance use/dependence and life stressors than non-Aboriginal prisoners (Department of Justice and Regulation 2015). People with an acquired brain injury also appear to be substantially overrepresented in the Victorian prison population. Drug and alcohol use appears to be the main cause of acquired brain injury among prisoners (Department of Justice 2011).

Offenders with a disability are characterised by the typical indicators of social disadvantage – homelessness, poor family/social networks, substance abuse, patchy schooling and lack of employment – and other factors specific to disability such as poor communication skills and an absence of everyday living skills (Department of Justice 2013).

### **Local integrated action**

Given the wide range of contributors to improving health and wellbeing, mechanisms for coordinated planning, policy alignment and program implementation are critical to minimise duplication and maximise use of resources. To achieve real improvements in health and wellbeing, especially among higher risk populations and disadvantaged groups, a coherent, aligned approach to population-based prevention planning, implementation and shared accountability for outcomes is required. This approach needs to be based on agreed roles and responsibilities.

Local integrated action can be enabled through existing planning and coordination mechanisms, including those described below.

- At the community level, the primary strategic planning mechanism for prevention efforts is the municipal public health and wellbeing plan, as mandated under the Public Health and Wellbeing Act. The Act provides a strong platform for an enhanced planning role for local government and aligns the planning cycle of municipal public health and wellbeing plans with council plans so that population health becomes a shared goal across all parts of the council.
- At the subregional level, Primary Care Partnerships are alliances of health and community services, local government and other agencies that facilitate collaborative planning and delivery of health promotion and primary healthcare.
- Each metropolitan hospital and major regional health service are required to appoint a Primary Care and Population Health Advisory Committee.
- Regional management forums are responsible for establishing shared place-based priorities that focus the efforts of local and state government departments at a regional level. The forums are chaired by Secretaries of government departments and bring together senior representatives from local government and regional offices of state government departments.

- Six commonwealth Primary Health Networks in Victoria replaced Medicare Locals from 1 July 2015. The key objectives of the networks are increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time.

## 9 People-centred approaches

People-centred approaches are delivered through a wide variety of service providers, including hospitals and health services. Health services can build strong partnerships and networks with other sectors that have a greater influence on the wider determinants of health.

### Strengthening prevention through person-centred health services

A wide range of high-quality preventive services are delivered by the Victorian healthcare system. Preventive services are also delivered by other providers, including the private sector, and Commonwealth funded primary care services under the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme, through general practice and pharmacy.

Preventive health services aim to detect and manage health problems early, or provide people with the information they need to make good decisions about their health. They include early detection and screening programs (such as the statewide cancer screening programs), counselling, immunisation, early intervention and the use of lifestyle modification and/or medications to prevent, manage or delay disease. Accessible and culturally appropriate preventive health services can make an important contribution to the health and wellbeing of populations at highest risk and who experience disadvantage.

health services can build strong partnerships and networks with other sectors that have a greater influence on the wider determinants of health



Primary care and community health play a central role, but it is increasingly recognised that almost all interactions with healthcare services and health professionals offer opportunities for person-centred preventive advice. This includes promoting health literacy and the encouragement of healthy behaviours.

However, the continued frequency of avoidable hospital admissions and the persistence of health inequalities, point to the fact that existing services do not always work together effectively as an integrated system of preventive care. Nor are the multiple interactions with patients and their families necessarily utilised to their full potential. This is an issue of particular importance in regard to chronic and complex conditions, and support for self-management, but also has implications for the opportunities missed at much earlier stages in the development of health problems.

In part this is an issue of workforce capability and leadership but also can reflect the priority given to preventive care in particular services, the financial incentives available, the accountability requirements and the existence and utilisation of effective referral pathways. There are organisational systems that support good practice such as: decision making; register and recall systems; and the preparedness to partner with others to deliver optimal prevention and care. The various barriers and difficulties associated with the split between the responsibilities of the state and federal governments are further challenges.

There are a wide range of models of good practice that can be drawn on to ensure that the full potential of the health system for prevention is realised. Many of these already exist in Victoria and Australia, but international practice also offers useful signposts such as the Accountable Care Organisations (Shortell et al. 2014) in the United States and the Making Every Contact Count (National Health Service UK 2012) initiative in the United Kingdom.

Of particular importance is the need for services to move from reactive models of care to those that see health services charged with responsibilities for the health and wellbeing of the populations they serve. To achieve this, these need to work in partnership with local government, human services and others as part of a local population health system.

With the introduction of the Commonwealth-funded Primary Health Networks, there are new opportunities for Victoria to lead the way in orienting the health system to adopt prevention as a core responsibility of all services within a population health model, and do better in keeping people well and out of hospital.

### **Empowerment and education**

To optimise health through the life course, including engaging with the health system, people need knowledge, skills, confidence and health literacy to manage their health and wellbeing. Low levels of health literacy are consistently associated with a range of negative health outcomes, including increased hospitalisations, greater use of emergency care, lower use of preventive services such as cancer screening, less ability to navigate the

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health system, and less ability for people to self-manage their health and that of their family. It is also important to support people across various settings to be engaged and active in wider health improvement activities, recognising the challenges posed for people who may have fewer resources and opportunities. Providing additional support to areas of socioeconomic disadvantage, and effectively engaging and supporting population groups with poorer health and wellbeing outcomes is essential.



# Part C: Accountability



# Governance and monitoring progress

Improving health and wellbeing is a shared responsibility across all levels of society and is beyond the scope of one agency or level of government. Managing or solving complex public health challenges requires broad, collaborative and innovative approaches that may demand societal-level changes. The impact of interventions on the health and wellbeing of Victorians also needs to be monitored, reported on and used to inform further action.

## Governance

Governance for this plan will occur through:

- a yearly forum held by government with key stakeholders to review the *Health and wellbeing status of Victoria*, to report on the progress of priorities, and to enlist commitments to future work
- the Victorian Secretaries Board providing oversight on government contributions to achieving the priorities of this plan.

## Action plan

A public health and wellbeing action plan will document detailed actions, strategies, timeframes and deliverables in line with the priorities of the plan, based on commitments and opportunities across the health sector, government agencies and the wider community.

The action plan will be developed alongside further technical work on the evidence base for prevention, on current patterns of investment and on the institutional arrangements for prevention activities in the state, taking account of the roles and responsibilities of all levels of government.

The action plan will become a 'living document' that will be updated (including with stakeholder contributions) and subject to regular reporting on changes and progress against a public health and wellbeing outcomes framework.

## Targets

The action plan will also set agreed targets for each of the priorities in this plan. Many program areas have targets set at the national, state or local levels, such as cancer screening participation rates or immunisation rates. Performance against such targets is reported at the program level.

This plan acknowledges the commitments made to specific targets by the Australia or Victorian governments to achieve specific targets. For example, as a member state of WHO, Australia is a signatory to the Global non-communicable diseases (NCD) action plan 2013–2020 (World Health Organization 2013) which sets out nine voluntary targets to be reached by 2025.

The Victorian government has committed to reaching targets set out in the National Strategies for blood borne viruses and sexually transmissible infections.

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## Monitoring and reporting

### Surveillance and data

Evidence-informed public health requires evidence on the health status of populations and how that varies over time and between populations. Health status is assessed using various sources of Victorian and Australian public health data collected by government. This data includes the Victorian Population Health Survey, the Victorian Child and Adolescent Monitoring System, the *Report on government services* and public health surveillance data on, for example, food samples, food safety and infectious diseases. Public health data is also collected by non-government organisations and the research community.

#### Examples of Victorian public health data

The Department of Health and Human Services publishes the Victorian Population Health Survey. This survey provides data on a range of indicators of public health and wellbeing at the state, regional and local government area levels.

The Department of Education and Training provides the Victorian Child and Adolescent Monitoring System which includes outcomes and indicators in four category areas: the child, family, community, services and supports.

The Productivity Commission's annual national *Report on government services* (Productivity Commission 2015) provides data for a range of health outcomes, hospitalisation and health risk factors for national, state and substate population groups.

Administrative data is collected by the Department of Health and Human Services about health service provision (hospital admissions and emergency department presentations), infectious disease surveillance, birth and birth defects, alcohol and drug services, housing, vulnerable children and disability.

The Public Health and Wellbeing Act requires those in charge of pathology services (laboratories) and medical practitioners to notify the Department of Health and Human Services of prescribed conditions and micro-organisms in food. The Victorian Government conducts surveillance on infectious diseases to pinpoint outbreaks and to ensure timely intervention to prevent the spread of disease.

## **Victorian public health and wellbeing outcomes framework**

A more detailed public health and wellbeing outcomes framework will be developed to guide regular reporting on health and wellbeing outcomes and their determinants. Data on education, crime, employment, housing, health protection and income security are examples of what could be included in the framework. The framework will be developed with other government departments, key stakeholders and experts to maximise integration with other outcomes frameworks.

### **Reporting**

Health status is regularly reported through a number of publications, including Victorian Population Health Survey reports and the biennial Chief Health Officer's report. Further reports, data and evidence summaries will be made available during the course of this plan.



# Appendix: Legislative context

Public health and wellbeing in Victorian is guided by a range of legislation, not all of which is health focused.

## *The Public Health and Wellbeing Act 2008*

The *Public Health and Wellbeing Act 2008* is a major legislative driver for improving the health and wellbeing of Victorians. The Act recognises that the State has a significant role in promoting and protecting the public health and wellbeing of people living in Victoria.

The Act requires that a state public health and wellbeing plan be prepared every four years, with the first plan produced in September 2011. Each plan needs to include a range of aspects pertinent to the prevention and protection of public health and wellbeing. According to s.49 of the Act the plan must:

- (a) identify the public health and wellbeing needs of the people of the State;
- (b) include an examination of data relating to health status and health determinants within the State;
- (c) establish objectives and policy priorities for—
  - (i) the promotion and protection of public health and wellbeing in the State;
  - (ii) the development and delivery of public health interventions in the State;
- (d) identify how to achieve the objectives and policy priorities referred to in paragraph (c) based on available evidence;
- (e) specify how the State is to work with other bodies undertaking public health initiatives, projects and programs to achieve the objectives and policy priorities referred to in paragraph (c).

The Act establishes six principles to guide public health efforts in the state:

- **Evidence-based decision making:** The best available, relevant and reliable evidence should be used to inform decisions regarding use of resources and selection of interventions that promote and protect public health and wellbeing.
- **Precautionary principle:** Where a health risk poses a serious threat, lack of full scientific certainty should not be used as a reason to postpone measures to prevent or control the health risk.
- **Primacy of prevention:** The prevention of disease, illness, injury, disability and premature death is preferable to remedial measures.
- **Accountability:** Decisions relating to the Act should be made in transparent, systematic and appropriate ways that include promoting a good understanding of public health issues to Victorians and providing the opportunity to participate in policy and program development.
- **Proportionality:** Decisions made and actions taken relating to the Act should be proportionate to the identified health risk sought to be prevented, minimised or controlled.

- **Collaboration:** Public health and wellbeing, in Victoria and at the national and international levels, can be enhanced through collaboration between all levels of government and industry, business, communities and individuals.

## Other legislation

Other recent Victorian legislation that has shaped public health and wellbeing includes the *Improving Cancer Outcomes Act 2014* and amendments to the *Tobacco Act 1987*. Amendments to the Tobacco Act have banned smoking in cars carrying children (2010), prohibited the display of tobacco products at retail point of sale (2011) and introduced outdoor smoking bans on patrolled beaches (2013) and around children's recreational areas such as playgrounds and sporting venues (2014). Further amendments prohibit smoking at entrances to schools, childcare centres, public hospitals and community health centres, and some Victorian Government buildings (2015).

Public health related legislation is also designed to protect the population from hazards to health, which include injuries and accidents, to control well-known risks to health such as food safety and to authorise or mandate specific population-wide interventions such as immunisation. Legislation designed specifically to prevent injury includes road safety and workplace safety laws, consumer protection laws, laws governing the use and transport of dangerous goods in industry and various laws designed to ensure the safety of essential community infrastructure. They include the *Radiation Act 2005*, the *Safe Drinking Water Act 2003* and the *Drugs Poisons and Controlled Substances Act 1981*.

The *Food Act 1984* provides the regulatory framework for the food industry to ensure that food sold in Victoria is safe, suitable and correctly labelled. National food standards, which are embodied in the *Food Standards Code*, form part of the Food Act.

Other legislation imposes controls to prevent, or minimise, air, water, soil and noise pollution and plays an important role in protecting human health and ecosystems. This legislation includes the *Environment Protection Act 1970* and the *Planning and Environment Act 1987*, which provides the state's framework for residential and industrial development. The *Climate Change Act 2010* requires the Department of Health and Human Services and local councils to consider climate change in state and municipal public health and wellbeing plans and sets out how this consideration should occur. The *Transport Integration Act 2010* includes objectives to support social and economic inclusion through promoting forms of transport with greatest benefit for health and wellbeing.

The *Sport and Recreation Act 1972* (amended in 2008) aims to promote the fitness and general health of the people of Victoria through encouraging active participation, encouraging higher standards of safety, improving the facilities available to the people of Victoria for leisure-time pursuits, and encouraging and assisting with the provision of additional opportunities for recreation.



The *Charter of Human Rights and Responsibilities*, introduced in 2006 commits parliament to promoting awareness and understanding of human rights in Victoria. A human rights culture ensures that the rights of all people are protected and promoted through policy, legislation and service delivery. The charter guides the work of the Victorian Government and informs its approach to public health and wellbeing.

Other laws are also of relevance to public health wellbeing such as laws governing the protection and care of children, carer recognition, liquor regulation, family violence and community safety.



# References

Alzheimer's Association 2015, *Physical exercise and diet*, viewed 21 March 2015, <[http://www.alz.org/research/science/alzheimers\\_prevention\\_and\\_risk.asp#studies](http://www.alz.org/research/science/alzheimers_prevention_and_risk.asp#studies)>.

Ansari Z, Carson NJ, Ackland MJ, Vaughan L, Serraglio A 2003, 'A public health model of the social determinants of health', *Soz Praventivmed*, vol. 48, no. 5, pp. 242–251.

Australian Bureau of Statistics 2001, *Measuring Wellbeing: Frameworks for Australian Social Statistics, 2001*, cat. no. 4160.0, Australian Bureau of Statistics, Canberra.

Australian Bureau of Statistics 2008, *National Survey of Mental Health and Wellbeing: Summary of Results, 2007*, cat. no. 4326.0, Australian Bureau of Statistics, Canberra.

Australian Bureau of Statistics 2012, *Year book Australia, 2012* cat. no. 1301.0, Australian Bureau of Statistics, Canberra.

Australian Bureau of Statistics 2013a, *2011 Census of Population and Housing: Country of Birth Profile, Victoria, 2013*, cat. no. 2010.2, Australian Bureau of Statistics, Canberra.

Australian Bureau of Statistics 2013b, *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012–13*, cat. no. 4727.0.55.001, Australian Bureau of Statistics, Canberra.

Australian Bureau of Statistics 2013c, *Australian Health Survey: Updated Results 2011–2012*, cat. no. 4364.0.55.003, Australian Bureau of Statistics, Canberra.

Australian Bureau of Statistics 2013d, *Estimates of Aboriginal and Torres Strait Islander Australians, June 2011*, cat. no. 3238.0.55.001, Australian Bureau of Statistics, Canberra.

Australian Bureau of Statistics 2013e, *Personal Safety, Australia, 2012*, cat. no. 4906.0, Australian Bureau of Statistics, Canberra.

Australian Bureau of Statistics 2013f, *Profiles of Health, Australia, 2011–13*, cat. no. 4338.0, Australian Bureau of Statistics, Canberra.

Australian Bureau of Statistics 2013g, *Retirement and Retirement Intentions, Australia, July 2012 to June 2013*, cat. no. 6238.0 Australian Bureau of Statistics, Canberra.

Australian Bureau of Statistics 2014a, *Australian Health Survey: Nutrition First Results - Food and Nutrients, 2011–12*, cat. no. 4364.0.55.007, Australian Bureau of Statistics, Canberra.

Australian Bureau of Statistics 2014b, *Australian Social Trends, 2014*, cat. no. 4102.0, Australian Bureau of Statistics, Canberra.

Australian Bureau of Statistics 2014c, *Prisoners in Australia, 2014*, cat. no. 4517.0, Australian Bureau of Statistics, Canberra.

Australian Bureau of Statistics 2015, *Customised report: Australian Health Survey: nutrition first results - foods and nutrients, 2011–12*, Australian Bureau of Statistics, Canberra.

Australian Institute of Health and Welfare 2011, *Health and the environment, a compilation of evidence* cat. no. PHE 136, Australian Institute of Health and Welfare, Canberra.

Australian Institute of Health and Welfare 2013, *Australia's Welfare 2013*, cat. no. AUS 174, Australian Institute of Health and Welfare, Canberra.

Australian Institute of Health and Welfare 2014a, *Australia's Health 2014*, cat. no. AUS 178, Australian Institute of Health and Welfare, Canberra.

Australian Institute of Health and Welfare 2014b, *Mortality inequalities in Australia 2009–2011*, cat. no. AUS 184, Australian Institute of Health and Welfare, Canberra.

Australian Institute of Health and Welfare 2014c, *National Drug Strategy Household Survey detailed report 2013*, cat. no. PHE 183, Australian Institute of Health and Welfare, Canberra.

Australian Institute of Health and Welfare 2014d, *Oral health and dental care in Australia: Key facts and figures trends 2014*, cat. no. DEN 228, Australian Institute of Health and Welfare, Canberra.

Australian Institute of Health and Welfare 2015, *Physical inactivity*, viewed 27 May 2015, <<http://www.aihw.gov.au/risk-factors-physical-inactivity/>>.

Australian Institute of Health and Welfare: Bradley C 2013, *Hospitalisations due to falls by older people, Australia: 2009–10*, Australian Institute of Health and Welfare, Canberra.

Begg SJ, Vos T, Barker B, Stevenson C, Stanley L, Lopez AD 2007, *The burden of disease and injury in Australia 2003*, cat. no. PHE 82, Australian Institute of Health and Welfare, Canberra.

Business Council of Australia 2011, *Selected facts and statistics on Australia's healthcare sector*, Business Council of Australia, Melbourne.

Collins D, Lapsley H 2008, *The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/5*, Macquarie University, University of Queensland and University of New South Wales, Canberra.

Collins D, Lapsley H 2011, *The social costs of smoking in Victoria in 2008/09 and the social benefits of public policy measures to reduce smoking prevalence*, Quit Victoria and the VicHealth Centre for Tobacco Control and Cancer Council Victoria, Melbourne.

Commission on Social Determinants of Health 2008, *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report for the Commission on Social Determinants of Health*, World Health Organization, Geneva.

Consultative Council on Obstetric and Paediatric Mortality and Morbidity 2014, 2010 and 2011, *Victoria's Mothers and Babies, Victoria's Maternal, Perinatal, Child and Adolescent Mortality*, State Government of Victoria, Melbourne.

Council of Australian Governments 2008, *Closing the Gap in Indigenous Disadvantage*, viewed 18 August 2015, <[http://www.coag.gov.au/closing\\_the\\_gap\\_in\\_indigenous\\_disadvantage](http://www.coag.gov.au/closing_the_gap_in_indigenous_disadvantage)>.

Department of Education and Training 2015a, (personal communication), *2014 Victorian Student Health and Wellbeing Survey (About You)*, State Government of Victoria, Melbourne.

Department of Education and Training 2015b, (personal communication), *Victorian Child Health and Wellbeing Survey: Summary findings 2013*, State Government of Victoria, Melbourne.

Department of Health 2012, *Koolin Balit: Victorian Government strategic directions for Aboriginal health 2012-2022* viewed 16 August 2015, <<http://www.health.vic.gov.au/aboriginalhealth/koolinbalit.htm>>.

Department of Health 2013, *Victorian secondary school students' use of licit and illicit substances in 2011: Results from the 2011 Australian Secondary Students' Alcohol and Drugs (ASSAD) Survey*, State Government of Victoria, Melbourne.

Department of Health 2014a, *Australian Health Management Plan for Pandemic Influenza*, Department of Health, Canberra.

Department of Health 2014b, *The health impacts of the January 2014 heatwave in Victoria*, State Government of Victoria, Melbourne.

Department of Health 2014c, *Victorian Health Information Surveillance System*, viewed 18 February 2015, <<http://www.health.vic.gov.au/healthstatus/interactive/vhiss.htm>>.

Department of Health 2014d, *Victorian Population Health Survey 2011–12*, survey findings, State Government of Victoria, Melbourne.

Department of Health and Human Services 2015a, *Community Sports Infrastructure Fund*, viewed 16 August 2015, <<http://www.sport.vic.gov.au/community-sports-infrastructure-fund>>.

Department of Health and Human Services 2015b, *Health and wellbeing status of Victoria. Victorian Public Health and Wellbeing Plan 2015–2019 companion document*, Department of Health and Human Services, Melbourne.

Department of Health and Human Services 2015c, (personal communication), *Regulation, Health Protection and Emergency Management Division*, State Government of Victoria, Melbourne.

Department of Health and Human Services 2015d, *Refugee and asylum seeker health*, viewed 15 August 2015, <<http://www.health.vic.gov.au/diversity/refugee.htm>>.

Department of Health and Human Services 2015e, *Victorian Code of Conduct for Community Sport*, viewed 16 August 2015, <<http://sport.vic.gov.au/make-sport-fair-and-drug-free/victorian-code-of-conduct-for-community-sport>>.

Department of Health and Human Services 2015f, *Victorian Population Health Survey 2011–2012 - Social Capital*, State Government of Victoria, Melbourne.

Department of Health England 2013, *Wellbeing Why it matters to health policy: Health is the top thing people say matters to their wellbeing*, viewed 13 August 2015, <[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/277566/Narrative\\_\\_January\\_2014\\_.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/277566/Narrative__January_2014_.pdf)>.

Department of Human Services 2001, *Environments for Health Municipal Public Health Planning Framework*, viewed 17 August 2015, <<http://www.health.vic.gov.au/localgov/guides-planning.htm>>.

Department of Human Services 2012, *The Victorian state disability plan 2013–2016*, Victorian Government Department of Human Services Melbourne, Victoria.

Department of Justice 2011, *Acquired Brain Injury in the Victorian Prison System*, State Government of Victoria, Melbourne.

Department of Justice 2013, *Embracing the Challenges: Corrections Victoria Disability Framework 2013–2015*, State Government of Victoria, Melbourne.

Department of Justice and Regulation 2015, *Aboriginal Social and Emotional Wellbeing Plan*, State Government of Victoria, Melbourne.

Doll R 2004, 'Mortality in relation to smoking: 50 years' observations on male British doctors', *British Medical Journal*, vol. 328, no. 1519, pp. 1–9.

Food Standards Australia New Zealand 2015, *Food Standards Code*, viewed 19 August 2015, <<http://www.foodstandards.gov.au/code/Pages/default.aspx>>.

Foundation for Alcohol Research and Education 2015, *The hidden harm: Alcohol's impact on children and families*, Foundation for Alcohol Research and Education, Canberra.

Friel M, Clarke D 2011, 'Meeting the challenging care of co-occurring disorders', *Medical Journal of Australia. Supplement: depression, anxiety and substance use*, vol. 195, no. 3, pp. S5–S6.

Gao C, Ogeil RP, Lloyd B 2014, *Alcohol's burden of disease in Australia*, Foundation for Alcohol Research and Education, VicHealth, Turning Point, Canberra.

Heart Foundation Victoria 2012, *Healthy by Design*, Victoria, viewed 17 August 2015, <<http://www.heartfoundation.org.au/driving-change/current-campaigns/local-campaigns/Pages/victoria-healthy-design.aspx>>.

Heart Foundation Victoria 2014, *Prevalence of Cardiovascular Disease (CVD) in Victoria*, viewed 16 July 2015, <<http://www.heartfoundation.org.au/information-for-professionals/data-and-statistics/Pages/interactive-map-victoria.aspx>>.

Independent Inquiry into Insecure Work in Australia 2012, *Lives on Hold: Unlocking the potential of Australia's workforce*, Independent Inquiry into Insecure Work in Australia, Melbourne.

Institute for Health Metrics and Evaluation 2013, *Global Burden of Disease (GBD)*, Institute for Health Metrics and Evaluation, Seattle.

Jardine A, Endo T, Bright M, Macleod SL, Harper C 2010, 'Risk factors impact on the burden of disease in Queensland, 2007', *Queensland Health*, vol. 2, no. 6, pp. 1–6.

Kelly K, Dudgeon P, Gee G, Glaskin B 2009, *Living on the edge: social and emotional wellbeing and risk and protective factors for serious psychological distress among Aboriginal and Torres Strait Islander people*, Cooperative Research Centre for Aboriginal Health, Darwin.

Kilpatrick D, Acierno R, Saunders B, Riesnick S, et al. 2000, 'Risk factors for adolescent substance abuse and dependence: Data from a national sample', *Journal of Consulting and Clinical Psychology*, vol. 68, no. 1, pp. 19–30.

Lim S, Vos T, Flaxman A, Danaei G, et. al 2012, 'A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010', *The Lancet*, vol. 380, no. 9859, pp. 2224–2260.

Lowe M, Whitzman C, Badland H, Davern M, Hes D, Aye L, Butterworth I, Giles-Corti B 2013, *Liveable, Healthy, Sustainable: What Are the Key Indicators for Melbourne Neighbourhoods?*, University of Melbourne, Melbourne.

McKinsey Global Institute 2014, *Overcoming obesity: An initial economic analysis*, viewed 17 August 2015, <<https://www.noo.org.uk/news.php?nid=2733>>.

Melbourne Metro Rail Authority 2015, *Melbourne Metro Rail*, viewed 16 August 2015, <[www.dtpi.vic.gov.au/transport/major-projects/melbourne-metro-rail-project](http://www.dtpi.vic.gov.au/transport/major-projects/melbourne-metro-rail-project)>.

National Disability Insurance Agency 2014, *National Disability Insurance Scheme*, viewed 16 August 2015, <<http://www.ndis.gov.au/>>.

National Health Information Standards and Statistics Committee (NHISSC) 2009, *The National Health Performance Framework (2nd Edition)* <<http://meteor.aihw.gov.au/content/index.phtml/itemId/392569>>.

National Health Service UK 2012, *Making Every Contact Count*, viewed 10 August 2015 <<http://www.makingeverycontactcount.com/>>.

National Public Health Partnership 2006, *The Language of Prevention*, National Public Health Partnership, Melbourne.

Olshansky S, Passaro D, Hershow R, Layden J, Carnes B, Brody J, Hayflick L, Butler R, Allison D, Ludwig D 2005, 'A Potential Decline in Life Expectancy in the United States in the 21st Century', *The New England Journal of Medicine*, vol. 352, no. 11, pp. 1138–1145.

- Parks Victoria 2015, *Healthy Parks Healthy People*, viewed 17 August 2015, <<http://parkweb.vic.gov.au/about-us/healthy-parks-healthy-people>>.
- Parliament of Victoria 2014, *Improving Cancer Outcomes Act 2014*, viewed 17 August 2015, <<http://www.legislation.vic.gov.au/>>.
- Productivity Commission 2015, *Report on Government Services*, Australian Government, Canberra.
- Royal Commission into Family Violence 2015, *Royal Commission into Family Violence*, viewed 16 August 2015, <<http://www.rcfv.com.au/>>.
- Schofield D, Callander E, Shrestha R, Passey M, et al. 2013, 'Multiple chronic health conditions and their link with labour force participation and economic status', *PLoS ONE*, vol. 8, no. 11, pp. 1–7.
- Schweinhart LJ, Montie J, Xiang Z, Barnett WS, et al. 2005, *Lifetime effects: The High/Scope Perry Preschool study through age 40 (Monographs of the High/Scope Education Research Foundation, 14)*, MI: High/Scope Press, Ypsilanti.
- Shonkoff JP, Boyce WT, McEwen BS 2009, 'Neuroscience, molecular biology, and the childhood roots of health disparities: building a new framework for health promotion and disease prevention', *The Journal of the American Medical Association*, vol. 301, no. 21, pp. 2252–2259.
- Shortell S, Addicott R, Walsh N, Ham C 2014, *Accountable care organisations in the United States and England - Testing, evaluating and learning what works*, The Kings Fund, London.
- State Government of Victoria 2015a, *Ice Action Plan*, viewed 17 August 2015, <<http://www.vic.gov.au/news/ice-action-plan.html>>.
- State Government of Victoria 2015b, *Plan Melbourne*, viewed 16 August 2015, <<http://www.planmelbourne.vic.gov.au/Plan-Melbourne>>.
- Stephoe A, Shankar A, Demakakos P, Wardle J 2013, 'Social isolation, loneliness, and all-cause mortality in older men and women', *Proceedings of the National Academy of Sciences*, vol. 110, no. 15, pp. 5798–5801.
- Suicide Prevention Australia 2011, *Position statement: alcohol, drugs and suicide prevention*, viewed 10 August 2015, <<http://suicidepreventionaust.org/wp-content/uploads/2012/01/Suicide-Prevention-Australia-Alcohol-Drugs-and-Suicide-Prevention-2011.pdf>>.
- The British Academy 2014, *"If you could do one thing..." Nine local actions to reduce health inequalities*, The British Academy, London.
- UNHCR 2014, *UNHCR Global Trends 2013*, United Nations High Commissioner for Refugees, Geneva.
- United Nations Population Fund 2015, *World Population Trends*, viewed 25 May 2015, <<http://www.unfpa.org/world-population-trends>>.



Victorian Auditor-General 2014, *Heatwave management: reducing the risk to public health*, Victorian Auditor-General's Office, Melbourne.

WorkSafe Victoria 2012, *Healthy workers, healthy business*, WorkSafe Victoria, Melbourne.

World Health Organization 2005, *Preventing chronic disease: a vital investment: WHO global report*, World Health Organization, Geneva.

World Health Organization 2007, *The world health report 2007 - A safer future: global public health security in the 21st century*, World Health Organization, Geneva.

World Health Organization 2010, *Key components of a well functioning health system*, World Health Organization, Geneva.

World Health Organization 2011, *10 facts on health inequities and their causes*, viewed 12 May 2015, <[http://www.who.int/features/factfiles/health\\_inequities/en/](http://www.who.int/features/factfiles/health_inequities/en/)>.

World Health Organization 2013, *Global action plan for the prevention and control of noncommunicable disease 2013-2020*, World Health Organization, Geneva.

World Health Organization 2014, *Age-Friendly World*, viewed 1 July 2015, <<http://agefriendlyworld.org/en/>>.

World Health Organization 2015a, *Food Security*, viewed 25 May 2015, <<http://www.who.int/trade/glossary/story028/en/>>.

World Health Organization 2015b, *Global strategy on diet, physical activity and health*, World Health Organization, Geneva.

World Health Organization 2015c, *Sexual and reproductive health*, viewed 10 April 2015, <[http://www.who.int/reproductivehealth/topics/sexual\\_health/conceptual\\_elements/en/](http://www.who.int/reproductivehealth/topics/sexual_health/conceptual_elements/en/)>.

World Health Organization 2015d, *World Health Day 2015: From farm to plate, make food safe*, viewed 27 May 2015, <<http://www.who.int/mediacentre/news/releases/2015/food-safety/en/>>.

World Health Organization Regional Office for Europe 2014a, *The case for investing in public health*, WHO Regional Office for Europe, Geneva.

World Health Organization Regional Office for Europe 2014b, *Review of social determinants and the health divide in the WHO European Region: final report*, World Health Organization, Denmark.

