

# Health Promotion and Prevention

## Background Paper

This paper provides background information to the PHAA and AHPA Health Promotion and Prevention Policy Position Statement, providing evidence and justification for the public health policy position adopted by Public Health Association of Australia and Australian Health Promotion Association and for use by other organisations, including governments and the general public.

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## EXECUTIVE SUMMARY

### Focus

The background paper draws on existing evidence to explain the importance of health promotion and prevention in Australia. It emphasises the need for overarching, strategic leadership for health promotion and prevention beyond a focus on specific topics or particular diseases. The background paper supports the joint PHAA and AHPA policy position statement in its call to action for Australian governments and key decision makers to prioritise health promotion and prevention.

### Key messages

#### A multifaceted, population approach is vital

- Decades of experience and learning indicates that health promotion and prevention is achieved most effectively through a whole of systems approach that is targeted at addressing the determinants of health and shifting the distribution of power and resources towards health equity for all.
- Effective health promotion and prevention also requires multifaceted population-wide approaches to reshape the environments in which people live and in which they make choices.
- Reshaping unhealthy environments through a combination of legislative, policy and program responses does more to promote health than campaigns that rely only on efforts to change behaviours.

#### Health promotion and prevention are cost-effective but inadequately funded

- Evidence demonstrates that population health promotion and prevention activities are cost-effective and can improve health, while also contributing to social and economic progress. As such, funding for health promotion and prevention should be regarded as a worthwhile investment by decision makers in Australia and increased to meet the aim of the National Preventive Health Strategy.
- Australia's health policy priorities continue, however, to focus predominately on treating illness. Investment in the promotion of health and the prevention of illness in Australia is lower than the OECD average. The National Preventive Health Strategy 2021-2030 has still not been enacted into policy or implemented.
- Current investment is inadequate given the costs associated with chronic disease, the increasing burden of preventable disease and the worsening impact that preventable health problems are expected to create in the future.

#### Stronger leadership is essential

- Current support for health promotion and prevention is fragmented at the national and state/territory level. Focus is mainly on specific diseases and individual behaviours, rather than on a more cohesive, integrated and holistic health promotion approach.

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- Strengthened national leadership is essential to harness the considerable benefits that will emerge from improved health, wellbeing and equity in Australia. The new Australian Centre for Disease Control should focus on prevention of non-communicable diseases in addition to communicable diseases.
- Action is required to improve evaluation and reporting, systematise prioritisation, enhance funding effectiveness and strengthen workforce capacity. Broad directions for action in each of these areas are summarised in the background paper.

### Limitations

This background paper was developed via a rapid review. The rapid review approach allowed for the gathering of some evidence in what is a very large field, spanning both behavioural and social health promotion and prevention. The background paper draws primarily on review papers, evaluations of practice, policy analysis papers and statements from national and global bodies. Given the rapid approach, the review cannot be considered inclusive of all evidence related to health promotion and prevention.

### Intended audiences

Australian Federal, State/Territory, Local Governments; non-government health and social service agencies; policy makers; program managers; AHPA and PHAA members; and the media.

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### Acknowledgements

Thanks to all those who have provided feedback on earlier drafts and versions of this background paper. Thanks also to Elyse Beauchamp (Student Intern) for her work in defining key terms.

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## BACKGROUND PAPER

### Purpose

This background paper presents evidence regarding the key role of health promotion and prevention in contributing to population health, wellbeing and health equity. The background paper informs the recommendations that are outlined in the joint Public Health Association of Australia (PHAA) and Australian Health Promotion Association (AHPA) policy statement on health promotion and prevention.

The purpose of the joint policy statement is to urge Australian governments and key decisionmakers in public, private and non-government organisations to prioritise health promotion and prevention as part of their strategic activities. Effective prioritisation will necessitate sustained investment in cost-effective activity to harness the future economic and social benefits that will flow from [improving health and preventing illness](#).

### Context

This background paper draws from existing academic literature and strategic policy. Although valuable, many recent policy documents related to illness prevention and health promotion are issue based and/or chronic disease focused; a coordinated and cross-sectorial approach is required. This background paper is purposefully broad to provide a foundation for united leadership across all aspects of health promotion and prevention. The evidence provided in the background paper supports the importance of addressing the determinants of health and wellbeing holistically, through acting to reduce inequities by applying a whole of systems approach.

The background paper and joint policy statement are focused on Australia, but the supporting evidence includes global literature and learnings. The background paper has been produced via a rapid review of evidence. As such it primarily considers key review papers, evaluations of practice, policy analysis papers and statements from national and global bodies.

The background paper is written within the context of ongoing debates about the meaning and preferred application of related terminology. Such debates, while conceptually important, have the potential to weaken advocacy efforts by disrupting unity among public health advocates. For this reason, explanation of key terms is provided in a supplement to the background paper to document the agreed understandings upon which the joint policy statement is based (see Supplement 1).

Within this background paper the phrase *'health promotion and prevention'* is used in an inclusive manner. It is intended to encompass all associated activities, including but not limited to efforts to optimise wellbeing, to prevent health problems, to prevent injuries, and to reduce inequities. Further elaboration on the broad range of activities that are involved in the promotion of health and the prevention of ill health is provided throughout.

## Critical underpinnings of health promotion and prevention

### *Broad focus with shared foundations*

Health promotion and prevention activities focus on facilitating changes that will enhance wellbeing and prevent the development of health problems. While health promotion and prevention work reflect slightly different foci (see Supplement 1), both approaches arise from the 'new public health'

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and prioritise:

- strategies that will support health equity and create healthier environments to improve opportunities for healthy living
- involvement of a broad range of partners across sectoral areas and within public, private and non-government organisations
- use of multifaceted approaches, and
- application of a holistic focus to promote all aspects of wellbeing.

Based on the holistic and multi-sectoral approaches applied, health promotion and prevention activity occurs in multiple settings that extend beyond traditional health contexts and include schools, workplaces, neighbourhoods and cities. Health promotion and prevention roles are also diverse and may include a focus on policy development and implementation, program delivery, advocacy or research and evaluation.

### *Population focus is powerful*

Some forms of health promotion and prevention activity are focussed on individuals (see Supplement 1). There is, however, wide and increasing recognition of the power of broader interventions that are targeted at populations rather than individuals, and which seek to change the environments in which people live.<sup>1-3</sup> Action at the population level can shift the distribution of power and resources towards good health and health equity for all.<sup>1</sup> Population strategies seek to address the social determinants that influence health, wellbeing and equity.

*Supporting individuals to access secondary and tertiary illness prevention services and to make healthy choices is important. However, the focus of this paper and the joint policy statement is on populations, and systems level interventions to create healthy environments. Without healthy environments, opportunities for healthy choices are restricted.*

### *Social, cultural and commercial determinants of health are integral*

Abundant evidence shows that health, equity and wellbeing are strongly influenced by the socioeconomic, political and cultural environments that people are exposed to.<sup>1-6</sup> The factors that influence and shape the distribution of socioeconomic, political and cultural resources are now widely recognised in research and policy as social determinants of health (SDH).<sup>1,2</sup> The SDH include but are not limited to income, wealth, education, food, housing, discrimination, social relationships, social exclusion, transport, employment, the natural and built environments and gender.<sup>1-4</sup> As emphasised by the WHO Commission on Social Determinants of Health,<sup>1</sup> the SDH also include the distribution of power, money and resources, which influence conditions of everyday life.<sup>7</sup>

Commercial determinants of health are the impacts of for-profit actors in shaping the health of populations.<sup>8,9</sup> While commercial actors can make a positive contribution through providing essential services and products and providing decent employment conditions and income, a substantial number of commercial actors are escalating avoidable ill health, inequities, and planetary damage.<sup>9</sup> Commercial actors have vast wealth and undue influence, and power asymmetry causes difficulty for health promoters acting to counter harms from commercial determinants of health,<sup>8</sup> with commercial actors lobbying for policies that harm health and

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opposing action on social determinants of health to reduce inequities.

Cultural determinants of health as set out in the National Preventive Health Strategy<sup>10</sup> include six cultural domains: connection to country, family, kinship and the community, Indigenous beliefs and knowledge, cultural expression and continuity, Indigenous language and self-determination and leadership. There are protective effects for health from determinants associated with each of these cultural domains.<sup>10, 11</sup>

Modifying the social, cultural and commercial determinants of health makes health possible through a social justice focus that acknowledges “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being”<sup>12, n.p.</sup>, the need to support capabilities for living well, and the importance of environments that are conducive to wellbeing.<sup>1, 12, 13</sup> For example, a policy and legislative focus on protecting the natural environment will assist in minimising and/or preventing climate change. Addressing climate change will, in turn, avert or minimise the many associated human health impacts, including heat-related disorders, malnutrition, poverty and mental health problems.<sup>14-16</sup> Another example is the Coronavirus supplement to income support payments (a \$550 per fortnight supplement introduced temporarily in 2020) which was estimated to reduce the number of people on unemployment benefits skipping meals by half, enabled most recipients to afford more fresh fruit and vegetables and meat, and was estimated to reduce the number of people on unemployment benefits struggling with medical costs by 40%.<sup>17</sup> Adopting a focus on SDH also directs attention to the need to further social justice.

#### *Target the health equity gradient*

Differences in health status between population groups caused by *avoidable and unfair* exposures to detrimental socioeconomic, political and/or cultural conditions are recognised as health inequities.<sup>1, 13, 18</sup> Health inequities manifest as a social gradient in health, which runs from the top to the bottom of the socioeconomic spectrum.<sup>1, 19</sup> Along this gradient, those with greatest access to resources have the best health outcomes. This is a global phenomenon and it means that health inequities affect most people in a society- *not only the very poor*.<sup>1, 2, 20</sup>

The unequal distribution of health compromising experiences and conditions is not a natural or inevitable phenomenon.<sup>1</sup> It is instead the result of disadvantages that are driven by resource-poor social environments and the policies, programs and economic arrangements that shape such environments. It is the task of health promotion and prevention activities to tackle these issues. Strategies used to do this at a population level include advocacy for the creation and implementation of healthy public policy and legislation, and adoption of a whole of systems approach to understanding and acting to achieve health equity improvements for all Australians.

#### *Focus on achieving healthy public policy via whole of systems approach*

The environments in which we are born, grow, live, play and work are multifaceted and are not shaped solely by governments or health systems.<sup>18</sup> As such, the evidence on health promotion and prevention directs attention to the role of all social systems in affecting health and health equity – this includes cultural norms and determinants, systems implemented by Australian

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governments (federal, state/territory and local) and also the actions (or inactions) of industry and other non- government entities.<sup>21, 22</sup>

In addition, the current evidence makes clear that many sectors outside of the traditional boundaries of the health system shape the SDH through their policies and actions.<sup>23, 24</sup> This means that to be most effective health promotion and prevention activity must be targeted at all aspects of systems across all sectors.<sup>1</sup>

Recognition of the importance of shared responsibility and action is not new. It has guided health promotion efforts for several decades.<sup>21, 25</sup> Such recognition underpinned the

*Promoting health and preventing illness requires a whole of system response. This involves the combined efforts of public, private and non-government organisations. It involves all sectors that shape the environments in which people grow, live and work. Improved health cannot be achieved by the health sector alone.*

Declaration of Alma-Ata<sup>26</sup> and the Ottawa Charter for Health Promotion,<sup>21</sup> and it led to initial interest in, and ongoing support for, Healthy Cities and Health in All Policies approaches around the world.<sup>24, 27</sup> Adding further impetus, and drawing renewed attention to the need to include industry and other non-government partners, the United Nations<sup>28</sup> and its agency the World Health Organisation (WHO)<sup>29</sup> have called for national leadership to understand and address the health effects of all policies and actions across *all* areas of activity. In 2013, an Australian Senate inquiry into Australia's national response to the WHO Commission on Social Determinants of Health

recommended consideration of SDH in *all* relevant policy development activities.<sup>30</sup> The importance of such recognition is also reinforced in the United Nation's Sustainable Development Goals,<sup>31</sup> the Shanghai Declaration,<sup>32</sup> and the Global Charter on Public Health.<sup>33</sup> Evidence indicates, however, that *sustained* whole of systems action to address SDH remains elusive.<sup>34-36</sup> Enhancing future whole of systems activity for health is, therefore, vital.

### *Prioritise proportionate universalism*

Effective health promotion and prevention improves health for the whole population including for particular groups who live in disadvantaged circumstances.

*Universal approaches* apply to a whole population (e.g. all Australians, all women, all men, all children or all students). This approach is based on the philosophy of equal access, and underpins universal education and health care in Australia. However, evidence suggests that universal access does not provide universal benefit.<sup>13, 37, 38</sup> This is because universal policies and programs favour those who are already in advantaged positions while failing to *proportionately* improve the circumstances of those living in less advantaged conditions. This maintains (or even widens) health inequities (see Figure 1).

*Targeted approaches* apply to a prioritised sub-group within a population (see Figure 1). Priority is usually directed to sub-groups who are considered to be exposed to higher risks than the mainstream population based on their characteristics or circumstances, and/or the ways that other individuals and systems may discriminate against them (such as people with low income,

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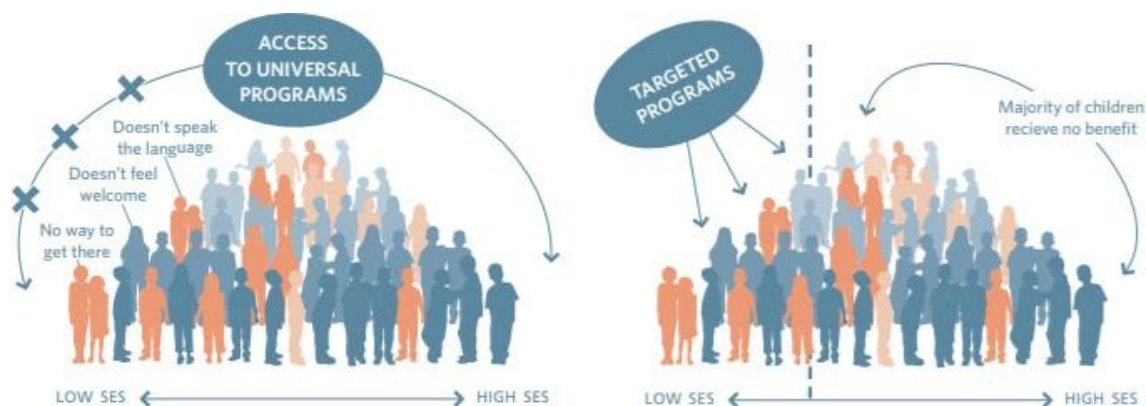
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poor health status or minority ethnicity).

Figure 1: Universal versus targeted intervention



Source: Human Early Learning Partnership (2011)<sup>39</sup>

Evidence shows that targeted approaches may address the consequences of inequities rather than their causes.<sup>37</sup> Furthermore there is a tendency for targeted interventions intended to address structural causes (particularly within policy) to drift toward an isolated focus on individuals' behaviours and education for individual behaviour change.<sup>40-42</sup> While focusing on supporting healthy living is important, approaches must also target upstream structural factors to ensure the broader causes of ill health and health inequity are addressed.

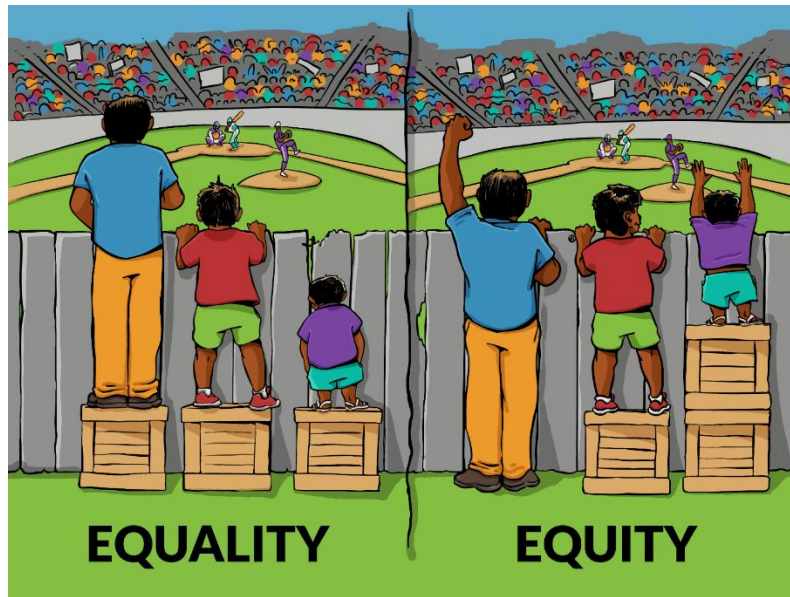
To overcome the shortcomings of both approaches and to capitalise on their strengths, a blended approach called proportionate universalism has been called for. *Proportionate universalism* involves the implementation of universal interventions that are implemented with a scale and an intensity that is proportionate to the level of need.<sup>13, 43</sup> The intensity of implementation and support is determined by the level of disadvantage experienced at different points of the health equity gradient<sup>13</sup> (See Figure 2).

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**Figure 2: Difference between universal provision (equality) and a proportionate universal approach focused on achieving health equity**

**Source:** Interaction Institute for Social Change | Artist: Angus Maguire <sup>44</sup>

*A multifaceted approach improves effectiveness*

Evidence also supports multifaceted health promotion and prevention responses, which target all aspects of regulatory mechanisms integrated within a whole of system framework.<sup>21, 45, 46</sup> The reduction in cigarette smoking in Australia offers a clear example of the effectiveness of a multifaceted approach. It utilised legislative controls (including those that restrict marketing and availability), organisational policy reform (for example smoking bans in workplaces, schools and restaurants) as well as programs that provide additional supports to individuals who smoke or who are at risk of smoking related disease.<sup>47-49</sup> Despite an overall reduction, rates of smoking prevalence continues to differ across the country, for example rates of current smoking in Australia's most disadvantaged socioeconomic areas are still more prevalent than the prevalence in the least disadvantaged socioeconomic areas.<sup>50-52</sup> Sufficient attention to proportionate provision with consideration of social, cultural and economic determinants of health, and intersectionality, are required to ensure inequity is addressed. Notably, the investment in Tackling Indigenous Smoking has seen positive outcomes.<sup>53</sup>

**Why is health promotion and prevention important?**

Many of the factors that impact negatively on people's health and impede realisation of their full potential can be prevented or delayed through a focus on promoting health and health equity.<sup>1, 25</sup> Furthermore, effective health promotion and prevention work can delay or prevent people moving into higher risk categories for disease and slow the progression of disease or disability once it develops.<sup>54</sup> The potential benefits associated with promoting health and preventing illness are considerable. Health promotion and prevention also have important economic benefits with estimates suggesting that every dollar invested in preventive health saves an estimated \$14.30 in

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healthcare and other costs.<sup>55</sup>

*Better health, wellbeing and equity will enhance Australia's social and economic progress*

A healthy population contributes to the social and economic progress of Australia. The available evidence indicates that improving health across the population is likely to result in the following benefits:

- a decreased prevalence of communicable and non-communicable disease
- an increase in the average number of years that Australians can remain economically and socially productive
- reduced public reliance on welfare, social and health services
- reduced pressure on tertiary health care systems
- decreased demand on health care budgets and a concomitant increase in resources to direct to other priority areas
- lower levels of poverty
- lower rates of crime
- higher rates of business growth and investment, which may result in greater employment opportunities, and
- higher rates of education (primary, secondary and tertiary) completion across the population.<sup>1, 25, 45, 54, 56, 57</sup>

*Is health promotion and prevention cost-effective?*

A key question for decision makers relates to cost-effectiveness. Cost effectiveness in this area necessitates an assessment of the human and financial resources expended to create and implement an intervention balanced against the benefits it achieves, including the problems that it averts.<sup>58, 59</sup>

Research strongly supports the cost-effectiveness of health promotion and prevention activity. The evidence comes from controlled trials and well designed, rigorous observational studies. Some health promotion and prevention activities have been found to be cost-saving, but most generate flow-on benefits (such as reduced burden on health care) as a pay-off for investment.<sup>47, 58-61</sup> Effective health promotion and prevention also contributes to national economic and social productivity by increasing the number of Australians in good health and increasing the number of years that Australians remain in good health.<sup>54, 60, 62</sup>

Responses that involve a combination of actions generally produce the greatest benefit and are most cost-effective.<sup>47, 61</sup> Evidence to support this has emerged across multiple areas of health promotion and prevention practice, including in the areas of smoking cessation, cardiovascular disease prevention, child injury prevention, road trauma prevention, sudden infant death syndrome prevention and HIV/AIDS management and prevention.<sup>47, 63, 64</sup>

The prevention and control of HIV/AIDS in Australia was successful because of strong national leadership, the use of both targeted and universal approaches, sustained effort over time, and supportive legislative and policy interventions.<sup>63</sup> The response involved the introduction of

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national monitoring systems, innovative social marketing campaigns to raise awareness, harm minimisation tactics such as needle exchange programs, implementation of donor screening and blood testing to ensure the safety of blood supply for transfusions, and research to understand risk factors, patterns of transmission and treatment options.<sup>49 62</sup> These strategies have had a significant impact in slowing and containing the transmission of HIV in Australia and in improving the lives of those already infected. The cost of the health promotion and prevention response from 1984 to 2010 is estimated to be \$607 million; the net benefit is estimated at \$2.54 billion.<sup>47</sup>

In terms of singular actions, legislated taxes to reduce consumption of health harming substances are consistently shown to be highly effective.<sup>47</sup> The benefits and cost-effectiveness are even greater when such legislated taxes are supported by marketing regulation and the availability of healthy alternatives.<sup>58</sup> In contrast, media-based campaigns, have high upfront costs and there is a lack of evidence supporting their cost-effectiveness or value for money.<sup>65</sup>

Interventions targeted at children also have strong cost-effective potential. This is because promoting health in childhood can shape health over the life course and there is a longer timeframe for benefits to be realised.<sup>47</sup> For example, the Children's Ground Approach, a First Nations led 25 year program that invests directly in children's education and empowering children and their families, is designed to tackle intergenerational disadvantage and has an estimated benefit-cost ratio of 5.7.<sup>66</sup> Another example is the *Be Active Eat Well* program, a community-based capacity building program conducted in Victoria and designed to promote healthy eating and physical activity in children aged 4-12 years. Program evaluation demonstrated lesser weight gain and lesser increases in BMI scores among children in the intervention group than those in the control group within a 3-year period (2003-2006). Cost effectiveness analysis deemed the intervention as cost-effective with net costs per DALY saved of AUD27,798.<sup>67</sup>

While the benefits of most health promotion and prevention activities emerge over decades, there are some interventions that produce benefit over the short term.<sup>41</sup> An example is the protection and promotion of mental health in the workplace via strategies such as supportive workplace conditions that cater to employee needs and circumstances, job-security, equitable staff recognition systems as well as stress reduction strategies. Improved mental health at work can produce immediate returns in the form of reduced staff turn-over, increased productivity and reductions in staff absences.<sup>68-70</sup> Additionally, comprehensive mental health promotion interventions in the school setting that incorporate life skills and social and emotional learning have produced benefits for young people that include positive health behaviours, improved social and emotional functioning and academic performance.<sup>71</sup>

#### *The cost of not investing in future health promotion and prevention*

The costs associated with not acting to support and facilitate health promotion and prevention in the future are considerable. This is due, in particular, to the increasing burden of chronic health problems and health inequities.<sup>72</sup>

Currently one in two Australians suffer from chronic disease.<sup>73</sup> Chronic disease accounts 62% of the total disease burden.<sup>74</sup> Chronic disease rates in Australia also follow an equity gradient, with rates of chronic conditions higher for people living in lower socio-economic areas<sup>75</sup>. This is

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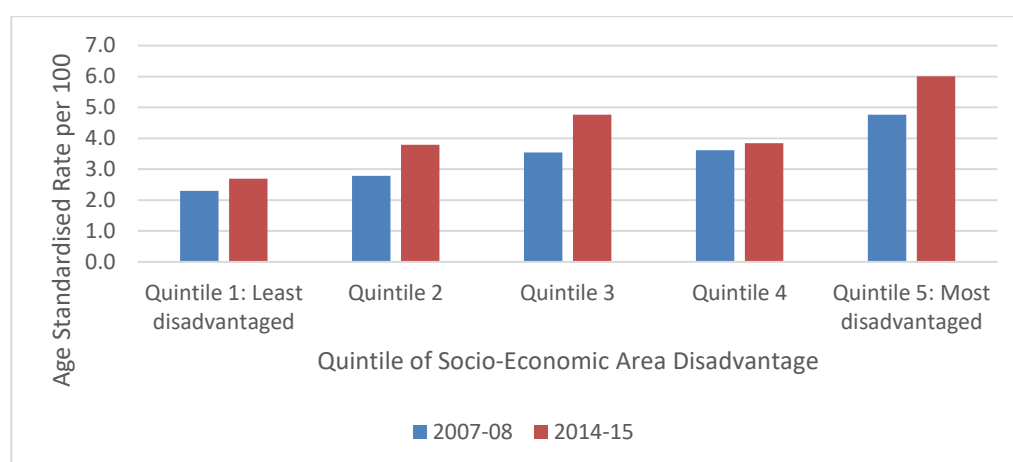
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demonstrated in Figure 3, which shows that although the rate of diabetes is increasing in the Australian population overall, it is those in the most disadvantaged circumstances who carry the greatest burden of this increase.

Much of the current and future projected burden is preventable through effective health promotion and prevention practice, especially policy action such as fiscal policies, regulation, social marketing and education.<sup>76</sup> Economic projections indicate that if health gaps along the health equity gradient were closed in Australia, 500,000 people could avoid suffering a chronic illness; 170,000 additional Australians could enter the workforce, and annual savings of \$4 billion in welfare support payments could be made.<sup>77</sup>

**Figure 3: Rate of Type 2 Diabetes in Australia over time**



**Source:** Public Health Information Development Unit (2020)<sup>52</sup>

*Note: This graph shows the estimated number of people with type 2 diabetes, expressed as a rate per 100 of population.*

Despite the potential for benefit, Australia’s health policy priorities continue to focus predominantly on treating illness rather than preventing it. Investment in the prevention of chronic diseases in Australia is much lower than the OECD average.<sup>76</sup> Overall, treating chronic disease costs the Australian community an estimated \$27 billion per year, which accounts for more than a third of the Australian national health budget.<sup>60</sup> It is estimated that Australia currently spends just more than \$2 billion of health sector budgets on prevention each year, or approximately \$89 per person. This expenditure is equivalent to only 1.34% of all health spending and just 0.13% of gross domestic product,<sup>60</sup> which is substantially less than New Zealand, Canada, the USA and the UK.

It is difficult to determine *exactly* how much *total* government expenditure is directed towards health promotion and prevention efforts because non-health sector activities are not accounted for as part of the ‘illness prevention’ budgets of Australian governments. This situation reflects a siloed approach to thinking and action, where accountability for health problems and recognition for health improvements is still not shared across sectors.<sup>76</sup>

What are the barriers to effective and sustained health promotion and prevention?

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### *Siloed approaches*

The siloed organisation of government, involving both departmental and budgetary silos, can impede the whole of systems action that is required to address the SDH.<sup>57</sup> All sectors have particular goals, and these are often framed as if they are independent of each other, rather than interconnected and integrated across policy areas. This is exacerbated by a general lack of high level (chief executive and ministerial) accountability for facilitating cross-sectoral approaches within government.<sup>78</sup>

To address siloing, those working in the health sector must act as stewards to strengthen capacity for collective action across sectors.<sup>79</sup> Some progress is being made in this area, driven in particular by initiatives based on Health in All Policies principles. Examples include the Healthy Parks, Healthy People approach<sup>80, 81</sup> and the numerous healthy planning initiatives that have emerged from the Healthy Cities movement.<sup>82</sup> Sustained attention on providing health stewardship for effective intersectoral action is imperative as part of future health promotion and prevention efforts.<sup>79</sup>

### *Short-termism*

There is pressure on governments and decision makers to prioritise short-term needs. A short-term outlook prioritises investment in activities that will produce results quickly, while threatening sustained action on, and investment in, activities that generate benefits over the medium to long-term.<sup>83</sup> Decision makers are also highly responsive to crises; more so than to gradually worsening social conditions and increasing health equity gaps.<sup>84</sup> These factors conflict with the prioritisation of, and sustained investment in, health promotion and prevention and can lead to under-funding and withdrawal of funding.<sup>83-85</sup> Short-termism can also make health promotion and prevention activity vulnerable to cuts and cancellation when budgets are stretched or when political and corporate imperatives necessitate quick results.<sup>84</sup>

Under-funding health promotion and prevention or funding it over the short-term can only impede a whole of systems approach. This is because short-term funding generally favours vertical programmes implemented within existing arrangements. Horizontal arrangements that cut across sectors and that involve the development of new collaborations and governance systems usually require longer and more resources to establish and sustain.<sup>38</sup>

A scan of health promotion and prevention policy over time suggests that there has been some improvement. While health promotion and prevention activity was generally funded annually in the past, some initiatives are now funded for two or three years at a time. Effort to ensure the further sustainability of funding in the future should continue to be prioritised. Adequate and long-term funding linked to defined priorities is essential for the delivery of effective health promotion and prevention.

### *Victim-blaming*

The pervasiveness of neoliberal beliefs within Australian society skews attention towards the agency of individuals, and their ability to make healthy choices. This is problematic because it deflects attention from the social, economic and political contexts that shape health.<sup>82,83</sup> Interpreting health problems through a lens of individual responsibility can lead to the blaming

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of individuals for not changing their behaviours. There are many factors outside of an individual's control, such as commercial determinants and daily living conditions, that impact the choices they are able to make about health behaviours.<sup>86</sup>

The strong emphasis on individual responsibility also makes it difficult to gain support from decision makers for health promotion and prevention activities that focus on reshaping the environments in which people live. This can be politically unpopular if people are held responsible for their social and economic situation, and the associated health impacts. A key example of this relates to community resistance to programs that are implemented to support prisoners or people recently released from prison.<sup>87</sup> In addition, blaming individuals for their health problems is disempowering. Disempowerment makes behaviour change more difficult, and therefore health promotion needs to maintain a focus on individual and collective autonomy and self-determination.<sup>86, 88</sup>

#### *Lack of coherence in approaches*

As explained in greater detail previously, health problems that stem from the SDH are preventable, but they require sustained and multifaceted responses. There are increasing examples of comprehensive and sustained approaches to health promotion and prevention (for example in the areas of obesity prevention,<sup>89</sup> tobacco control, and sexual health education) but there is still a long way to go. Inadequate investment leads to dispersed and sporadic approaches, particularly without coherent national leadership.<sup>45</sup> In addition, frequent reforms and restructuring within governments may compromise partnerships between health and non-health sectors.<sup>78</sup> Fragmented decision-making structures and processes across sectors also restrict opportunities for effective planning and implementation.<sup>57</sup>

#### *Sporadic leadership*

Overarching national leadership in health promotion and prevention waxes and wanes in Australia (as demonstrated by the closure of the Australian National Preventive Health Agency in 2014). There is a dearth of policy at the federal and state/territory level in Australia that provides overarching direction and support for health promotion and prevention beyond specific issues or specific population groups. Where such overarching leadership does exist, it is highly vulnerable to political shifts and funding stress. This was demonstrated with the launch of the National Preventive Health Strategy 2021-2030 by the Liberal Government in 2021. Since then, with a change of government, the strategy has still not been fully enacted into policy or implemented.

#### *Focus on deficit rather than strengths*

Where policy does exist it is commonly focussed on health *problems* rather than health promotion. While it is important to understand particular problems and the associated epidemiology, the dominant focus on problems can come at the cost of attention on building upon existing strengths through a health promotion framework. The emphasis on problems communicates that there is failure, a helplessness, an area of need.<sup>90</sup> It may also disempower those represented as having the deficit and creates a dependency on external resources and solutions.<sup>30</sup> Another major problem with this approach is that it often comes too late;

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intervening after the problem is already established rather than working to prevent it.

Some exceptions do exist. However, these are generally offered by health promotion organisations rather than by the governments that have the capacity to control national and state/territory budget allocations. The Victorian Health Promotion Foundation (VicHealth) launched a new 10-year strategy in 2023 that focuses on reshaping systems to create a fairer and healthier Victoria. The strategy focuses on the different actors and factors that impact health and wellbeing, with long-term investment.<sup>91</sup> Furthermore, the Closing the Gap Strategy at the national level acknowledges the ongoing strength and resilience of Aboriginal and Torres Strait Islander people. Closing the Gap is underpinned by the belief that Aboriginal and Torres Strait Islander people should have a genuine say in the design and delivery of policies, programs and services that affect them better outcomes are achieved.<sup>92</sup>

What will facilitate health promotion and prevention in the future?

This background paper has emphasised the importance of health promotion and prevention activity being:

- targeted at shaping social, cultural, political and physical environments in ways that are conducive to better health
- undertaken via diverse roles and in multiple settings
- targeted at addressing the social determinants of health and shifting the distribution of power and resources towards health equity for all
- undertaken via a whole of systems approach involving public, private and non-government organisations across all sectors, and
- based on a multifaceted approach, involving a suite of legislative, institutional, policy and program interventions.

To support future practice, actions must also be taken to strengthen leadership, improve evaluation and reporting, systematise prioritisation, enhance funding effectiveness and strengthen workforce development.

#### *Strengthen leadership*

- While strong leadership is currently provided by non-government organisations and advocacy groups across Australia this cannot be considered a substitute for cohesive national leadership. Strengthened political leadership at the national level is vital.<sup>33</sup>
- In addition to funding the National Preventive Health Strategy, a national policy for health promotion and prevention is required.
- Introducing a national policy will facilitate a systematic and comprehensive approach to producing cost-effective improvements in health, reducing inequities and harnessing the associated social and economic benefits. A national policy should emphasise the importance of promoting health, equity and wellbeing via the activities of all sectors, and advocate for shared accountability for health across government, industry and other non-government organisations.

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- Health sector leadership must be strengthened at all levels of government to ensure health promotion and prevention remain resourced across budget and political cycles, and during crises.
- Health sector leadership can support health promotion and prevention by integrating these as key priorities within health sector policy.
- Stronger stewardship for promoting health beyond the health sector is also required.<sup>79</sup> Health in All Policies and Healthy Cities are internationally regarded approaches that can be used by the health sector to facilitate health promoting activity in non-health sectors.
- Australian governments at all levels could also demonstrate greater valuing of health promotion and prevention by implementing integrated governance mechanisms. One strategy involves ensuring health promotion and prevention representation on whole of government committees, cabinet committees and on health portfolio executive committees.
- To support implementation of health promotion and prevention action across public, private and non-government organisations, a national agency dedicated to wellbeing should also be established in Australia. This agency would be different from a health department in that it would not oversee provision of illness treatment services. Instead, it would exist to provide direction, advocacy and investment to support health promotion and prevention activity across sectors. Funding such an agency would assist in keeping health promotion and prevention on the agendas of decision makers to counter short-termism. Relatedly, it is important that the Australian Centre for Disease Control also focus on prevention, not only infectious diseases.

#### *Improve evaluation and reporting*

- A national wellbeing agency could lead and/or advocate for evaluation of health promotion initiatives across sectors and across Australia. Routinely evaluating *all* health promotion initiatives will provide a rigorous evidence base that will assist in identifying the most cost-effective actions.
- Evaluations of cost-effectiveness should include assessments of SDH related costs and benefits.<sup>22, 60</sup> To further support a whole of systems approach, evaluations also need to consider costs and benefits beyond the traditional interests of the health sector.
- Increasing the availability of rigorous evidence about the potential benefits of health promoting activity for non-health sectors may facilitate increased investment and commitment. For example, the education sector may be more likely to progress actions to improve mental health of students if cost saving benefits can be demonstrated in reducing teacher stress and classroom disruption, in addition to the associated health systems savings.<sup>57</sup>
- Evaluation research should generate practical, policy relevant recommendations to inform ongoing adaptation and improvement.<sup>61</sup> Reports and recommendations also

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need to be made publicly available so that policy makers, practitioners and other decision makers can learn from and build upon past efforts.

- Accountability for promoting health and preventing illness across all sectors of government must be increased. The AIHW, Australia's Health series is a positive step, but a strategy that requires action in response to data about (lack of) progress is needed to ensure reductions in health inequities and improve health. This could be organised in a similar to the reporting structure that currently governs the Closing the Gap initiative in Australia.

#### *Systematise prioritisation*

- A systematic approach to establishing priorities for health promotion and prevention is important. Without prioritisation, efforts tend to become scattered across many areas, sometimes with duplication, and this dilutes effectiveness. Prioritising fewer areas for action allows for increased intensity of effort and improves likelihood of success.
- A national policy for health promotion and prevention and a national agency will guide prioritisation.
- Mechanisms for coordinating the range of actors involved in whole of systems responses are also required. Such mechanisms need to provide opportunities for the range of actors involved to gather and agree on priorities for action in systematic ways. In doing so, it is important to recognise that while different actors may have different roles, responsibilities and capacities, working towards common goals is empowering and unifying.
- Established health promotion and prevention initiatives that have already proven effective in guiding priority setting at the national and local levels across multiple sectors are Healthy Cities (particularly via the WHO European Healthy Cities Network and the Healthy Cities alliance across Asia and the Pacific) and Health in All Policies. Healthy Cities provides a good example of a multifaceted approach involving action at the policy and local level, seeking structural change, environment modification and community capacity building to promote health.

#### *Enhance funding*

- Sustained funding is vital to support effective health promotion and prevention and to protect against the vulnerabilities created by political shifts and short-termism.
- Greater flexibility in funding structures is also required. Current, siloed funding structures within government departments restrict co-investment and collaboration on efforts that will produce co-benefits for multiple sectors.<sup>78</sup> This channels money towards the core business of departments only and introduces a culture of competition between departments. Challenging the predominance of vertical, rigid funding structures will open new opportunities for intersectoral action, and promote greater cooperation around activity that may promote health and prevent illness.<sup>57</sup>
- Reinvestment of money raised from dedicated taxes on health damaging products like

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tobacco and alcohol, or returns from state-controlled gambling, should be reinvested into health promotion and prevention activities.<sup>93</sup> This will assist in protecting against the future burden on health care systems associated with consumption of such products.

#### *Strengthen workforce development*

- The Global Charter for Public Health<sup>33</sup> stresses the importance of building public health workforce capacity. This involves workforce planning, supportive systems and infrastructure, standards, accreditation and ongoing training.
- Opportunities for health promotion accreditation are available in Australia via the International Union for Health Promotion and Education.
- While it is important to support health promotion professionals, this must be done in a way that avoids reinforcing silos. Therefore, it is also important to build public health capacity in the broader Australian workforce in areas that influence health, such as transport, housing, education and urban planning.<sup>47</sup> Doing so is necessary to address the SDH but is also important in ensuring that key health promotion objectives (such as local community participation) can be achieved in all sectors.<sup>94</sup>
- A critical component of both workforce development and enhancing leadership is ensuring that those who have policy responsibility for health (at all levels of government) have the skills and knowledge required to value and stimulate health promotion and prevention activity. Such skills and knowledge are not necessarily the same as those held by clinicians or economic managers.

#### *Summary*

The evidence that has been summarised in this background paper emphasises the importance and potential benefits of valuing and investing in health promotion and prevention. Protecting health promotion and prevention against the vagaries of political cycles is essential to harness future social and economic benefits. It is clear that promoting health and preventing disease is far more cost-effective than treating illness. It is also clear that improved population health will produce co-benefits that reach far beyond the health sector. Decision makers across sectors and at all levels of government have the power to improve health and reduce inequities. Now is the time to use that power to strengthen commitment to health promotion and prevention, to support cost-effective action, and to harness the considerable savings and population benefits that will result.

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## SUPPLEMENT 1: EXPLANATION OF KEY TERMS

This supplement explains key terms that are relevant to the Joint Policy Statement, and provides background information about each. The supplement is intended to represent the agreed understandings upon which the joint policy statement is based.

### Public health

Public health refers to the study of disease and positive attributes in whole populations.<sup>25</sup> The World Health Organisation defines Public Health as “*the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society*”. This distinguishes public health from other roles of the health system because it goes beyond the treatment of individuals to encompass the promotion of health and wellbeing and the prevention of disease, disability and injury.<sup>25, 95</sup>

There has been a long history of public health development in Australia. The current era is termed the ‘new public health’ to differentiate it from previous eras where a focus on measures such as sanitation was prominent, and efforts to change individual behaviour dominated.<sup>25</sup> The new public health has been strongly influenced by WHO policies, including the Alma Ata Declaration of Health for All and the Ottawa Charter. The new public health emphasises the need to focus on shaping environments in ways that facilitate healthy behaviours.<sup>25</sup> It emphasises collective responsibility for health through actively encouraging intersectoral action and it directs attention to the health impact of global forces.<sup>25</sup> Both health promotion and prevention activities are prioritised within the new public health and are generally orientated towards whole of system action, underpinned by a social justice lens.

### Health promotion

Over decades health promotion practice has also evolved, drawing on evidence and experience about what is most effective and by responding to the broader new public health movement.<sup>96, 97</sup> The ecological approach to health promotion is supported by the most recent evidence<sup>96</sup> and this model underpins the discussion paper and joint policy statement.

The *ecological approach* acknowledges the reciprocal relationship between the health-related behaviours of individuals and populations and the environments in which they grow, live, work and play.<sup>98</sup> This approach emphasises that behaviour does not occur in a vacuum, but is rather influenced by a combination of environmental exposures, structural determinants and the expression of individual agency.<sup>99</sup> Those implementing an ecological approach focus on environments at all levels (micro, meso, exo and macro) and implement actions within a range of settings.<sup>98, 100</sup> This approach also acknowledges the importance of a comprehensive and multifaceted response to issues, based on efforts to seek change at individual, environmental and systems levels.<sup>99, 100</sup>

The ecological approach combines elements of both the biomedical and social approach to health promotion, and builds upon the learnings derived from their application. The *biomedical approach* focuses on risk behaviours and healthy living strategies.<sup>101</sup> It emphasises health education with the intention of changing knowledge, attitudes and skills. The *social approach* to health promotion focusses on addressing the broader determinants of health,

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including via intersectoral collaboration, and it includes actions to reduce social inequities.<sup>101</sup> The focus is primarily on systems level change, including action to enable equitable access to health care.

The biomedical approach dominated pre-1970s health promotion efforts<sup>101</sup> and is still applied under some treatment models. It has been shown to be limited and largely ineffective, however, because it relies on the singular strategy of health education, it generally focuses on people's deficits or risks, and it treats people in isolation of the environments that shape their health and wellbeing, which may even widen health inequities.<sup>41, 102-104</sup> The social approach to health promotion gained traction from the mid-1970s onwards<sup>101</sup> as it overcomes some of the shortcomings of the biomedical model. However, the social approach has been criticised for deferring responsibility almost entirely to social structures and denying the power of individual agency.<sup>105</sup>

Adoption of the ecological approach combines the strengths of other approaches by integrating a commitment to health promotion action at the population level, with recognition of individuals' agency and contexts.<sup>99</sup> Ultimately, within the ecological model, health promotion is intended to enable people to increase control over their health via a multifaceted response that will shift the determinants of health in ways that are conducive to wellbeing and health equity.<sup>21, 46</sup>

### **Illness prevention**

At its core, illness prevention involves efforts to reduce the likelihood that illness will develop, and to reduce the severity and impact of illness if it occurs. As such, illness prevention (like health promotion) is concentrated on wellbeing. Illness prevention focuses mostly on efforts to prevent decline in wellbeing and this is achieved through a focus on those who are well, those who are well but at risk, and those who are already experiencing illness. The concept of illness prevention can be broken down into different levels, with different activities at each.

#### **Primordial prevention**

This level of prevention has considerable overlap with an ecological approach to health promotion. Primordial prevention activity is intended (like health promotion) to avoid the emergence of risk factors for disease by acting on the social, economic and cultural determinants that may give rise to risk factors.<sup>106</sup> Such action may involve, for example, intervention in the education system to improve literacy outcomes so that students leaving school will not be exposed to the health damaging experiences associated with low literacy levels during adolescence and adulthood (such as unemployment, low income and low self-esteem).

#### **Primary prevention**

Primary prevention also has some overlap with population health promotion. Primary prevention is focussed on reducing risk factors for illness and it is implemented before illness develops. Primary prevention may be undertaken through efforts to change environments in ways that reduce or eliminate risks, alter individual behaviours and increase population resistance to disease should an outbreak occur.<sup>107</sup> Examples include literacy programs for adults, legislation mandating the use of seatbelts by car users, introduction of healthy school canteen policy to

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reduce the number of sugary foods for sale and population immunisation campaigns.<sup>108</sup>

### **Secondary prevention**

Secondary prevention involves action to halt the progression of an illness once it develops and it aims to prevent future long-term complications.<sup>107</sup> This is achieved through early diagnosis, prompt treatment of a disease to slow its progression, and rehabilitation programs to assist people to recover.<sup>108</sup> Examples include routine screening to detect breast cancer in early stages. While secondary prevention is integral, it is largely focussed on individuals, and is outside the scope of this background paper and the joint policy statement.

### **Tertiary prevention**

Tertiary prevention aims to reduce the impact of disease that has advanced beyond its early stages. This is achieved by retraining, re-educating and/or rehabilitating people who have already developed long-term health problems in order to improve their ability to function, their quality of life and their life expectancy.<sup>107</sup> Examples include chronic disease self-management programs for diabetes or physiotherapy to assist patients to walk again after injury.<sup>108</sup> While tertiary prevention is important, it is largely focussed on individuals, and is outside the scope of this background paper and the joint policy statement.

### **Summary**

The information provided in this supplement to the background paper emphasises the commonalities that underpin health promotion and prevention approaches. Population focussed health promotion and prevention efforts stem from the new public health.

Both are also based on an ecological approach that prioritises changing social, political and economic conditions in ways that are conducive to health, while acknowledging the influence of individual agency and focussing on supporting healthy living. To influence environments, both health promotion and prevention efforts rely upon effective intersectoral action, involving key stakeholders across public, private and non-government organisations.

Multifaceted approaches are also prioritised, with a combination of strategies most effective in underpinning effective health promotion and public health. Ultimately, both health promotion and prevention have a focus on wellbeing at their core- with health promotion prioritising wellbeing optimisation and prevention focussing on preventing or delaying wellbeing decline.

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## References

1. Commission on the Social Determinants of Health. Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. Geneva: World Health Organization; 2008.
2. Australian Institute of Health and Welfare. Social Determinants of Health: AIHW, Australian Government; 2024 [Available from: <https://www.aihw.gov.au/reports/australias-health/social-determinants-of-health>].
3. Baum, F. People's Health and the Social Determinants of Health. *Health Promotion Journal of Australia*. 2018;29(1):8-9.
4. Wilkinson, R. G., Marmot, M. *Social Determinants of Health: The Solid Facts*: World Health Organisation; 2003.
5. Flavel, J., et al. Explaining Health Inequalities in Australia: The Contribution of Income, Wealth and Employment. *Australian Journal of Primary Health*. 2022;28(6):474-81.
6. Marmot, M., Friel, S. Global Health Equity: Evidence for Action on the Social Determinants of Health. *J Epidemiol Community Health*. 2008;62(12):1095-7.
7. Friel, S., et al. Power and the People's Health. *Social Science & Medicine*. 2021;282:114173.
8. Freeman, T., et al. Illustrating the Impact of Commercial Determinants of Health on the Global Covid-19 Pandemic: Thematic Analysis of 16 Country Case Studies. *Health Policy*. 2023;134:104860.
9. The Lancet. Commercial Determinants of Health: The Lancet; 2023 [Available from: <https://www.thelancet.com/series/commercial-determinants-health>].
10. Department of Health. National Preventive Health Strategy: Australian Government; 2021 [Available from: [https://australianwomenshealth.org/wp-content/uploads/2023/07/national-preventive-health-strategy-2021-2030\\_11.pdf](https://australianwomenshealth.org/wp-content/uploads/2023/07/national-preventive-health-strategy-2021-2030_11.pdf)].
11. Verbunt, E., et al. Cultural Determinants of Health for Aboriginal and Torres Strait Islander People – a Narrative Overview of Reviews. *International Journal for Equity in Health*. 2021;20(1):181.
12. Constitution of the World Health Organization. *American Journal of Public Health and the Nations Health*. 1946;36(11):1315-23.
13. Marmot, M., Bell, R. Fair Society, Healthy Lives. *Public Health*. 2012;126:S4-S10.
14. Parise, I. A Brief Review of Global Climate Change and the Public Health Consequences. *Australian Journal for General Practitioners*. 2018;47:451-6.
15. Frumkin, H., et al. Climate Change: The Public Health Response. *Am J Public Health*. 2008;98(3):435-45.
16. Galvão, L. A., et al. Climate Change and Social Determinants of Health: Two Interlinked Agendas. *Glob Health Promot*. 2009;Suppl 1:81-4.
17. ACOSS. 'I Can Finally Eat Fresh Fruit and Vegetables': Survey of 955 People Receiving the New Rate of Jobseeker and Other Allowances: Australian Council of Social Services; 2020 [Available from: <https://www.acoss.org.au/wp-content/uploads/2020/06/200624-I-Can-Finally-Eat-Fresh-Fruit-And-Vegetables-Results-Of-The-Coronaviru...pdf>].
18. Dahlgren, G., Whitehead, M. *Policies and Strategies to Promote Equity in Health*: World Health Organization, Regional Office for Europe; 1992.
19. Donkin, A. J. M. Social Gradient. *The Wiley Blackwell Encyclopedia of Health, Illness, Behavior, and Society*. p. 2172-8.
20. Marmot, M. Social Inequalities, Global Public Health, and Cancer. In: Vaccarella S, Lortet-Tieulent J, Saracci R, editors. *Reducing Social Inequalities in Cancer: Evidence and Priorities for Research*: International Agency for Research on Cancer; 2019.
21. World Health Organization. Ottawa Charter for Health Promotion, 1986. Copenhagen: World Health Organization. Regional Office for Europe; 1986.
22. Fleming, M., Baldwin, L., eds. *Health Promotion in the 21st Century: New Approaches to Achieving Health for All*: Routledge; 2021.
23. World Health Organization. Key Learning on Health in All Policies Implementation from around the World – Information Broucher: World Health Organization and Government of South Australia; 2018 [Available from:

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<https://www.preventivehealth.sa.gov.au/assets/downloads/KeyLearningonHiAPImplementationInformationBrochure.pdf>].

24. Green, L., et al. 'Health in All Policies'-a Key Driver for Health and Well-Being in a Post-Covid-19 Pandemic World. *Int J Environ Res Public Health*. 2021;18(18).
25. Baum, F. *The New Public Health*: Oxford University Press; 2015.
26. World Health Organization. Declaration of Alma-Ata: International Conference on Primary Health Care 1978 [Available from: [https://cdn.who.int/media/docs/default-source/documents/almaata-declaration-en.pdf?sfvrsn=7b3c2167\\_2](https://cdn.who.int/media/docs/default-source/documents/almaata-declaration-en.pdf?sfvrsn=7b3c2167_2)].
27. De Leeuw, E., et al. *Healthy Cities: Promoting Health and Equity – Evidence for Local Policy and Practice: Summary Evaluation of Phase V of the WHO European Healthy Cities Network*: World Health Organization. Regional Office for Europe; 2014 2014.
28. United Nations. Political Declaration of the Third High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases, and Mental Health: World Health Organization and the United Nations; 2023 [Available from: Political declaration of the high-level Meeting of the General Assembly on the prevention and control of non-communicable diseases].
29. World Health Organization. Rio Political Declaration on Social Determinants of Health: World Health Organization; 2011 [Available from: <https://www.who.int/publications/m/item/rio-political-declaration-on-social-determinants-of-health>].
30. Senate Community Affairs Reference Committee. Australian's Domestic Response to the World Health Organisation's Commission on Social Determinants of Health Report: Commonwealth of Australia; 2013 [Available from: [https://www.aph.gov.au/parliamentary\\_business/committees/senate/community\\_affairs/completed\\_inquiries/2010-13/socialdeterminantsofhealth/report/index](https://www.aph.gov.au/parliamentary_business/committees/senate/community_affairs/completed_inquiries/2010-13/socialdeterminantsofhealth/report/index)].
31. United Nations. United Nations Sustainability Development Goals 2015: United Nations; 2017 [Available from: <https://www.undp.org/sustainable-development-goals>].
32. World Health Organization. Shanghai Declaration on Promoting Health in the 2030 Agenda for Sustainable Development. *Health Promotion International*. 2017;32(1):7-8.
33. Lomazzi, M. A Global Charter for the Public's Health—the Public Health System: Role, Functions, Competencies and Education Requirements\*. *European Journal of Public Health*. 2016;26(2):210-2.
34. Baum, F., et al. Australian Experiences. In: Raphael D, editor. *Tackling Health Inequalities: Lesson from International Experiences* Canada; 2012.
35. Institute of Health Equity. *Review of Social Determinants and the Health Divide in the WHO European Region: Final Report*: World Health Organization; 2013.
36. Wilderink, L., et al. A Theoretical Perspective on Why Socioeconomic Health Inequalities Are Persistent: Building the Case for an Effective Approach. *Int J Environ Res Public Health*. 2022;19(14).
37. National Collaborating Centre for Determinants of Health. *Let's Talk: Universal and Targeted Approaches to Health Equity*: National Collaborating Centre for Determinants of Health, St. Francis Xavier University; 2013.
38. Carey, G., et al. Towards Health Equity: A Framework for the Application of Proportionate Universalism. *International Journal for Equity in Health*. 2015;14(1):81.
39. Human Early Learning Partnership. *Policy Brief: Proportionate Universality*: University of British Columbia; 2011.
40. Baum, F. From Norm to Eric: Avoiding Lifestyle Drift in Australian Health Policy. *Aust N Z J Public Health*. 2011;35(5):404-6.
41. Baum, F., Fisher, M. Why Behavioural Health Promotion Endures Despite Its Failure to Reduce Health Inequities. *Sociol Health Illn*. 2014;36(2):213-25.
42. Hunter, D., Tannahill, C. Getting to Grips with Health Inequality at Last? *BMJ*. 2010;340:c684.
43. Fisher, M., et al. Implementing Universal and Targeted Policies for Health Equity: Lessons from Australia. *International Journal of Health Policy and Management*. 2022;11(10):2308-18.
44. Change, I. I. F. S. *Illustrating Equality Vs Equity*: Interaction Institute for Social Change; 2016 [Available from:

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W [www.phaa.net.au](http://www.phaa.net.au)

<https://interactioninstitute.org/illustrating-equality-vs-equity/>].

45. Keleher, H. *Prevention and Public Health Strategies to Inform the Primary Prevention of Family Violence and Violence against Women*: VicHealth; 2017.
46. World Health Organization. *Bangkok Charter for Health Promotion in a Globalised World*: World Health Organization; 2008.
47. Gruszin, S., et al. *Advocacy and Action in Public Health: Lessons from Australia over the 20th Century*. Australian National Preventative Health Agency; 2012.
48. Syme, S. L. The Prevention of Disease and Promotion of Health: The Need for a New Approach. *European Journal of Public Health*. 2007;17(4):329-30.
49. Gould, T., et al. Advocacy for Health: Revisiting the Role of Health Promotion. *Health Promotion Journal Australia*. 2012;23(3):165-70.
50. Greenhalgh, E. M., et al. Prevalence of Smoking in Other High-Risk Sub-Groups of the Population. In: Greenhalgh EM, Schollo EM, Winstanley MH, editors. *Tobacco in Australia: Facts and Issues*: Cancer Council Victoria; 2022.
51. Purcell, K. R., et al. Tobacco Control Approaches and Inequity—How Far Have We Come and Where Are We Going? *Health Promotion International*. 2015;30(suppl\_2):ii89-ii101.
52. PHIDU. *Inequality Graphs: Time Series*: Torrens University; 2020 [Available from: <https://phidu.torrens.edu.au/inequality-graphs-introduction>].
53. Thomas, D., Calma, T. Tackling Indigenous Smoking: A Good News Story in Australian Tobacco Control. *Public Health Research & Practice*. 2020;30(3):e3032019.
54. Butler, R. N., et al. New Model of Health Promotion and Disease Prevention for the 21st Century. *Bmj*. 2008;337(7662):a399.
55. Department of Health and Aged Care. *Health Protection, Preventive Health and Sport: Australian Government 2022* [Available from: <https://www.health.gov.au/sites/default/files/2023-10/health-protection-preventive-health-and-sport-budget-2023-24.pdf>].
56. Economist Intelligence Unit. *Financing the Future: Choices and Challenges in Global Health*: Economic Intelligence Unit; 2015.
57. Mcdaid, D., Wismar, M. Making an Economic Case for Intersectoral Action. In: McDaid D, Sassi F, Merjur S, editors. *Promoting Health, Preventing Disease: The Economic Case*: Open University Press; 2015.
58. Vos, T., et al. *Assessing Cost-Effectiveness in Prevention : Ace—Prevention September 2010 Final Report*. University of Queensland; 2010.
59. World Health Organization. Regional Office For, E., et al. *Using Economic Evidence to Help Make the Case for Investing in Health Promotion and Disease Prevention*: World Health Organization. Regional Office for Europe; 2018 2018.
60. Jackson, H., Shiell, A. *Preventive Health- How Much Does Australia Spend and Is It Enough*. Canberra: Foundation for Alcohol Research and Education; 2017.
61. Merkur, S., et al. *Promoting Health, Preventing Disease: Is There an Economic Case?* : World Health Organization; 2013.
62. Bloom, D. E., et al. *The Effect of Health on Economic Growth: Theory and Evidence* National Bureau of Economic Research; 2001 [Available from: <https://www.nber.org/papers/w8587>].
63. Gupta, G. R., et al. Structural Approaches to Hiv Prevention. *The Lancet*. 2008;372(9640):764-75.
64. Government of South Australia. *Primary Prevention Plan 2011–2016*: SA Health, Government of South Australia; 2011.
65. Martine, S., et al. *Mass Media to Communicate Public Health Messages in Six Health Topic Areas: A Systematic Review and Other Reviews of the Evidence*. Public Health Research [Internet]. 2019; 7(8). Available from: <http://dx.doi.org/10.3310/phr07080>.
66. Children’s Ground. *Cost-Benefit Analysis of the Children’s Ground Approach*: Children’s Ground; 2021 [Available from: <https://childrensground.org.au/wp-content/uploads/2023/10/CG-CBA-Final.pdf>].
67. Moodie, M. L., et al. *The Cost-Effectiveness of a Successful Community-Based Obesity Prevention Program*:

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- The Be Active Eat Well Program. *Obesity*. 2013;21(10):2072-80.
68. Goetzel, R. Z., Ozminkowski, R. J. The Health and Cost Benefits of Work Site Health-Promotion Programs. *Annu Rev Public Health*. 2008;29:303-23.
69. Keyes, C. L. Promoting and Protecting Mental Health as Flourishing: A Complementary Strategy for Improving National Mental Health. *Am Psychol*. 2007;62(2):95-108.
70. Benach, J., Muntaner, C. Precarious Employment and Health: Developing a Research Agenda. *J Epidemiol Community Health*. 2007;61(4):276-7.
71. Barry, M. M., et al. A Systematic Review of the Effectiveness of Mental Health Promotion Interventions for Young People in Low and Middle Income Countries. *BMC Public Health*. 2013;13(1):835.
72. AIHW. Australian Burden of Disease Study 2023: Australian Government 2023 [Available from: <https://www.aihw.gov.au/reports/burden-of-disease/australian-burden-of-disease-study-2023/contents/about>].
73. ABS. Health Conditions Prevalence: Australian Bureau of Statistics; 2022 [Available from: <https://www.abs.gov.au/statistics/health/health-conditions-and-risks/health-conditions-prevalence/latest-release>].
74. AIHW. Australian Burden of Disease Study: Australian Government 2022 [Available from: <https://www.aihw.gov.au/reports/burden-of-disease/australian-burden-of-disease-study-2022/contents/summary>].
75. AIHW. *Geographical Variation In Disease: Diabetes, Cardiovascular and Chronic Kidney Disease*: Australian Institute of Health and Welfare; 2023.
76. Wilcox, S., Collaboration, A. H. P. Chronic Diseases in Australia: The Case for Changing Course 2014 [<https://www.vu.edu.au/mitchell-institute/prevention-risk/chronic-diseases-in-australia-the-case-for-changing-course>].
77. Brown, L., et al. The Cost of Inaction on the Social Determinants of Health: Analysis and Policy Observatory; 2012 [Available from: <https://apo.org.au/node/29676>].
78. Delany, T., et al. Health in All Policies in South Australia: What Has Supported Early Implementation? *Health Promotion International*. 2015;31(4):888-98.
79. Baum, F. E., et al. Changes Not for the Fainthearted: Reorienting Health Care Systems toward Health Equity through Action on the Social Determinants of Health. *Am J Public Health*. 2009;99(11):1967-74.
80. Maller, C., et al. Healthy Nature Healthy People: 'Contact with Nature' as an Upstream Health Promotion Intervention for Populations. *Health Promot Int*. 2006;21(1):45-54.
81. Parks Victoria. *Health Parks Healthy People*: Parks Victoria; 2018.
82. Hancock, T. The Evolution, Impact and Significance of the Healthy Cities/Healthy Communities Movement. *J Public Health Policy*. 1993;14(1):5-18.
83. Bacigalupe, A., et al. Learning Lessons from Past Mistakes: How Can Health in All Policies Fulfil Its Promises? *J Epidemiol Community Health*. 2010;64(6):504-5.
84. Mcginnis, J. M., et al. The Case for More Active Policy Attention to Health Promotion. *Health affairs (Project Hope)*. 2002;21(2):78-93.
85. Limb, M. "Culture of Short Termism" Threatens Health and Care Services, Warn Lords. *BMJ*. 2017;359:j4983.
86. Dougherty, C. J. Bad Faith and Victim-Blaming: The Limits of Health Promotion. *Health Care Anal*. 1993;1(2):111-9.
87. Levy, N. Less Blame, Less Crime? The Practical Implications of Moral Responsibility Skepticism. *Journal of Practical Ethics*. 2015;3(2):1-17.
88. Tengland, P.-A. Behavior Change or Empowerment: On the Ethics of Health-Promotion Goals. *Health Care Analysis*. 2016;24(1):24-46.
89. Swinburn, B., Wood, A. Progress on Obesity Prevention over 20 Years in Australia and New Zealand. *Obes Rev*. 2013;14 Suppl 2:60-8.
90. Morgan, A., Ziglio, E. Revitalising the Evidence Base for Public Health: An Assets Model. *Promot Educ*.

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W [www.phaa.net.au](http://www.phaa.net.au)

- 2007;Suppl 2:17-22.
91. Vichealth. Vichealth Strategy: VicHealth; 2023 [Available from: <https://www.vichealth.vic.gov.au/resources/vichealth-strategies/strategy-2023-2033>].
  92. Closing the Gap. Closing the Gap: A New Way of Working Together: Closing the Gap; nd [Available from: <https://www.closingthegap.gov.au/>].
  93. World Health Organization, editor Global Health Promotion Scaling up for 2015: A Policy Brief Review of Major Impacts and Developments over the Past 20 Years and Challenges for 2015: Working Paper. *6th Global Confernce on Health Promotion*; 2005; Bangkok, Thailand.
  94. Johansson, H., et al. "It Depends on What You Mean": A Qualitative Study of Swedish Health Professionals' Views on Health and Health Promotion. *BMC Health Services Research*. 2009;9(1):191.
  95. Public Health Association of Australia. Who We Are 2018 [Available from: <https://www.phaa.net.au/about-us/who-we-are>].
  96. Richard, L., et al. Ecological Models Revisited: Their Uses and Evolution in Health Promotion over Two Decades. *Annual Review of Public Health*. 2011;32(Volume 32, 2011):307-26.
  97. Australian Health Promotion Association. What Is Health Promotion? 2018 [Available from: <https://www.healthpromotion.org.au/our-profession/what-is-health-promotion> ].
  98. Green, L. W., et al. Ecological Foundations of Health Promotion. *Am J Health Promot*. 1996;10(4):270-81.
  99. Stokols, D. Establishing and Maintaining Healthy Environments. Toward a Social Ecology of Health Promotion. *Am Psychol*. 1992;47(1):6-22.
  100. Kok, G., et al. The Ecological Approach in Health Promotion Programs: A Decade Later. *Am J Health Promot*. 2008;22(6):437-42.
  101. Vichealth. What Is Health Promotion? 2017 [Available from: <https://www.vichealth.vic.gov.au/media-and-resources/vce-resources/defining-health-promotion>].
  102. Cattan, M., et al. Preventing Social Isolation and Loneliness among Older People: A Systematic Review of Health Promotion Interventions. *Ageing and Society*. 2005;25(1):41-67.
  103. Watt, R. G. From Victim Blaming to Upstream Action: Tackling the Social Determinants of Oral Health Inequalities. *Community Dentistry and Oral Epidemiology*. 2007;35(1):1-11.
  104. Whitehead, D. Health Education, Behavioural Change and Social Psychology: Nursing's Contribution to Health Promotion? *J Adv Nurs*. 2001;34(6):822-32.
  105. Gorin, S. S. Models of Health Promotion. In: Gorin SS, Arnol J, editors. *Health Promotion in Practice*: John Wiley & Sons; 2006.
  106. Giampaoli, S. Primordial Prevention of Cardiovascular Disease - the Role of Blood Pressure. *European Cardiovascular Disease* 2007;3(2):20–1. 2007.
  107. World Health Organization. Disease Prevention and Early Detection of Disease: World Health Organization; 2018 [Available from: <https://www.emro.who.int/about-who/public-health-functions/health-promotion-disease-prevention.html>].
  108. Institute for Work and Health. Primary, Secondary and Tertiary Prevention: Institute for Work and Health; 2015 [Available from: <https://www.iwh.on.ca/what-researchers-mean-by/primary-secondary-and-tertiary-prevention>].

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