## HEALTH PROMOTION AND ITS NATIONAL CONTEXT

**AIM:** To explain the meaning, process and reasons for health promotion and the related terms risk management, action research and health planning. To describe the development of Australian health promotion in the context of national and international policy development. To explain the potentially transformative process of a holistic and effective approach to health promotion in Australia.

## A HOLISTIC APPROACH TO HEALTH PUTS THE PHYSICAL BODY IN CONTEXT

In 1946 the World Health Organization (WHO) of the United Nations (UN) defined health as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. This is a much wider perspective than the medical model of health, which places the emphasis on finding a cure for physiological symptoms and infirmities, rather than on dealing with the total environment, which may have wholly or partly caused the physiological condition.

Thus, health promotion has a focus on protection of health and prevention of illness, as distinct from its treatment. It also deals primarily with total population health, or that of specific communities, rather than with the situation of the sick individual. It focuses primarily on the environmental and social influences that adversely affect health in order to reduce their risks. It may also try to influence risky and thus potentially damaging behaviours, such as smoking, high fat diet, lack of exercise, unsafe use of alcohol or unsafe sex.

Our genetic make-up and age are vital factors explaining our level of health. However, there are other important influences such as socio-economic status (wealth) and related lifestyle. An eminent American study of the ten leading causes of death in the US concluded that of all deaths:

> 50% of premature mortality could be attributed to unhealthy behaviour and lifestyle; 20% to human biology; 20% to the physical environment and 10% to inadequate health care. (Australian Institute of Health and Welfare, 1992, p.19)

Consider the kind of economic and social factors which might contribute to these estimated percentages in the US and how they might differ in underdeveloped and developed countries.

A study of Australians in a global context shows that their health is comparatively very good, except for the health of indigenous people. This comparison will be undertaken in the next lecture, which primarily addresses two concerns. Firstly, there is a clear relationship between being poor and early death, globally and also within countries. Secondly, health is strongly influenced by the natural, economic, political and cultural environment, including the management of work and unemployment. It is difficult to separate the influence of these powerful structural factors on health from the social relationships and personal habits adopted by individuals, which may also explain their wellbeing or lack of it.

Great leaps forward in public health have been made in all countries where governments have undertaken major engineering related development to ensure clean water supply and effective sanitation and drainage. Housing standards are also important and relate closely to wealth. However, major causes of death in Australia tend more clearly to relate primarily to personal lifestyle - particularly the long-term effects of smoking, alcohol consumption and obesity. To what extent we can blame ourselves or tobacco, alcohol and fast food advertising for this remains a moot question. We should tackle both our personal and political problems.

Health is also influenced by cultural attitudes to risk and levels of health related knowledge. For example, motor accidents and work related accidents are a major problem globally and also in Australia. It is a general cultural expectation in this country that men will take more risks at work and in play than women, and they generally do. State of mind, such as feelings of being stressed, anxious, depressed or angry are also important health indicators related to the surrounding culture. For example, high youth and indigenous suicide rates are an Australian national shame. All cultural risk factors are in turn related to our family history, identity and feelings of personal worth. When we think of our health in a holistic way, we begin to realise that we may be able to understand and do a lot more to prevent and treat many of our sicknesses than a doctor can.

**HEALTH PROMOTION FOCUSES ON ILLNESS AND INJURY PREVENTION**

The Australian National Health and Research Council (NHMRC) is the principal expert body advising the elected politicians who are Commonwealth and State Health Ministers – the Australian lawmakers. The implementation of policy is the responsibility of government health departments, regional health services, local governments and a wide range of other organizations, depending on the issues of concern. In 1995 the NHMRC stated that the attainment of population health should be guided by four basic principles which encompass a focus on prevention, an understanding of the causes and determinants of illness, evidence based practice, and community participation in decisions which affect health. Australian development has generally followed the principles adopted by nations which signed the WHO Ottawa Charter in 1986. It states that health promotion calls for building healthy public policy; creating supportive environments; strengthening community action; developing personal skills and reorienting health services to meet cultural and personal needs more effectively.

In Australia, the focus on **prevention** of disease is vital in an era when the introduction of the universal, taxpayer funded Medicare system has meant that Australians may tend to think of health as the doctor's business rather than their own. However, the greatest contributions to extending life in the 20$^{th}$ century have come primarily from general social development and public health measures such as sewerage, drainage, rubbish removal, water provision and purification, immunisation, personal hygiene, better family planning and improved nutrition. Without **community participation** in decisions which affect health we would not be a proper democracy, and individuals would become even more passively accustomed to the idea that professionals should and do know much more about us than we know about ourselves. Constantly looking for **the causes and determinants of illness** is vital, for our health as individuals and communities, so that we can promote our own health, and not become passively dependant on the medical prescription, whether or not it is effective, and regardless of its side effects. The latter may be substantial. We know, for example, that the inappropriate use of antibiotics simply makes their future use less effective for everybody.

The success of pharmaceutical research and the pharmaceutical industry, in combination with the increasing influence of the medical profession, have meant that today we tend to focus on physiological explanations for illness, whether our symptoms are physical or mental. We tend to think of unwanted mental state as needing medical treatment, and there is a thriving medical drug industry, at the same time as other mind altering substances are considered major social problems or are banned. The development of **evidence based** practice is necessary so that we know, as a community and as individuals, which treatments really improve our health and which are mainly just costing us money or even causing additional problems. Because most of the money for health research currently goes towards drug and medical research, we have little idea of whether other treatments for mental or physical disability might be just as effective.

## HEALTH PROMOTION HAS SIMILARITIES WITH RISK MANAGEMENT

Work and unemployment may both be causally related to poor health. The NHMRC's definition of health promotion is a general one consistent with the concept of risk management, which is required in all Australian workplaces as a result of the passing of state occupational health and safety (OHS) acts in the 1980s. Under OHS acts every employer must provide a safe place of work and workers must work safely. Employers are responsible for the identification and treatment of risks at the workplace in consultation with workers who must be provided with information and training relevant to working safely. The process of health risk identification and treatment is simple and clear. It can be applied to reduce risks not only for workers, but also for consumers, the broader community or the environment.

The risk management process is outlined in the Australian risk management standard (AS/NZS 4360:1999), produced by the Australian Standards Association. It is defined as a logical and systematic method of identifying, analysing, assessing, treating, monitoring and communicating risks associated with any activity in a way that will enable organizations to minimise losses and maximise opportunities. In order to undertake the risk management process a person must **consult** with relevant others to establish the work context for the undertaking. They then **identify** the risks, which appear to exist in that work context. The risks are **analysed and prioritised** in terms of their likely severity and frequency. Strategies to **treat** the risks are then devised, implemented and **monitored**. The outcome of these strategies is then **evaluated.** This process is also consistent with the basic requirements of quality management and environment management as they are outlined in international standards (ISO 9004.1 and ISO 14004).

Hazards to health are best controlled at their source if possible, rather than by providing personal protective equipment, which may have other problems. An engineering solution for a hazard might be introduced (such as a machine for lifting patients in a hospital). Alternatively, a less hazardous chemical might be used in production, in substitution for a more toxic one. If a hazard cannot be engineered out, or isolated from where major production is occurring, it may be possible to change work processes to reduce exposure to it. For example, rotating groups of workers so that they are not constantly working on the same tasks but have job variation may reduce their risk of occupational overuse injury. Unless the injured person is a truck or machine driver, machine related injury appears less likely than in the past, when machines were often manufactured without effective guards in place, or guards were taken off to speed up production. Repetitive manual handling, the use of chemicals in production, and noise remain major sources of slow onset injury or disability for workers in Australia today. Work related stress and psychosocial problems also need to be faced and dealt with as early as possible. Seeking medication for stress could produce additional dangers at work.

## HEALTH PLANNING IS DIRECTLY RELATED TO HEALTH PROMOTION

In health planning one also looks at a community and its environment in order to identify and prioritize the major risks to health in order to control them. Eagar, Garrett and Lin provide a range of health planning schemas which outline related and straightforward cycles of data and goal driven consultative behaviour aimed at continuous improvement of environmental and health service outcomes. Two examples of activity cycles are provided below. Which of them may be appropriate will depend upon the job to be done. However, both establish similar processes of goal setting, action and review. You should think about how such activities might help you gather and act upon evidence in order to achieve continuous improvement in processes and outcomes related to health promotion or health risk reduction in specific situations.

**Goal setting:** through identification of problems to be solved, needs to be met, opportunities to be seized and aspiration of stakeholders to be met.

**Plan formulation:** through systematic analysis of alternatives, setting of criteria to choose amongst the options, and examination of consequences of proposed actions

**Plan implementation:** through deploying a range of actions such as budgets, project schedules and regulatory measures

**Monitoring and feedback:** through reviewing achievements and updating the information, thus maintaining the currency of the plan.

Or, as another example:

1. Select health issue(s) of concern
2. Identify risks
3. Evaluate population risk levels (at present and in future)
4. Select program to eliminate or reduce risks
5. Compared needed programs with existing programs
6. Adjust resources
7. Evaluate

## HEALTH PROMOTION HAS SIMILARITIES WITH ACTION RESEARCH

The philosopher Karl Popper stated that all social administration should be conducted as experimentation and thereby combine discovery and implementation in one process. Kurt Lewin is sometimes seen as the father of action research, which has similarities with this experimental approach to social administration. Lewin stated that action research proceeds in a spiral of steps composed of a cycle of planning, action and fact finding about the results of action. He also noted the importance of standards, saying that one cannot judge whether an action has led to improvement unless one has criteria for evaluating the positive or negative relationship between effort and its desired outcome. Action research is particularly popular with the teaching and social work professions, working with students and communities. Kurt Lewin and the Tavistock School of researchers often also worked in a manufacturing industrial relations context.

Hart and Bond say that action research is cyclic action in which aims, actions and evaluations are linked. The characteristics of action research are that it is:

- educative
- problem focused and future oriented
- a change oriented intervention which aims at improvement, and stakeholders may participate

I have provided all the above discussion to show that health promotion is a relatively straightforward process, which just about anybody can do at a basic level. It may be called different things and given different emphases depending upon each writer's specialist background, career goals and level of sophistication. However, as the great British scientist Thomas Huxley said at the end of the 19th century:

> ‘The vast results obtained by science are won by no mystical faculties, by no mental processes, other than those which are practised by every one of us, in the humblest and meanest affairs of life’.

In other words, try searching for good evidence, think it through with interested others, and use your common sense to make decisions in the light of the information gathered and the related general expectations about what is good practice. You will be surprised how useful the application of common sense is. It beats rote learning almost every time.

**AUSTRALIAN NATIONAL HEALTH PROMOTION GOALS BEGAN IN THE 1980S**

In 1981 Australia formally committed itself to the promotion of better health. This followed the WHO Alma-Ata declaration, which established health as a fundamental human right and stated the highest possible level of health is a most important world goal. In 1986 Australia’s Better Health Commission was established and produced the report 'Looking Forward to Better Health'. This was the same year that the WHO produced its Ottawa Charter, which stated that the supports for health include peace, shelter, food, income, a stable economic system, sustainable resources, social justice and equity. The implications of this view are enormous if government takes them seriously, because health becomes not merely one of many government portfolios and activities, but the broad umbrella goal beneath which all other policy should be developed and implemented. For example, to think of the control of violence in a health related context produces quite different policy remedies than those formed in an earlier era.

This holistic and health centred approach to life was assisted by the 1992 UN Declaration on Environment, which committed signatories to ecologically sustainable goals. The first principal of the Rio Declaration is that health is at the centre of human development and that all people are entitled to a healthy and productive life in harmony with nature. Undertaking programs to improve air and water quality or to reduce loss of biodiversity and improve land use should connect us back to a more healthy life in general. This work is also necessary for the wellbeing of future generations. Planning community education and employment strategies, which are related to environment protection, should be a key aspect of sustainable development policy.

In 1988 'Health for All Australians' was Australia's plan for achieving the goal of health for all by the year 2000. Australian Health Ministers set national goals, targets, strategies and performance measures aimed at better health outcomes into the twenty-first century. The conditions targeted for health promotion and improved health service delivery were based on the most common causes of hospital entry and death in Australia. These are cardiovascular disease, cancers, injury and mental health. A national program aimed at improving Aboriginal health was also established because indigenous people die fifteen to twenty years earlier than other Australians. Diabetes prevention and management and a range of other national health priorities, were later added.

The Australian national criteria for setting health goals include their public health significance; the ability to effectively implement practices to achieve them, and the ability to measure achievement. The importance of developing benchmarking is also taken into account. Benchmarking is the ability to undertake performance comparison, preferably based on consistent international and national data collection.

Social justice goals contained in the national health goals, targets and strategies have particular relevance for the health of people of lower socio-economic status, non-English speaking background and indigenous people. Principle national goals are that Australians should have access to a comprehensive range of health care services regardless of financial status, race,

culture or language, and that health services should be of consistently high quality across Australia. Fostering participation of communities and individuals in decision making at all levels of health service planning and delivery, in order to identify and reduce barriers to access are key related goals. People should know they have these national rights in policy, to ensure they are obtained in practice.

## STATE GOVERNMENTS IMPLEMENT JOINTLY DEVELOPED NATIONAL GOALS

Australian State and Territory governments agreed to implement strategies in their regions in order to achieve national health goals. In NSW the government's 'Vision for Health' outlined the strategies to be undertaken in that state in support of the national health goals and targets related to cardiovascular disease, cancers, injury and mental health, and to deal with additional issues of major concern such as HIV/AIDS, diabetes, and some key problems for the health of men, women, children and rural dwellers. One plan, for example, was to integrate diabetes services more effectively into the public health system and into health services provided by the private sector. A major aim is to improve access to diabetes care for Aboriginal communities and others in rural areas.

The NSW government's 'Vision' is that a philosophy of continuous improvement will be adopted in all areas of government health responsibility. This is hindered by the fact that many health services provide little comparable or publicly available information about their treatment outcomes. Another problem is that the research and education goals of higher education and related institutions are driven mainly by professional aims rather than being co-ordinated to critically assist the achievement of national and regional health priorities. A third concern is that knowing what diseases kill and hospitalise people is only the first step in the development of a more holistic and better managed approach to identifying and treating community health problems, which may be multiple and interrelated. For example, an unemployed person may know that the combination of boredom and chain smoking may be killing them and costs a lot of money, but may also need the discipline of smoke free workplace requirements to help them stop.

## A CONTRACTUAL, OPEN APPROACH TO SERVICE DELIVERY IS REQUIRED

In 1999 the national expert advisory group on safety and quality in Australian health care recommended that Health Ministers lead the way in promoting a safety and quality enhancement ethos throughout the whole health system. They suggested that national requirements for health care organizations to develop, maintain and review readily accessible consumer information could be specified through government health care agreements and related contracts. They recommended a national effort to improve the education and training of health providers and administrators in order to improve their readiness to work in a team environment and advised that curricula for continuous quality improvement should be included in all undergraduate, postgraduate and continuing education and training. Much more emphasis needs to be given to holistic, regional and community based health-planning, promotion, and also to related education and research. What are the problems for health that can be identified in your community? How should they be prioritised in relation to their severity and frequency of occurrence? What steps might be taken with others to reduce these problems? What was the outcome of these activities?

## POLICY IS MADE IN AN INCREASINGLY INTERNATIONAL MARKET

The emerging world view, reflected in international trading agreements, is that, unless another course of action is shown to be in the public interest, elected governments should primarily be the regulator or community standard setter, rather than the provider of specific services. However,

government should also ensure effective provision of crucial services to a nationally required minimum standard, especially in areas where the community needs them, but where the market neglects to provide them because they are unprofitable. The private sector should primarily be the provider of goods and services, but both private and public sector service providers should do this as competitively and transparently as possible. Openness is necessary so that all people can compare outcomes of service provision, in order to promote continuous improvement.

The private sector appropriately has profit as its primary goal, but it must also conform to law and related government policies. Government organizations may provide services in addition to their primary regulatory functions. When they do so, their legislated goals and related requirements should drive their service delivery behaviour. However, they should also undertake these functions according to good commercial principles. Where both the private sector and government provide services, they should normally do so on a 'level playing field', that is according to the same (national) rules and standards. This emerging global consensus has led to Australia selling off or contracting out a range of services formerly provided by government. When services are contracted out, strong surveillance over operations should be maintained, so that competitive outcomes are known to communities, taxpayers and those who serve them. The community generally need to extend their surveillance capacity over all professional activities and their outcomes, to ensure that service outcomes are transparent to purchasers and users.

## NATIONAL STANDARDS GUIDE REGIONAL AND LOCAL COMMUNITIES

Australia is seeking to develop a national economy with related national standards which may guide development undertaken by local communities. However, the establishment of non-Aboriginal law and policy direction in Australia has been primarily State based. This is because the present day Australian political context grew from 19th century white settlements. Before 1901, when the federal Constitution was adopted, the Australian States were British colonies independent of each other. Constitutionally, the Commonwealth of Australia was a federation of six states. Australia now has 20 million people and almost one third of them are in New South Wales. The country needs to have a single set of clear national laws, which are regionally administered. Differing state and territory laws and administrative requirements are expensive red tape, which also hinder effective comparison of the performance of governments, and of all other private or public sector organizations.

In 1989 state governments began a staged review of all their laws to update their requirements and make them clear. During the early 1990s a number of special meetings of the Council of Australian Governments (COAG) supplemented the regular meetings of the Ministerial Councils where all State, Territory and Commonwealth Ministers from each government portfolio meet to decide upon policies which may later be translated into law across Australia. COAG brought together all heads of government, including the Prime Minister, the state and territory Premiers or Chief Ministers, and the President of the Australian Local Government Association, with a totally new sense of unity and purpose centred on bringing about a more competitive and integrated national market, and developing more efficient and effective arrangements for the delivery of services in areas of shared government responsibility.

The COAG conferences agreed to mutual recognition of state laws and regulations where national standards and regulations were not seen as essential to the efficient working of the national economy. The meetings also decided to reform government generation and expenditure of funds. If the Commonwealth pays for services then perhaps it should also establish their national policy, and the States should administer it. Currently the States have the major policy responsibilities, but the Commonwealth has the taxation and funding powers.

Among other things, COAG agreed that uniform food standards should apply across the nation and be regulated by a national food authority, which would seek to promote consistency between domestic and international food standards, in recognition of the benefits to be gained from increased international harmonisation. COAG also agreed to national policy and regulation of the use of chemicals in all areas of Australian life. It agreed to pursue a national approach to transport, electricity, and financial institutions. Commitment was made to the rationalisation of overlap or duplication of legislation and services in many other areas including health, aged care, housing, training and labour market programs, disability services, and child care. There was also consideration of a report by the newly established Commonwealth Aboriginal and Torres Strait Islander Commission (ATSIC) to achieve greater co-ordination of the delivery of programs and services by the three levels of government to Aboriginal and Torres Strait Islanders. (This body was abolished in 2004, in favour of greater local community responsibility for indigenous health.)

COAG also agreed on the development of an intergovernmental agreement on the environment. There was consensus about the need to develop national guidelines for air and water quality standards, and for a national approach to the assessment and control of genetically engineered organisms. National leaders also gave particular attention to national ecologically sustainable development requirements and the greenhouse effect. They recognised that new economic and trade opportunities could open up for Australia through the development of more environmentally sound processes and products, and agreed to encourage industry to vigorously take up this challenge. How can these goals be implemented in the Australian regional and local context?

In related meetings COAG agreed to the development of national standards for occupational health and safety, including the transport, storage and use of dangerous goods. Members also agreed that disability services, social security benefits and labour market programs should primarily be the responsibility of the Commonwealth rather than the states. Mutual recognition for occupations and training was indicated as preferred only in cases where health and safety or environmental considerations dictated that national standards would not be more appropriate.

COAG adopted four principles for the allocation of roles and responsibilities among levels of government in Australia. The first was the **Australian nation principle** which stated that all governments in Australia would recognise the social, political and economic imperatives of nationhood and work co-operatively to ensure that national issues are resolved in the interests of Australia as a whole. The **subsidiarity principle** stated that responsibilities for regulation and for allocation of public goods and services would be devolved to the maximum extent possible and consistent with the national interest, so that government is accessible and accountable to those affected by its decisions. The **structural efficiency principle** requires increased reform in the public sector to complement private sector reform, and indicated that inefficient Commonwealth/State divisions of function could no long be tolerated. The **accountability principle** required the structure of intergovernmental arrangements to promote democratic accountability and the transparency of government to the electorate.

In late 1992 the Commonwealth passed a Mutual Recognition Act which allowed Commonwealth law to override any State or Territory law which is inconsistent with the principles of mutual recognition. In 1993 States and Territories passed mutual recognition legislation of their own. Such matching legislation was necessary because under the Australian Constitution it was unlikely that the Commonwealth could impose mutual recognition requirements on reluctant states. The adoption of mutual recognition legislation thus entrenched the powers of the Commonwealth to give effect to a bone fide international treaty on any subject. International treaties are normally ratified by Australia as a result of each State first indicating separately that

its laws and related service provision already meet the requirements of the relevant convention. If an international convention is signed before this occurs, it means that a lot of new money will have to be found for its implementation.

## NATIONAL COMPETITION POLICY ALSO REQUIRES IMPLEMENTATION

In mid 1994 national competition policy was introduced followed by the Competition Policy Reform Act in 1995. Before this happened the Hilmer report had recommended examination of laws restricting competition and supporting monopoly. Hilmer argued that no participant in the market should engage in anti-competitive conduct unless this is in the public interest, and that universal and uniformly applied rules of market conduct should apply to all market participants regardless of the form of business ownership. Any conduct with anti-competitive potential said to be in the public interest should be required to be assessed by an appropriate transparent assessment process, to demonstrate the public costs and benefits claimed. Hilmer argued that competition policy should be consistent with, and support reforms to develop an open, integrated domestic market for goods and services. It should remove unnecessary barriers to trade and competition, and reduce complexity and eliminate administrative duplication in recognition of the increasingly national operation of markets.

Review of all Australian law then began as a result of the government requirement to implement competition policy. This process has allowed a great many important health policy issues to be pursued in a comparatively democratic way. Review advertisements are placed in the newspapers and any group or individual may make a submission, sometimes after consideration of an issues paper produced by the review. In this way the laws are considered by parliament after consultation with a wide range of experts and stakeholders. The idea is develop a more rational regulatory structure where the costs and benefits of national policy and regulation are more open to public input, more evidence based, and reviewed on a regular basis. Without this approach, laws become increasingly outdated, inconsistent, incomprehensible and overly influenced by the specific conditions of particular court cases. The fact that many people know nothing of the law does not alter the reality that its prescriptions determine how taxpayer's money is supposed to be spent. Every health worker should get used to reading law to find out about health entitlements and many other matters. You may search for information related to any Australian law at www.austlii.edu.au Basic plain English information on law is also available on Australian government websites.

## HEALTH PROMOTION OCCURS AT A VARIETY OF ORGANISATIONAL LEVELS

Health promotion may be carried out with a consistent approach but at a range of very different levels of complexity – internationally, nationally, regionally, on an industry, workplace or local community basis, or in regard to a particular hazard or problem. First examine the environmental context to identify and prioritize the problems. Then establish the goal of the health promotion program. Outline and implement actions to achieve the goal. Try to measure the results.

For example, according to the Australian Institute of Health and Welfare, tobacco smoking is the single largest preventable cause of death in Australia. The main elements of public health action in tobacco control are:

- Taxation policies
- Regulation of tobacco products
- Promotion of (and in some cases, legislation for) smoke-free indoor areas
- Education campaigns

- Community development and partnership building

People working on such a large problem would obviously require a very diverse range of skills and knowledge. An effective focus on population health also requires not only the national elevation of health policy, but also its integration with major portfolios where Ministers and their departments are used to operating in a much more independent and isolated fashion (in secretive, empire building silos). The development of a national health promotion focus can become a major tool for improving the nation. Alternatively, it can mainly be a source of reports put out by public servants in publicly funded health service administration areas, which are largely ignored.

**YOU USUALLY NEED TO TAKE A BROADLY COORDINATED PERSPECTIVE**

In your work and life you should try to make sure that the necessary transformation to a health focused view of Australian policy and life occurs. This usually requires one to work broadly and democratically, and also to accept responsibility. Some health workers tend to stick their head in the sand about the cost of health treatments, or froth at the mouth about 'economic rationalism' without looking at whether expenditure is good or bad value for the community and taxpayer. In fact, one of the most useful things a health worker can do is to take an intelligent interest in all aspects of health and economic management in order to become involved in ensuring that good health policy brings about a better society. This is far from an impossible dream, but it usually requires a much broader perspective than one's own professional and specialist advancement.

If you were a health service manager employed by industry or in the community, your employer might also put you in a position to make workplace hazard reduction a major aim. To undertake your project you would first gain approval from your employer to develop **a prevention program**, including a related **time frame** and **budget** to support the following components:

- Establish a planning group
- Assess the needs of the community in the workplace
- Identify the program goals or targets (a target is usually numerical, e.g. manual handling injuries will be reduced by 20% in the target population over a 2 year period)
- Clearly set the program goal/s
- Set the program objectives (these may be specific subsets of more general goal/s)
- Develop strategies (activities to reduce the problem)
- Design the action plan
- Evaluate the outcome (Performance indicators are evaluation measures. In regard to manual handling the performance indicator is likely to relate to the original injury reduction targets established earlier.)

A similar program might be developed for a community rather than a workplace context. This is discussed in later lectures.

## CONCLUSION

Health promotion involves a focus on preventing the causes and determinants of illness, evidence based practice and community participation in decisions affecting health. It is broader than the medical approach, which focuses on treating the sick individual. The process for undertaking health promotion is similar to that of health risk management, a term familiar in the Australian workplace as a result of OHS requirements. It involves establishing the strategic and

organisational context in order to identify and prioritise the health risks, which are inherent in the work and its environment. Strategies to treat the risks are then devised. The outcome of practice is then evaluated. Doing this is consistent with the requirements of quality management. In Australia, national health priorities were introduced in the 1980s. They were the reduction of cardiovascular disease, cancers, injuries, diabetes and better mental health. Other goals were added later. A program for improving Aboriginal health is also a major government priority. Some of the key determinants of poor health in Australia are work and unemployment, smoking, alcohol abuse, lack of exercise, poor nutrition, obesity and motor accidents. Suicide is a major mental health problem. For best results a wide range of strategies require development and research into their comparative effectiveness. A more holistic and regionally managed approach to health promotion and community development is necessary in the future. This is required by the national policy direction and common sense.

**FURTHER READING:**

While this lecture has been based on a wide range of books and articles, those books listed below may be of particular interest. What you may want to read depends on where you are going. The Australian Institute of Health and Welfare is an authoritative source, which produces an overview volume entitled **Australia's Health** every two years. If you read a number of recent editions you will develop an understanding of current directions. Some other suggestions are outlined below. Although the recommended publications depend on the particular lecture, they may also be useful in relation to other topics discussed in this subject.

Commonwealth Department of Human Services and Health, Better Health Outcomes for Australians, AGPS, Canberra, 1994.

Eagar, K., Garrett, P and Lin, V. Health Planning: Australian Perspectives, Allen & Unwin, 2001.

Hart, E. and Bond, M. Action Research for Health and Social Care, London, Open University Press, 1995.

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NSW Health, Caring for Health: The NSW Government's Vision for Health, Govt. Printer, Sydney, 1995.

Osborne, D. and Gaebler, T. Reinventing Government, Plume Division of Penguin Books, USA, 1991.

Standards Australia, Risk Management, AS/NZS 4360:1999, Strathfield, 1999.

Wass, A. Promoting Health, Harcourt Brace & Co., Marrickville, 1994.