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Promoting Better Health Through Healthy Eating and Physical Activity

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Victorian Auditor-General's Office

Auditing in the Public Interest

The Hon. Robert Smith MLC
President
Legislative Council
Parliament House
Melbourne

The Hon. Jenny Lindell MP
Speaker
Legislative Assembly
Parliament House
Melbourne

Dear Presiding Officers

Under the provisions of section 16AB of the *Audit Act 1994*, I transmit my report on *Promoting Better Health Through Healthy Eating and Physical Activity.*

Yours faithfully

DDR PEARSON
Auditor-General

20 June 2007

Foreword

As a public policy objective, good health has few rivals. Good health underpins people's enjoyment of life and their contribution to the community. In addition to its social importance, the economic importance of good health is clear to all.

Today, some of the major threats to good health are largely avoidable. Physical inactivity, unhealthy eating and being overweight are the most important preventable causes of chronic diseases such as type 2 diabetes, heart disease and many types of cancer. The social and economic costs of these diseases are enormous and have the potential to increase significantly over the coming years.

Health promotion activities aim to reduce the incidence of chronic disease by encouraging people to adopt healthier behaviours. This audit examined whether the Victorian Government's investment in health promotion had encouraged Victorians to adopt healthier eating habits, to exercise more regularly and to achieve healthy weight levels.

The audit found that the Government had recognised the risks presented by the growing number of Victorians who are overweight or obese. Government agencies were found to have acted to address these risks by better coordinating their activities, by improving how they planned the activities, and by gathering better evidence as a basis for these plans.

However, these efforts have not significantly slowed the increase in obesity nor the incidence of preventable chronic disease. The audit found that the current approach to promote healthy eating and physical activity needs to be strengthened. The evidence base, and therefore the targeting of effort, could be improved, as could the planning and coordination of programs across government.

The audit recommends that the health promotion agencies work together to upgrade the evidence base used to guide and refine the State's health promotion activities. With respect to planning and coordination, the audit recommends that the Department of Human Services (DHS) should lead the development of a comprehensive and detailed plan to address obesity in Victoria. The audit further recommends that DHS should review the adequacy of the governance arrangements for health promotion in Victoria to maximise the benefits of whole-of-government coordination.

DDR PEARSON
Auditor-General

20 June 2007

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1 Executive summary

1.1 Background, scope and objectives

For Australians, about 70 per cent[1] of the burden of disease is due to chronic conditions. These conditions have many, complex causes. They are persistent, and lead to worsening health and often death. The most common chronic conditions are cancer, heart disease, lung disease, stroke, diabetes, arthritis, asthma and depression[2].

For Victorians, about one-third of the chronic disease burden has been attributed to changes in largely avoidable risk factors such as tobacco smoking, excessive alcohol consumption, physical inactivity, unhealthy eating and excess weight. Over the last 30 years, lifestyle changes in exercise and eating habits have led to more Victorians becoming overweight or obese. Taken together, physical inactivity and unhealthy eating are the most important, preventable causes of chronic disease and their impact is increasing.

The economic and social costs to Victoria are significant and, on current trends, are set to increase rapidly over the next decade. The rise in type 2 diabetes is one such example of a chronic disease that is closely connected to these risk factors.

The number of Victorians living with diabetes increased by 77 per cent between 2001 and 2006 driven by the additional 68 000 people diagnosed with type 2 diabetes[3]. Hospital admissions for diabetes complications have more than doubled over the same period. The direct, annual health costs of diabetes in Victoria rose from $361 million in 2001 to $637 million in 2006. On current trends, costs will exceed $1 billion by 2015.

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[1] National Public Health Partnership 2001, *Preventing Chronic Disease: A Strategic Framework Background Paper,* National Public Health Partnership, Melbourne.

[2] National Health Priority Action Council 2006, *National Chronic Disease Strategy*, Department of Health and Ageing, Canberra.

[3] Diabetes Australia – Victoria 2007, *New and Total Victorian Registrants for the National Diabetes Services Scheme 2002-2006,* Diabetes Australia – Victoria, Melbourne.

There is an increasing body of evidence to illustrate the effectiveness of health promotion to reduce the onset of chronic disease[4]. Health promotion is about preventing disease and promoting wellbeing by:

- providing people with the information, support and motivation to encourage and enable them to adopt healthy lifestyles
- changing peoples' life circumstances to remove the social, economic and environmental barriers to adopting healthier lifestyles.

The audit assessed whether Victoria's health promotion strategies have been effective in addressing the risk factors of unhealthy eating and physical inactivity. We reviewed the plans and programs of 7 lead agencies involved in health promotion and 43 local agencies delivering programs within 7 council areas. We examined whether these agencies had:

- formed well-informed and coordinated plans
- implemented these plans as intended
- evaluated how well plans had achieved their objectives.

1.2 Conclusions

The growing importance of obesity has been recognised in Victoria. Positive steps have been taken by the Department of Human Services (DHS) and other agencies and there are plans to do more. These positive developments include:

- setting up the *Go For Your Life* initiative to coordinate a whole-of-government approach to physical inactivity and unhealthy eating
- helping local agencies improve their health promotion planning by providing best practice frameworks and assisting them to apply these
- funding programs to collect some objective information on these risk factors and compiling evidence on what programs work best to address them
- increasing funding for programs to encourage physical activity and healthier eating.

However, to date, the combined efforts of government have not significantly slowed the increase in obesity underpinning the rise in preventable chronic diseases such as type 2 diabetes.

This audit found some gaps and weaknesses in the current approach to promoting healthy eating and physical activity. The audit identified a need to strengthen:

- the evidence base used to guide and refine the State's investment
- the planning and coordination of programs across government.

[4] National Public Health Partnership 2001, op. cit.

To strengthen the evidence base, agencies need to:

- build a better understanding of the risks and outcomes of unhealthy eating and physical inactivity through improved data gathering and monitoring
- compile and distil the lessons on what works best from the existing evidence, and apply this knowledge when forming and updating plans
- consistently evaluate the effectiveness of programs in terms of their impact on unhealthy eating and physical inactivity.

To strengthen planning and coordination, agencies need to:

- further improve the current cross-government plan to tackle obesity
- make sure that the current governance arrangements are capable of delivering a plan to significantly reduce the exposure of Victorians to these risk factors.

1.3 Recommendations

Part 7: Strengthening the approach to health promotion

1.1 That DHS designs and implements an ongoing approach to data collection and monitoring that will inform the plans of lead and local agencies through an objective understanding of obesity-related risk factors, and the consequent health and wellbeing risks and outcomes.

1.2 That DHS, VicHealth and the Department for Victorian Communities (DVC) work to improve agencies' understanding of the evidence on program effectiveness by setting up a structured approach to:

- review the existing evidence and distil guidance on the effectiveness of programs to address the risk factors underpinning obesity
- identify the important gaps in our understanding and implement a plan to address these gaps
- update guidance on program effectiveness in the light of further research and the ongoing evaluation of programs in Victoria
- put in place mechanisms to communicate this guidance across central government and to the local agencies responsible for planning health promotion programs.

1.3 That DHS, VicHealth, DVC and the Department of Education collaboratively improve the evaluation of the health promotion projects they fund to address unhealthy eating, physical inactivity and obesity by:

- designing evaluation frameworks to measure the impacts of programs on these risk factors
- working with other lead agencies to use consistent indicators of impact across similar programs
- providing practical guidance and training to local agencies showing them how to apply these frameworks
- using this information to report on the impacts of programs.

1.4 That local councils regularly evaluate Municipal Public Health Plans and, in the design and scope of the evaluation, include information to understand how these plans have achieved their objectives.

1.5 That the *Go For Your Life* (*GFYL*) secretariat coordinates the development of a comprehensive plan to address unhealthy eating, physical inactivity and obesity for Victoria. The plan needs to:

- use the existing evidence to set specific objectives for each population group
- define a coordinated and costed program to achieve these objectives
- provide detailed evaluation and reporting frameworks to ensure that the impacts of projects on the program objectives are clearly understood
- document the mechanisms for adjusting the plan in the light of the emerging evidence on effectiveness.

1.6 That DHS reviews the current *GFYL* governance arrangements and makes recommendations on the arrangements needed to deliver effective whole-of-government programs to reduce obesity. In conducting the review DHS should consult the other lead agencies working in this area and seek input from the State Services Authority in relation to good practice governance arrangements.

RESPONSE provided by Secretary, Department of Human Services

The Department of Human Services welcomes this report. The Department has placed significant emphasis on strengthening health promotion practice in recent years and your report identifies positive developments that have occurred in the promotion of physical activity and healthy eating to prevent disease and reduce its unequal burden.

Through 'Go for your life' and other key initiatives such as the roll out of statewide health promotion priorities, the Department is demonstrating an ongoing commitment to working across sectors to further develop the state's approach to promoting physical activity and healthy eating. The 'Go for your life' Strategic Plan (released in October 2006) and the new governance arrangements agreed by Ministers in May 2007 provide a framework for these activities. The plan also commits the Government to long-term action, leveraging where it can the involvement of the whole community, including other levels of government, non-government organisations, professional and peak bodies and industry.

DHS also acknowledges the challenges highlighted in the report. Action is required to further develop and apply the evidence base for the promotion of physical activity and healthy eating to policy and practice. Improving planning and coordination across government and agencies, and collaborative work with those outside government are clearly key considerations. The Department has identified a number of priority projects to address these challenges.

The current review of the Victorian Population Health Survey and the pilot of the Victorian Health Monitor planned for 2007/08 aim to address existing gaps in the Victorian health surveillance system and improve access to data on health and lifestyle issues.

Action on the health promotion priorities will include the development of new evidence-based resources on two key risk factors underpinning obesity- physical activity and accessible and nutritious food, and will better support agencies to use evidence to guide their practice.

Existing evaluation frameworks, which have been noted in the audit report, require a renewed focus to ensure that agencies are supported to use them in practice. The establishment of common indicators relating to the risk factors of physical activity and accessible and nutritious food will be a key area of work to support this.

An effective approach to the promotion of physical activity and healthy eating relies on strong links between research/evaluation, policy, practice and monitoring. While a number of initiatives are underway to strengthen these links, I am confident that the recommendations contained in this report will guide further work by DHS to address these important issues.

RESPONSE provided by Chief Executive Officer, VicHealth

VicHealth congratulate the audit team on the report and the sound recommendations that have been developed to improve the state's investment and effectiveness in health promotion. Strengthening the evidence base and better planning and coordination of programs across government are critical factors that are necessary in addressing the risk factors of unhealthy eating and physical inactivity. We look forward to working collaboratively with central and local agencies to implement the recommendations that have emanated from this performance audit. VicHealth recognises that a follow up process to determine progress on the outcomes of the audit recommendations is likely to occur after a 2 year period, however because of the growing importance and urgent action needed to prevent escalation of obesity and chronic conditions we propose that mechanisms for government to report on progress at the 12 month mark be considered.

VicHealth supports the 6 key recommendations outlined on page 3-4 of the audit report. Some suggested word changes, comments and issues to consider are outlined under each recommendation below:

Recommendation 1.1

VicHealth supports this recommendation as collection, coordination and access to complementary data sets that monitor chronic disease related risk factors such as healthy eating and physical activity is lacking.

However any data collection and monitoring must reflect the needs of all central and local agencies that have the responsibility to plan, deliver and evaluate physical activity and healthy eating initiatives. The feasibility of providing data that can be 'broken down' to local area level should be investigated to inform community planning.

There is a significant amount of data currently being collected across a range of central and local agencies including non government organisations, for example: physical education and sport participation by DoE; participation in sport and active recreation activity by SRV/VicHealth through the ERASS survey; physical activity participation administered through the Office for Children's Child Health and Well Being Survey; children's weight related data in Maternal and Child Health Centres and the community survey that has been recently developed by the Community Indicators Victoria project through the McCaughey Centre, VicHealth Centre for Mental Health Promotion and Community Well Being.

Before designing and implementing new systems and approaches DHS should work with stakeholders to investigate existing data sources collected across multiple disciplines and consider ways to aggregate the data and make it accessible to lead agencies and local areas to inform planning.

RESPONSE by Chief Executive Officer, VicHealth - continued

Recommendation 1.2

VicHealth supports this recommendation but recognises that to effectively achieve the desired outcomes (eg. addressing research gaps, disseminating evidence), additional human and financial resources are needed.

Obesity is a complex issue and therefore requires a multi strategic approach across sectors to address the social, environmental and economical determinants. Such an approach makes it difficult to attribute effectiveness to a single intervention. There is a need to broaden the evidence base to go beyond individual behaviour change programs to look at broader systems and environmental changes that are required to reduce the risk of obesity.

VicHealth commends the requirement for DHS, VicHealth and DVC to work together to improve our understanding of program effectiveness however it is critical that a lead agency is identified to 'drive' the process and ensure that the stated activities are implemented and the outcomes achieved.

Recommendation 1.3

VicHealth supports this recommendation and recognises the importance of evaluating the impact of programs as well as the process. Generic indicators by which funded activity at state, regional and local level can be measured is required. Evaluation frameworks will need to reflect an ability to measure effectiveness across different sectors, settings and contexts. Engagement of key stakeholders in the development of these frameworks is essential to ensure relevance and 'buy in' across the State.

VicHealth has been working in consultation with funded projects at a local level to develop evaluation frameworks and common indicator sets to measure program impacts. We have also provided some training and professional development to local agencies on this issue. There appears to be a lack of competency and skill in Victoria to undertake impact and outcome based evaluation. The existing capacity within and external to government to evaluate health promotion activity on an ongoing basis would need to be determined to effectively implement this recommendation.

Again, additional resources will be needed to achieve the outcomes required from this recommendation.

RESPONSE by Chief Executive Officer, VicHealth - continued

Recommendation 1.4

VicHealth supports this recommendation and commend the improvements that local agencies have made in creating a more coordinated approach to the planning and delivery of health promotion.

However local agencies' access to skilled evaluation resources is varied and often limited. Councils have little capacity to undertake impact evaluation, receiving no recurrent health promotion dollars from State/Federal Government sources to plan, implement or evaluate programs.

Recommendation 1.5

VicHealth supports this recommendation and the need to set specific objectives for each population group. The development of a coordinated, programmatic approach to GFYL is favoured rather than funding a range of fragmented initiatives across government that are not linked or coordinated at either a central or local level. The capacity of GFYL secretariat to influence the different funding imperatives of government departments to invest in an evidence based program that addresses obesity in Victoria may require further consideration.

Recommendation 1.6

VicHealth gives in principle support for this recommendation but not in its current form. Our concerns relate to the potential lack of independence and impartiality this version presents. We would suggest that no partners in GFYL lead such a review and that it is conducted by a completely independent party. VicHealth believes that commissioning an agency that is not a partner in the GFYL initiative is essential to ensure objectivity and a non-biased view.

This approach reinforces the message that obesity is a whole-of-government issue and that the responsibility to address it does not lie with one agency alone. In determining the arrangements needed, the independent reviewer should examine the potential role of statutory authorities, non government organisations and local agencies in the effective delivery of whole-of-government initiatives to reduce obesity.

RESPONSE provided by Secretary, Department for Victorian Communities

The Department for Victorian Communities (DVC) supports the audit report and the recommendations provided.

The Victorian Government's 'A Fairer Victoria' policy outlines the State Government's commitment to reducing disadvantage and strengthening communities. This policy complements the Whole of Government 'Go for your life' Strategic Plan (2006 – 2010) which aims to increase levels of physical activity and healthy eating for Victorians and to promote stronger and healthier communities.

RESPONSE provided by Secretary, Department for Victorian Communities - continued

Sport and Recreation Victoria (SRV), through Sport and Recreation 2005-2010: A Five Year Plan for SRV, aims to build an inclusive, collaborative and strong sport and recreation sector supporting a more active Victoria. The promotion of physical activity and greater access and opportunities for participation in sport and recreation by all Victorians is at the forefront of this vision. A dedicated Physical Activity Unit was created in SRV to develop and implement the physical activity segment of the 'Go for your life' strategy.

The Office for Senior Victorians (OSV) is committed to enhancing the quality of life of seniors by promoting positive ageing and encouraging the community to plan for an ageing population. The Seniors 'Go for your life' program promotes active living by Seniors through a range of initiatives which create opportunities for health, wellbeing and physical activity.

The Office for Youth (OfY) is committed to providing opportunities for young people to develop their skills and awareness of a healthy lifestyle which leads to being active, confident and resilient members of their communities. The Teenagers 'Go for your life' Positive Body Image Strategy aims to raise awareness and provide resources and information to encourage healthy lifestyle choices for youth.

DVC acknowledges the recommendations provided in this report and is committed to the following:

- *Strengthening the evidence base to guide and refine the State's investments and enhance the planning and coordination of programs across Government, including taking steps to address some of the issues identified in the report by:*
    - *enhancing systems for data collection and reporting; and*
    - *investigating options for electronically aggregating project data through new e-grant initiatives now being developed.*
- *Working with the Department of Human Services (DHS), Department of Education, VicHealth and other key stakeholders to increase coordination across Government and to establish evaluation frameworks;*
- *Working with DHS to further develop a comprehensive plan to address issues of obesity and to specifically increase healthy eating and physical activity; and*
- *Providing support, training and workforce development to local agencies to encourage sustainability of programs.*

RESPONSE by Secretary, Department of Education

Recommendation 1.3

The Department of Education supports this recommendation. The Department of Education acknowledges the importance of education in promoting healthy choices and healthy lifestyles among school aged children. The Department will continue to work closely with the Department of Human Services, VicHealth and the Department for Victorian Communities to improve the monitoring, planning and evaluation of health promotion projects.

RESPONSE by Chief Executive Officer, Macedon Ranges Shire Council

We support all the recommendations contained in the audit report, in particular those that will promote the enhanced availability of data and increased rigour in evaluation. We also have a number of comments on the document, as follows:

Structural factors underpinning health lifestyle choices

We strongly support the importance of "changing peoples' life circumstances to remove the social, economic and environmental barriers to adopting these healthier lifestyles" (section 2.2 p 6). Research has well documented that provision of health information and lifestyle behaviour programs is insufficient in bringing about behaviour change unless these barriers are addressed. We reference Len Symes[5] in our work with communities: people are more likely to make informed choices about their health and lifestyle when they have a ***sense of control*** *about their lives, a* ***sense of hope*** *about their future, and a* ***sense of belonging*** *in their society.*

The Audit Report assumes this will be addressed by the Fairer Victoria policy, and we would certainly support its endeavours at the strategic level. However, Fairer Victoria does not provide opportunities for the development of locally driven projects to address these social, economic and environmental barriers. Its focus on targeted support to disadvantaged communities, while commendable, does not provide opportunities for more widespread activities that can foster the sense of control, hope and belonging mentioned above.

This is particularly relevant given that lack of physical activity, poor nutrition, obesity and diabetes are prevalent across the socio-economic strata: we would recommend the broad resourcing of locally driven community development initiatives, with long term outcome evaluative measures.

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[5] *Social Determinants of Health: the Community as an Empowered Partner*, S. Leonard Syme, paper presented to the Communities in Control Conference, convened by Our Community and Catholic Social Services, April, 2003.

RESPONSE by Chief Executive Officer, Macedon Ranges Shire Council – continued

Role of Municipal Public Health Plans

There are a number of recommendations regarding municipal public health plans (MPHPs). Whilst we support the move in local government to encompass a broader, social model of health in MPHPs, and indeed have embraced this approach ourselves, we wish to highlight that resources are extremely limited in enabling adequate and collaborative implementation and evaluation of many of the objectives.

As indicated in your report, whilst having legislative responsibility for developing MPHPs, including health promotion, local government is not a major provider of health promotion activities (nor is it funded to do so). We certainly support the role of local government in facilitating and coordinating a shire-wide health planning process, and believe we have a leadership role in supporting other agencies in implementing their activities in this area. However, as our community health colleagues have identified, the resources available to agencies in the shire for health promotion activities are minimal, and make it difficult to adequately address many of the priorities identified in health planning.

Lack of Recommendations Regarding Current Funding Models

We applaud the recognition of the constraints contained in the current models of funding for health promotion activities (section 4.4), and certainly concur that there is an overall shortfall of funding and that short-term funding threatens program sustainability.

Our Walking School Bus Program is in a similar position to the example cited by the East Gippsland Shire, in that it is unlikely to be viable into the future. A review over the next few months may well recommend we withdraw the program prior to the end of the service agreement.

We would also argue that funding locally based programs via a regional or sub-regional model dissipates both the resources and the outcomes. Funds for programs based in Bendigo but ostensibly targeted at the wider regional (Loddon Mallee) population rarely find their way to outlying shires like ours. Health promotion associated with Women's Health would be a prime example of this. Similarly, small project funds such as Go For Your Life, are diluted even further when distributed via Primary Care Partnerships to participating local government areas.

Of major concern is the lack of recommendations in the audit report to address these funding constraints. This was identified as a significant issue by most if not all participating agencies, and given it is discussed at length in the report it is disappointing there is no action proposed. We would be keen to hear a response from the relevant ministers regarding the issues.

RESPONSE by Chief Executive Officer, Whitehorse Community Health Service

Whitehorse Community Health Service supports the recommendations made in the audit report and additional comment is made in regard to particular sections of the report in Parts 4 and 7.

Whilst aspects have been covered in the report, the overall issue of building and sustaining organisational capacity for health promotion has not been clearly articulated in the report. In order for organisations to work with local communities to promote health, a range of organisational structures and processes, a skilled workforce and adequate resources are required and the report identifies that there is great disparity in health promotion capacity across the various organisation's in the review.

In the community health sector, the introduction of the DHS Integrated Health Promotion Framework in 2002 provided CHSs with the opportunity to improve their capacity for health promotion. However, this has been very ad hoc, as agencies have all tried to re-invent the wheel by trying to identify best practice approaches to capacity building and there has been no evaluation of the impact of these efforts. The community health and PCP sector in particular would benefit greatly from leadership from DHS in this area. This could take the form of prescribing models for building health promotion capacity in organisations and targeted training and tools for model implementation. Again, funding of demonstration projects across the community health and PCP sector would be a positive way of capturing effective existing capacity building practice/models.

RESPONSE by Chief Executive Officer, City of Whittlesea

Conclusions 1.2

It is too early to see mid-term and long-term impacts and outcomes on chronic disease rates as a result of health promotion interventions in the last 2-3 years, which was the extent of audit material requested from Whittlesea Council.

Other conclusions presented are supported.

Recommendation 1.1

This Recommendation is supported.

Recommendation 1.2

This Recommendation is supported and is required to assist agencies in implementing effective health promotion interventions.

RESPONSE by Chief Executive Officer, City of Whittlesea - continued

Recommendation 1.3

This Recommendation is welcomed. Stronger State Government support in developing consistent evaluation frameworks is required, particularly in the measurement of impacts and longer-term outcomes.

Recommendation 1.4

This is a very resource intensive Recommendation. Under the Health Act 1958, Section 29B, it provides for "periodic evaluation of programs and strategies" in the MPHP, and an annual review of the MPHP. Whittlesea Council currently meets these requirements.

To evaluate the Objectives of the MPHP (impact evaluation) and the Goals of the MPHP (outcome evaluation) has significant resource and financial implications for Councils, and would require support.

Recommendation 1.5

Supported.

Recommendation 1.6

Supported.

2 About health promotion: Promoting physical activity and healthy eating

2.1 What is health promotion and why is it important?

For Australians, about 70 per cent[1] of the burden of disease is due to what are termed "chronic" conditions. These conditions have many complex causes. They are persistent, and lead to a gradual worsening of health, and often death. The most common chronic conditions are cancer, heart disease, lung disease, stroke, diabetes, arthritis, asthma and depression[2].

It is only in the last century that chronic diseases have surpassed infectious diseases such as measles, cholera and smallpox, as the major cause of poor health in Australia. Some of the change has occurred with major advances in the prevention and treatment of infectious diseases and because people are more exposed to the possibility of chronic disease because they are living longer. In addition, lifestyle changes that have accompanied greater prosperity have increased the risks of developing many of these conditions.

The World Health Organization (WHO) defined health promotion as "the process of enabling people to increase control over and to improve their health"[3]. The Victorian Auditor-General's Office's Annual Plan for 2005-06 identified the importance of the burden of disease caused by chronic conditions and the growing body of evidence about the economic and social benefits of preventing these conditions. The audit considered that it was timely to investigate the State's investment in health promotion and prevention programs.

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[1] National Public Health Partnership 2001, *Preventing Chronic Disease: A Strategic Framework Background Paper,* National Public Health Partnership, Melbourne.

[2] National Health Priority Action Council 2006, *National Chronic Disease Strategy*, Department of Health and Ageing, Canberra.

[3] World Health Organization, *The Ottawa Charter for Health Promotion*, Geneva, 1986.

2.2 Victoria's approach to health promotion

In line with the WHO, the Victorian Government has adopted a "social model of health" to guide its approach to health promotion. This recognises that health is influenced by more than individual lifestyles and the provision of health care, and that political, social and environmental factors are critical[4].

Health promotion is about preventing disease and promoting wellbeing by:

- providing people with the information, support and motivation to encourage and enable them to adopt healthy lifestyles
- changing peoples' life circumstances to remove the social, economic and environmental barriers to adopting these healthier lifestyles.

Applying this approach requires coordinated planning and action across many government agencies. Some agencies will be directly responsible for promoting health, while others outside the health sector will play an important role in removing barriers to change. The Department of Human Services (DHS) defined "integrated health promotion" as when agencies collaborate using a mix of health promotion interventions to address priority health and wellbeing issues[5].

The Victorian Government is committed through its *A Fairer Victoria* policy to addressing disadvantage and its health impacts, and improving the health outcomes of those Victorians most at risk through targeted support[6].

In September 2006, the Victorian Minister for Health endorsed 7 health promotion priorities for 2007-2012[7], aimed at improving health and reducing health inequalities. These priorities included promoting physical activity and active communities, and accessible and nutritious food[8].

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[4] Department of Human Services 2003, *Integrated Health Promotion – A Practice Guide for Service Providers*, Department of Human Services, Melbourne, p. 5 and p. 29.

[5] Ibid., p. 3.

[6] Department of Premier and Cabinet 2005*, A Fairer Victoria*, Department of Premier and Cabinet, Melbourne, p. 5.

[7] Determined through a statewide consultation process conducted by the Department of Human Services and VicHealth between February and May 2006.

[8] Department of Human Services 2007, *Health Promotion Priorities for Victoria 2007-2012,* Department of Human Services, Melbourne.

2.3 Why focus on healthy eating and physical activity?

From our research and consultations with key stakeholders, we concluded that the audit should look at the risk factors of physical inactivity and unhealthy eating. These factors lead to people becoming overweight and obese, and are the most important preventable causes of chronic disease. Furthermore, these impacts are on an upward trend and this is most clearly seen with the increase in conditions directly related to these risk factors, such as type 2 diabetes.

2.4 Who plays a part in addressing these risks?

The "social model of health" approach requires the involvement of a wide range of organisations and layers of jurisdiction in addressing these risks. To provide a context for the audit findings, we summarise the roles of the most important players within the following categories:

- nationwide agencies
- state government agencies with direct health promotion responsibilities
- state government agencies which influence the wider environment
- local councils
- non-government agencies.

2.4.1 Nationwide agencies

The Commonwealth Department of Health and Ageing is responsible for providing access to health services and helping people to stay healthy through health promotion and disease prevention activities at a national level. Services include aged care services, home-based care and the pharmaceutical benefits scheme (PBS).

The Council of Australian Governments (COAG) is the peak intergovernmental forum in Australia, comprising the Prime Minister, state premiers, territory chief ministers and the President of the Australian Local Government Association (ALGA). Its role is to initiate, develop and monitor the implementation of policy reforms that are of national significance and which require cooperative action.

The Australian General Practice Network (AGPN) is the peak national body representing 119 divisions of general practice and their state-based organisations across Australia. The network delivers local health solutions through general practitioners.

2.4.2 State agencies with direct health promotion responsibilities

DHS, the Victorian Health Promotion Foundation (VicHealth) and schools are agencies with direct health promotion responsibilities.

Department of Human Services

The parts of DHS with direct responsibility for health promotion are:

- the Rural and Regional Health and Aged Care Services (RRHACS) Division
- the *Go For Your Life* (*GFYL*) secretariat
- the Office for Children.

Through its Public Health, Primary Health and Aged Care branches, RRHACS is responsible for:

- informing state health promotion policy[9]
- contributing to health promotion planning
- coordinating initiatives at a state, regional and local level directly through its regional offices, primary care partnerships (PCPs)[10] and community health services (CHSs), and indirectly through its relationships with other government departments, local councils and non-government organisations.

The *GFYL* initiative was initially defined according to the administration of specific funding to encourage healthy eating and physical activity. In early 2006, the *GFYL* secretariat was moved to the Strategic Projects Branch of DHS and took on a broader role. The *GFYL* initiative has moved from its initial focus of raising awareness to now focus on local area initiatives, working better across government and evaluating the impacts of the initiative. The secretariat is responsible for:

- administering the initiative
- delivering the *GFYL* communications strategy
- influencing other departments to incorporate health promotion so that it is mainstreamed across government
- managing an evaluation of the *GFYL* initiative.

The Office for Children is responsible for managing and administering the Victorian Secondary School Nursing Program (SSNP). The program aims to improve the health and wellbeing of young people aged 12-18 years, and reduce negative outcomes and risk-taking behaviour.

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[9] Department of Human Services' role in health promotion, <www.health.vic.gov.au/healthpromotion/role> downloaded 16 January 2006.

[10] Primary Care Partnerships (PCPs), established by the Department of Human Services, to develop partnerships between primary health care agencies to improve service coordination and integrated health promotion.

VicHealth

Under the *Tobacco Act 1987* VicHealth invests $29 million annually into programs promoting health and preventing ill-health through a 3-year service agreement with DHS. Under the Act, VicHealth is required to:

- fund activity to promote good health and prevent ill-health
- increase awareness of programs for promoting good health in the community
- encourage and support community participation in healthy lifestyles
- fund research and development activities to support health and wellbeing
- allocate not less than 30 per cent of its funding to health promotion and not less than 30 per cent to sporting bodies.

Schools

Victorian schools are required to deliver health, physical and sports education to meet the curriculum requirements agreed with the Department of Education (DoE).

2.4.3 State agencies influencing the wider environment

Other state government agencies have programs which support the direct health promotion goals of DHS, VicHealth, local councils and schools. These include:

- the Department for Victorian Communities (DVC) through Sports and Recreation Victoria (SRV) which promotes and supports physical activity across Victoria; the Office of Senior Victorians (OSV) which promotes positive ageing in the community through social connectedness and physical activity; and the Office for Youth (OfY) which promotes positive body image through Teenagers *Go For Your Life*
- the Department of Sustainability and Environment (DSE) through its influence on the planning scheme
- the Department of Infrastructure (DoI) through the provision of active transport strategies and programs
- VicRoads through the planning for, and provision of, bicycle and pedestrian facilities.

2.4.4 Local councils

Under the 1993 general amendment to the *Health Act 1958,* local councils have a legislative responsibility for public health planning and health promotion. To meet this responsibility they must develop a Municipal Public Health Plan (MPHP) every 3 years and consult with DHS on this plan. Councils are also responsible for providing facilities to meet the recreational, sports and leisure needs of their communities, and for planning for healthy living environments.

2.4.5 Non-government organisations

Non-government organisations (NGOs) play a critical role in promoting health at the Commonwealth, state and local levels. Some better known examples of NGOs in the health promotion area are the National Heart Foundation (Victoria), Diabetes Australia - Victoria and the Cancer Council Victoria.

2.4.6 Terminology used in the audit report

Throughout the audit we use the terms:

- "lead agencies" to refer to government organisations with statewide responsibilities including government departments, VicHealth and VicRoads
- "local agencies" to refer to government organisations with responsibilities for planning and delivering health promotion across a part of the State including councils, DHS regional and local organisations and schools
- "agencies" to refer to both lead and local organisations.

2.5 Audit approach

The objective of the audit was to determine whether the State's investment in health promotion has been effective in addressing the risk factors of unhealthy eating and physical inactivity. The audit focused on programs aimed at preventing the initial occurrence of chronic disease by influencing these risk factors.

To be effective, agencies need:

- an evidence base to understand: the nature of these risks; what groups are most exposed to these risks; and what measures are most effective in addressing these risks
- well-informed plans based on the evidence and coordinated across agencies to maximise the impact on local communities
- a structured approach to evaluation to understand how well actions and plans have achieved their objectives.

The audit examined whether agencies had:

- formed plans which were clearly defined, well-informed and coordinated with the plans of other agencies
- implemented plans as intended and had monitored progress
- evaluated how well plans had achieved their objectives and used this to further improve performance.

The audit also looked at the available information on health outcomes to see how effective past actions had been in improving the health and wellbeing of Victorians.

The audit team examined information provided by the head office staff at DHS and its regional offices, VicHealth, DVC, DoE, DSE, DoI and VicRoads. The team also reviewed the plans and programs of local DHS delivery agencies, councils and schools in the following 7 local government areas: Greater Dandenong; Greater Geelong; Whitehorse; Whittlesea; Central Goldfields; Macedon Ranges; and East Gippsland. This shed light not only on local planning and delivery but also on the lead agencies working together to support and fund activity at the local level.

Many of the government-funded health promotion programs delivered through local agencies were reviewed. However, this approach did not encompass:

- programs aimed at pre-school children which were recently reviewed in the Victorian Auditor-General's May 2007 performance audit *Giving Victorian children the best start in life*
- sporting grants made directly to regional and local sporting organisations
- Commonwealth funded school programs such as *Active After Schools* aimed at increasing physical activity.

The audit was performed in accordance with Australian auditing standards applicable to performance audits, and included tests and procedures necessary to conduct the audit.

The total cost of this audit was $715 000.

2.6 Findings and recommendations

The report presents the audit findings and recommendations in Parts 3 to 7.

- Part 3 describes the growing importance of obesity-related risks in the Victorian context
- Parts 4, 5 and 6 present our findings for health promotion programs delivered to:
  - local communities through councils, PCPs and CHSs (Part 4)
  - Aboriginal people through specialist agencies (Part 5)
  - students in primary and secondary schools (Part 6)
- Part 7 describes how the approach to health promotion could be improved and strengthened. Audit recommendations are presented in this part of the report.

3 Risks posed by physical inactivity and unhealthy eating

At a glance

Background

This part of the report illustrates the impact of the risks posed by physical inactivity and unhealthy eating on the Victorian population.

Key findings

- The risk factors of physical inactivity and unhealthy eating have grown in importance over the last 30 years because of changes in society and how people have responded by adapting their lifestyles.
- These behaviours have led to many adults and children putting on weight, and to greater numbers becoming overweight or obese.
- These trends are having a significant and growing impact on the number of Victorians with a chronic condition, particularly for the more disadvantaged groups.
- Urgent action is needed to prevent the continued escalation of the burden imposed by these preventable chronic conditions, including higher health care costs and reduced productivity.
- Victoria currently allocates less than one per cent of recurrent health spending to health promotion.
- The cost of treating chronic conditions is rapidly increasing. For example, the audit estimated that the direct cost of diabetes in Victoria has risen from $361 million in 2001 to $637 million in 2006 and, on current trends, will reach $1 billion within 10 years.

3.1 Growing importance of risk factors

People have responded to changes in society by adapting their lifestyles. More people are now exposed to greater risks by eating more than they need or losing the balance in their diet, and by leading a more sedentary lifestyle.

The Victorian Population Health Survey[1] (VPHS) estimated that for adults in 2005:

- 9 in 10 did not meet the healthy eating guidelines for vegetable intake (5 serves per day) and 5 in 10 did not consume the recommended amount of fruit (2 serves per day)
- 1 in 4 males and almost 3 in 10 females did not achieve the levels of physical activity consistent with a healthy lifestyle.

3.2 Increasing number of overweight or obese adults and children

The Australian Diabetes, Obesity and Lifestyle (AusDiab) study independently measured the height and weight of a representative sample of Australian adults in 2000 and 2005. AusDiab found that the proportion of those overweight or obese had risen from 60 to 68 per cent in this 5-year period[2].

The VPHS showed that between 2002 and 2005, the proportion of Victorian adults that were overweight or obese increased from 45.5 to 47.9 per cent. These figures were based on self-reported measures and are likely to underestimate the true scale of the problem.

The proportion of Australian children aged between 7 and 15 that were overweight or obese doubled between 1985 and 1995 from 10 to 20 per cent[3].

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1 Department of Human Services 2006, *2005 Victorian Population Health Survey*, Department of Human Services, Melbourne.

2 ELM Barr, DJ Magliano, PZ Zimmet, KR Polkinghorne, RC Atkins, DW Dunstan, SG Murray, JE Shaw, *AusDiab 2005, The Australian Diabetes, Obesity and Lifestyle Study; Tracking the Accelerating Epidemic: Its Causes and Outcomes,* International Diabetes Institute, Melbourne 2006, p. 3 *and worked out from figures in Table 3.3*, p. 19.

3 Australian Institute of Health and Welfare 2004, *Risk Factors Data Briefing Number 2, A Rising Epidemic: Obesity in Australia*, Department of Health and Ageing, Canberra, Figure 1.

Information was gathered[4] on the height and weight of Australian children collected between 1901 and 2003. The analysis showed that the percentage of overweight or obese children:

- was stable and well under 10 per cent until the early 1970s
- accelerated to reach about 20 per cent by the mid-1990s
- stood somewhere between 25 and 30 per cent by 2003
- is likely to rise to the level found in the adult population (around 60 per cent) within 30 years if present trends continue.

3.3 Significant and growing impact of risk factors on chronic conditions, particularly for disadvantaged Victorians

3.3.1 Understanding the impact of these risk factors on all Victorians

The Victorian Burden of Disease Study found that in 2001 risk factors related to physical inactivity, and unhealthy eating accounted for over half the burden of disease[5]. The seriousness and urgency of changes since 2001 is best illustrated by the number of Victorians with diabetes. Type 2 diabetes is far more likely to occur in people who are overweight or obese.

Diabetes Australia - Victoria figures[6] show that the number of people registered as having diabetes in Victoria rose by 82 104 (77 per cent) over the last 5 years, from 107 207 in 2001 to 189 311 in 2006. An increase in type 2 diabetes was the main reason for this change with an additional 68 715 registrations. More than 3.5 per cent of Victorians are now registered as having diabetes and a similar number are thought to have the condition without knowing it. According to Diabetes Australia - Victoria, a further 500 000 Victorians are estimated to be at risk of developing the condition.

Figure 3A shows how, for each Victorian local government area (LGA), the percentage of people registered with diabetes has changed between 2001 and 2006. In 2001, all but 4 LGAs had less than 4 per cent of the population registered as having diabetes (as shown by the areas shaded green or yellow). For many LGAs, the percentage of registrations fell below 2 per cent. By 2006, the situation had changed markedly and registrations exceeded 4 per cent of the population (the red shaded areas) in the majority of areas.

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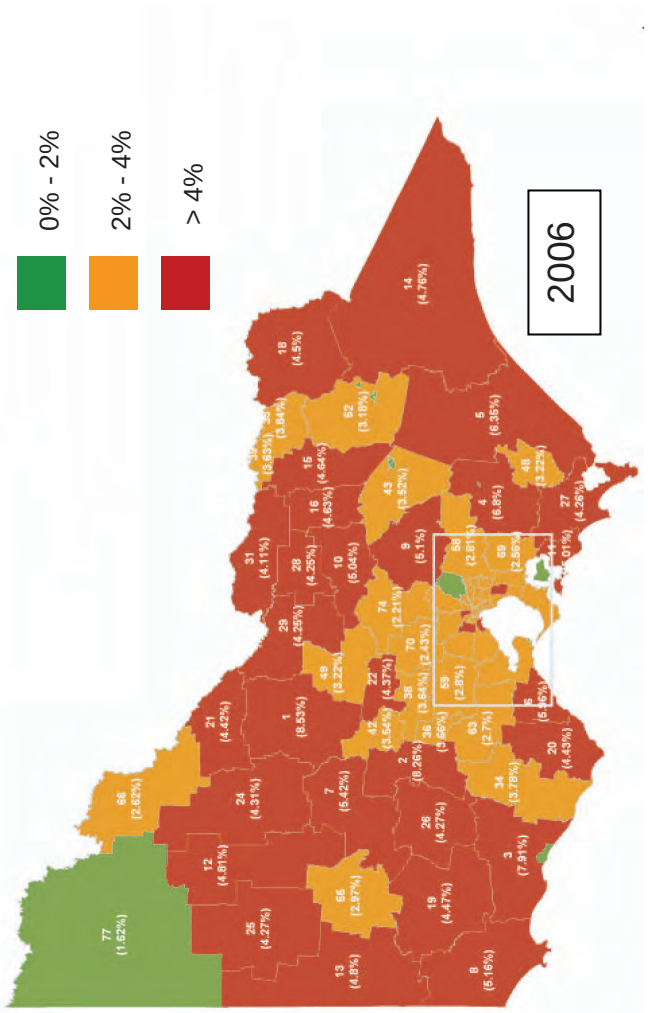
4 M Booth, T Chey, M Wake, K Norton, K Hesketh, J Dollman and I Robertson, *Change in the Prevalence of Overweight and Obesity among Young Australians, 1985, 1997 and 2004,* New South Wales Centre for Overweight and Obesity, Sydney, 2006.

5 Department of Human Services 2005, *2001 Victorian Burden of Disease Study; Mortality and Morbidity*, Department of Human Services, Melbourne.

6 Diabetes Australia – Victoria 2007, *New and Total Victorian Registrants for the National Diabetes Services Scheme 2002-2006,* Diabetes Australia – Victoria, Melbourne.

Figure 3A
Percentage of Victorians diagnosed and registered with diabetes

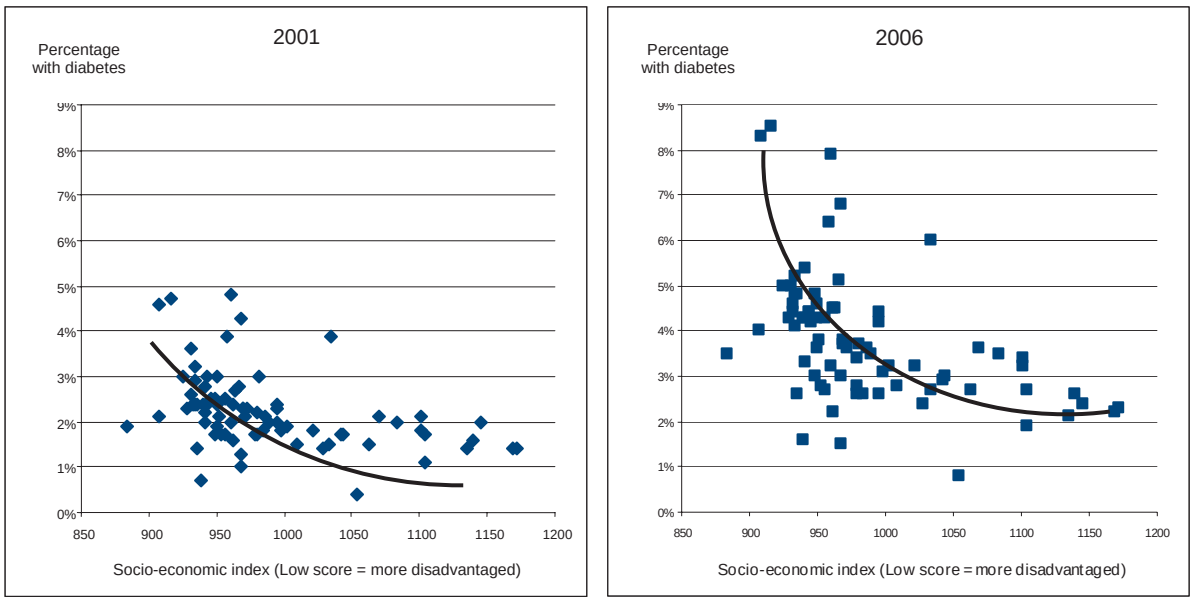


Source: Diabetes Australia – Victoria: National Diabetes Services Scheme, 2007.

3.3.2 Impact of these risk factors on disadvantaged Victorians

Figure 3B maps, for each Victorian LGA, the percentage of the population with diabetes[7] and the area's relative socio-economic disadvantage[8] for 2001 and 2006. Figure 3B shows the rapid growth in people living with diabetes, the greater prevalence of the condition in more disadvantaged areas, and the growing difference between the least and most disadvantaged areas.

Figure 3B
Percentage of Victorians registered with diabetes by level of socio-economic disadvantage for Victorian local government areas



Source: Victorian Auditor-General's Office, derived from Diabetes Australia - Victoria data, and Australian Bureau of Statistics 2001, *Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA) Victoria,* cat no. 2033.2.30.0012001.

These risk factors and related conditions also affect Aboriginal people more than the general population. In 2001 Aboriginal people were more likely than other Australians to be sedentary, to consume less fruit, and to be obese (31 per cent are obese compared to 16 percent for other Australians). As a consequence, 11 per cent of Aboriginal people were identified as living with diabetes in 2001 compared with 3 per cent of other Australians[9].

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[7] www.dav.org.au

[8] Australian Bureau of Statistics 2001, *Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA) Victoria*, cat no. 2033.2.30.0012001, Australian Bureau of Statistics, Canberra.

[9] Australian Institute of Health and Welfare 2006, *Chronic Diseases and Associated Risk Factors in Australia*, cat. no. PHE 81, Australian Institute of Health and Welfare, Canberra, pp. 57-8.

3.4 Need for urgent action to prevent the continued escalation of preventable chronic conditions

The burden of chronic disease, based on recent trends, is set to grow further. Australia currently uses 70 per cent of health funding to treat these conditions and this is forecast to grow to 80 per cent by 2020[10]. Failing to adequately address this trend will affect individuals and their families, and the wider community, in terms of higher health care costs and reduced productivity.

There is an increasing body of evidence to illustrate the effectiveness of health promotion to reduce the onset of chronic disease[11].

In Victoria, recurrent health spending was around $22 billion in 2004-05[12]. The cost of programs directly aimed at promoting better health amount to a small percentage of this recurrent figure. For example, the Department of Human Services (DHS) estimated that its Rural and Regional Health and Aged Care Services Division, responsible for public and primary health, spent $98.5 million on health promotion during 2005-06, including funding to VicHealth[13]. Of this, DHS estimated that $18 million was direct spending to promote healthy eating and physical activity.

These figures exclude other direct spending on the promotion of physical activity and healthy eating by other lead agencies and councils. When these activities are added, the total remains very small and we estimate is less than one per cent ($220 million) of recurrent health spending.

Rise in type 2 diabetes and the need for urgent action

The rise in type 2 diabetes illustrates the scale of the problem. Since the condition was identified as a national health priority in 1996, its prevalence has doubled. To date, the combined actions of all layers of government have not significantly slowed the growth in this condition.

Since 1995, DHS has estimated the number of hospitalisations thought to be avoidable through actions to prevent or better manage chronic disease[14]. Figure 3C shows how the number of avoidable admissions and bed days has grown between 2001-02 and 2004-05 in total and for diabetes-related admissions.

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10 National Public Health Partnership 2001, *Preventing chronic disease: A Strategic Framework Background Paper,* National Public Health Partnership, Melbourne.

11 Ibid.

12 Australian Institute of Health and Welfare 2007, *National Public Health Expenditure Report: 2004-2005*, Australian Institute of Health and Welfare, Canberra, p. 17.

13 Letter from the Secretary, Department of Human Services, Department of Human Services, Melbourne, 31 July 2006.

14 Department of Human Services 2006, *Victorian Ambulatory Care Sensitive Conditions, 2004-2005 Update*, Department of Human Services, Melbourne.

Avoidable hospital admissions have grown by 40 per cent or by 59 000 from 150 000 to 209 000 hospital admissions. This change is explained by the 126 per cent growth in diabetes-related admissions from 44 000 to 99 000.

The number of avoidable bed days due to diabetes complications has grown by 295 000 over this 3-year period, which more than explains the growth in the total avoidable bed days of about 218 000.

Figure 3C
Avoidable hospital admissions

	2001-02	2004-05	Change
Avoidable admissions			
Total for Victoria	149 826	209 183	59 357
Diabetes complications	43 884	99 317	55 433
Diabetes percentage	29%	47%	n.a.
Avoidable bed days			
Total for Victoria	782 092	999 887	217 795
Diabetes complications	305 891	601 216	295 325
Diabetes percentage	39%	60%	n.a.

Source: Victorian Ambulatory Care Sensitive Conditions, 2004-2005 Update, DHS.

Diabetes-related complications account for nearly half of avoidable hospital admissions and nearly two-thirds of avoidable hospital bed days.

Illustration of cost implications of these trends

The Commonwealth and Victorian governments have directed most funding towards treatment rather than early detection and prevention of chronic disease. Since 2003, the Victorian Government has introduced some further programs aimed at prevention and has recognised the need for further, urgent action[15]. However, the investment in health promotion remains very small.

The escalation in the costs of tackling chronic disease is illustrated by using diabetes as an example. The Australian Institute of Health and Welfare (AIHW) calculated the average annual costs of diabetes per case for the year 2000-01[16] as follows:

- direct health care expenditure of $1 469 (equivalent to $1 951 in 2006 prices[17])
- direct non-health costs, including home support, special foods and transport of $1 065 (equivalent to $1 414 in 2006 prices).

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[15] Department of Premier and Cabinet and Department of Treasury and Finance 2007, *Council of Australian Governments' National Reform Agenda 2006, Victoria's Plan to Address the Growing Impact of Obesity and Type 2 Diabetes,* Department of Premier and Cabinet, Melbourne.

[16] Australian Institute of Health and Welfare 2005, *Costs of Diabetes in Australia, 2000-01,* Australian Institute of Health and Welfare, Canberra.

[17] Australian Institute of Health and Welfare 2005, *Costs of Diabetes in Australia, 2000-01,* Australian Institute of Health and Welfare, Canberra, was used to inflate prices from 2001 to 2006.

The direct health care estimates are likely to understate the true costs of diabetes by missing some diabetes-related complications. These costs also do not include the indirect costs, such as lost income and productivity and the intangible costs associated with quality of life.

We applied these average Australian costs to the number of Victorians registered as having diabetes in 2001 and 2006, and estimated future costs if this trend increase in registrations continued. These figures are shown in Figure 3D.

Figure 3D
Direct costs of diabetes in Victoria ($m p.a., in 2006 prices)

	Direct health care costs	Direct non-health costs	Total
2001	209	152	361
2006	369	268	637
2010	498	361	859
2015	658	477	1 135

Source: Victorian Auditor-General's Office, applying AIHW health cost data and based on the number of people registered with diabetes through Diabetes Australia - Victoria.

The estimated direct costs of diabetes in Victoria have risen from $361 million in 2001 to $637 million in 2006. If this trend continues then these costs will approach $900 million in 2010 and exceed $1 billion in less than 10 years. These estimates represent only a portion of the costs of failing to address the health risks posed by physical inactivity and unhealthy eating. These costs fall on both the Commonwealth and Victorian governments.

4 Health promotion for local communities

At a glance

Background

This part of the report examines the current approach to health promotion by looking at the activities of lead agencies and local health promotion planning and delivery in 7 council areas.

Key findings

- Local agencies have improved the way they plan for, and deliver, health promotion by incorporating better practice approaches, using available health risk information and working with other local agencies.
- There were gaps in the evidence base describing the scale, trends and impacts of obesity risk factors and the effectiveness of programs to address these. The Department of Human Services (DHS) has worked to fill the gaps, but needs to do more.
- The need to better coordinate plans to address obesity through State policy has been recognised and a joint Commonwealth and State plan has been proposed.
- Current funding models limit the ability of agencies to properly plan for, coordinate and sustain health promotion programs. Lead agencies have recognised some of the challenges and limitations of current funding models and have taken steps to address some of these.
- Program evaluations, for the most part, did not provide sufficient information to determine whether plans had been effective. Evaluations were mostly limited to measures of process with few evaluations of program impact.

4.1 Local agencies have improved the way they plan for and deliver health promotion

4.1.1 DHS and VicHealth have helped local agencies move towards better practice planning

DHS and VicHealth have helped local agencies improve their planning by providing planning frameworks and supporting their implementation through training and funding. These frameworks encourage a coordinated approach to health promotion planning across government at a local level.

Our fieldwork, covering 7 council areas found that:

- all councils had a current Municipal Public Health Plan (MPHP) built on these better practice principles
- all primary care partnerships (PCPs) had 3-year community health plans which aimed to increase the collaboration between councils, community health services (CHSs) and other local organisations
- all CHSs had annual health promotion plans setting out their actions for promoting better health within their wider service delivery role.

The evaluation of the *Environments for Health*[1] framework used by councils identified the need to consolidate the existing framework material. DHS plans to consolidate and clarify existing frameworks, tools and resources within an overarching health promotion framework.

4.1.2 Changes to the planning scheme to encourage physical activity at a local level

Melbourne 2030[2] is the whole-of–government strategy for Melbourne which seeks to provide, among other things, a more walkable and liveable city. The *Melbourne 2030* policies support these aims which are reflected in recent planning provision changes.

[1] Department of Human Services 2003, *Environments for Health, Municipal Public Health Planning Framework,* Department of Human Services, Melbourne.

[2] Department of Sustainability and Environment 2002, *Melbourne 2030*, Department of Sustainability and Environment, Melbourne.

The Department of Sustainability and Environment had led changes to the new Sustainable Neighbourhoods provisions for residential subdivisions introduced into all Victorian planning schemes in October 2006[3]. These provisions include principles for the design of more liveable and sustainable communities. The principles encourage more compact neighbourhoods, a range of open spaces, safe and attractive walking and cycling networks, and easy movement between activities within neighbourhoods.

Our fieldwork visits found that councils were working to incorporate these changes in their planning processes. For example:

- Macedon Ranges Shire evaluates residential planning proposals using guidelines incorporating these principles
- East Gippsland Shire is developing an Urban Design Framework to incorporate these principles into the evaluation of planning proposals.

Councils had put considerable effort into the planning and development of open space, leisure and recreational facilities for their communities. As examples of this, both Whittlesea and Greater Dandenong councils had worked to understand community needs in this respect and to put in place plans to meet these needs.

4.1.3 Local agencies used the available information on health risks

The local agencies examined had drawn on the available health risk information to inform their planning. Specifically, these agencies drew on:

- the 2001 burden of disease results for each local government area
- information on the demographic characteristics of their local populations
- the state level risk factor information from the Victorian Population Health Survey (VPHS).

DHS used the Victorian evidence on the burden of disease and the risk factors underpinning this burden to set statewide health promotion priorities. DHS, in collaboration with VicHealth, did this through consultation with organisations involved in health promotion in Victoria. This exercise confirmed that the promotion of physical activity and healthy eating continued to be among the top 7 priorities for Victoria. All local agencies had goals and actions relating to physical activity and most had actions relating to healthy eating.

DHS regions and PCPs had also drawn on the Victorian Ambulatory Care Sensitive Conditions (ACSC) analysis. This identified the number of hospital admissions for chronic conditions which may have been avoided through earlier actions to prevent and better manage chronic conditions[4].

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[3] Department of Sustainability and Environment 2006, *Sustainable Neighbourhoods, provisions for Victorian planning schemes (residential subdivision),* Department of Sustainability and Environment, Melbourne.

[4] Department of Human Services 2006, *Victorian Ambulatory Care Sensitive Conditions, 2004-2005 Update*, Department of Human Services, Melbourne.

4.1.4 Local agencies were working together to promote health

There was evidence of regular communication and cooperation between local agencies. The extent to which local agencies worked together varied, from the regular communication of information and the coordination of specific projects, to the more widespread integration of plans to promote health.

In each area, the PCP played an important role in bringing different organisations together. Several PCPs had identified areas of overlap and duplication, and were working with member organisations to streamline and coordinate their efforts.

Figure 4A describes some of the examples of good coordination promoted by PCPs.

Figure 4A
PCPs bringing local agencies together

Example	Description
Promoting the health of older and frail people across the Macedon Ranges and Central Goldfield council areas	The Central Victorian Health Alliance PCP worked to help a range of organisations promote healthy eating and physical activity for older people within its catchment. The *Well for Life* program provided guidelines, assessment tools and training to support doctors, hospitals, aged care facilities, councils and CHSs.
Promoting community-led walking groups for older people in the Whittlesea council area	The North Central Metropolitan PCP through its *Healthy and Active for Seniors* initiative worked with councils, CHSs and the Northern Migrant Resource Centre to train community members to promote and lead walking groups specifically for older members of culturally diverse communities.
Promoting healthy eating and physical activity in local primary schools in the Whitehorse council area	The Inner East PCP drew together councils, CHSs, primary schools, doctors and parents to agree to joint action to reduce obesity in primary school children based on the Deakin University obesity prevention work at Colac. These organisations supported a pilot project in Whitehorse local government area with a similar model rolled-out across other councils in the PCP catchment. The PCP funded 20 local health practitioners to attend the Deakin obesity prevention short course to provide them with the tools, evidence and strategies to develop the project.

Source: Victorian Auditor-General's Office.

4.1.5 Room to further improve the planning and delivery of health promotion

While local agencies had adopted a better practice planning framework, the extent to which this had been applied as a shared and coordinated approach varied.

Some councils, such as Whitehorse, Whittlesea and Macedon Ranges, had a structured and comprehensive approach to consulting across council and the wider community. This had led to a strong and widespread commitment to shared objectives around physical activity and healthy eating. Other councils had started down this path but were not as advanced. All councils acknowledged that moving to a more inclusive and coordinated approach to health promotion required significant organisational change.

CHSs acknowledged the challenges of integrating health promotion within their traditional role of delivering health services to local communities based on the funding of service hours. These challenges are described in Figure 4B.

Figure 4B
Challenges of integrating health promotion into CHS service delivery

These challenges include:

- Determining what the incorporation of a health promotion role meant for the day-to-day activities of the range of health professionals employed by CHSs
- Helping these professionals to understand their health promotion role and how this should be incorporated within existing work practices
- Equipping staff with the skills to exercise this expanded role
- Deciding how to effectively allocate the health promotion budget across a range of areas including staff training, integrating health promotion into service delivery, building community capacity and delivering and evaluating local health promotion initiatives
- Determining the impact of health promotion on the health and wellbeing of clients.

Source: Victorian Auditor-General's Office.

Some CHSs, such as Whitehorse, had made considerable progress in addressing these challenges, but acknowledged that major organisational change was needed to do this and that there was much more to do. Other CHSs, such as the Cobaw CHS (in Macedon Ranges), found it more difficult to meet these challenges with a small team and more limited resources than some of the metropolitan agencies.

Councils, PCPs and CHSs acknowledged the need to better align their individual plans and described the factors which made this difficult to do:

- the availability of central funding strongly influenced what programs they implemented and partnerships were more likely where this funding required cooperation between agencies
- no one agency at a local level had a formal leadership role. However, PCPs were designed to provide the flexibility to allow the best equipped agency to lead a particular program
- the different plans of local agencies were not aligned in terms of their timing and duration. Often each agency needed to consult the same local organisations to inform these plans and this led to some duplication of effort
- establishing and maintaining effective working relationships to better align plans made heavy demands on the limited resources of local agencies.

4.2 Gaps in the evidence base describing health risks and the effectiveness of programs to address these at a local level

For the most part, local agencies did not have objective information on:

- the scale, trends and impacts of the obesity risk factors for their local area. Agencies used state-wide information on the risks and their local knowledge of the population to target health promotion towards those at most risk
- the effectiveness of measures to address these risk factors.

4.2.1 Gaining a better understanding of the risks and what programs are effective

Understanding the risks at a local level

The VPHS provides self-reported information on the obesity risk factors for the state and for DHS regions. Apart from the self-reported information in the VPHS, there are currently no independent, ongoing, objective measurements of physical activity and eating habits or the associated biomedical indicators of risk (for example, body mass index, high blood sugar and high blood cholesterol).

In Whitehorse, the CHS had commissioned a survey based on the VPHS covering the risks to the local population. The Whitehorse Population Health Survey was a partnership of the CHS, the Whitehorse Division of General Practice, Whitehorse City Council and Eastern Health. DHS and the Department for Victorian Communities (DVC) contributed funding for the data analysis, reporting and publication.

The survey provided:

- a self-reported measure of the risks to specific population groups within Whitehorse
- a baseline to track the trends in these risk factors. It is important to assemble objective, ongoing evidence about these risks at the level where plans are formulated and delivered.

Understanding what works best to address these risks

The plans that were reviewed included many actions aimed at reducing obesity by increasing physical activity and, to a lesser extent, encouraging healthy eating. For the most part, these actions were not linked to evidence about what works best to achieve these objectives.

This may be explained by gaps in the evidence base on the cost-effectiveness of alternative measures to address these risks.

4.2.2 DHS has worked to fill these gaps and plans to do more

To better understand the risk factors, DHS has collected information with the VPHS and has plans to build on this work. DHS has also been at the forefront of the interstate work to define and implement a national surveillance strategy for chronic disease.

DHS plans to pilot a health monitor survey to measure the eating habits, physical activity and key biomedical indicators of a sample of Victorians. We strongly support this work. DHS needs to design and implement an ongoing approach to surveillance that will adequately inform government and local agencies about these risk factors.

In terms of understanding what works best to address obesity risks, DHS has published:

- the Assessing Cost-Effectiveness (ACE) obesity study in 2006[5] and
- 2 evidence-based reviews on healthy eating for children[6] and strategies to reduce risk factors for cardiovascular disease (CVD) and diabetes[7].

The ACE obesity study gathered the available evidence to determine the cost-effectiveness and practicality of 12 interventions to reduce obesity in children and adolescents. One CHS, Plenty Valley in Whittlesea, drew on this recent work to plan a family-based program targeting families with overweight children. Other local agencies are likely to draw on this valuable research in shaping their future plans.

The evidence-based reviews evaluated:

- healthy eating interventions focusing on primary school-aged children[8]
- a mix of interventions for preventing CVD and diabetes[9].

DHS plans to extend this work by completing evidence-based reviews on physical activity and active communities and accessible and nutritious foods. The audit team supports this work to expand the evidence base to inform agencies planning health promotion.

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[5] Department of Human Services 2006, *ACE Obesity: Assessing Cost-Effectiveness of Obesity Interventions in Children and Adolescents*, Department of Human Services, Melbourne.

[6] Department of Human Services 2005, *Promoting Healthy Eating for Children: A Planning Guide for Practitioners,* prepared by Deakin University, Department of Human Services, Melbourne.

[7] Department of Human Services 2004, *Planning for Healthy Communities: Reducing the Risk of Cardiovascular Disease and Type 2 Diabetes through Healthier Environments and Lifestyles*, prepared by Deakin University, in partnership with the National Heart Foundation (Victorian Division) and Diabetes Australia – Victoria, Department of Human Services, Melbourne.

[8] Department of Human Services 2005, *Promoting Healthy Eating for Children, A Planning Guide for Practitioners*, op. cit.

[9] Department of Human Services 2004, *Planning for Healthy Communities: Reducing the Risk of Cardiovascular Disease and Type 2 Diabetes through Healthier Environments and Lifestyles*, op. cit.

Beyond this study, DHS needs to draw up a longer-term plan to fill gaps in the evidence, based on what works best to reduce obesity and prevent the onset of chronic disease. In doing this, DHS needs to determine how best to work collaboratively with other agencies.

4.3 Recognition of the need to better coordinate plans to address obesity

4.3.1 Positive measures to improve coordination

The government's *A Fairer Victoria* policy recognised the need to develop better ways of working together at a regional and local level[10]. The policy identified the benefits of government departments working more closely with councils and other organisations to identify issues and deliver appropriate responses through greater cooperation and consultation.

The scope of the *Go For Your Life* (*GFYL*) initiative has been expanded and the *GFYL* secretariat established to better coordinate activities across government departments. *GFYL* coordinates a wide range of health promotion programs to encourage physical activity and healthy eating. *GFYL* has improved the recognition of these programs and has established a recognisable and consistent "branding".

However, DHS has made it clear that while the *GFYL* strategic plan included a wide range of initiatives, its coordination role was restricted to a subset of these where it could directly influence the extent of coordination. In the light of this, it was not surprising that there were examples of programs, with similar health promotion objectives, which were not linked or coordinated.

4.3.2 Evaluation of the planning framework used by councils

The evaluation of the *Environments for Health* framework[11] identified the need for the improved coordination of activities across government in support of councils by:

- increasing local capacity through community development, work force and organisational capacity building, review mechanisms and resourcing
- reducing the complexity and improving the consistency of the planning requirements of state and Commonwealth agencies, for example, when applying for program funding.

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[10] Department of Premier and Cabinet 2005*, A Fairer Victoria*, Department of Premier and Cabinet, Melbourne, p. 13.

[11] Department of Human Services 2003, *Environments for Health, Municipal Public Health Planning Framework,* Department of Human Services, Melbourne*.*

4.3.3 Victorian Government's proposed plan to tackle obesity

In December 2006, the Victorian Government issued its proposed plan for joint Commonwealth and State action to tackle obesity and type 2 diabetes[12]. The plan recognised that past, successful efforts by governments to tackle complex, behaviour-related problems had been underpinned by a range of mutually reinforcing initiatives. Successful efforts to reduce smoking and the road toll involved a comprehensive approach to preventing harm and injury.

Addressing the risk factors underpinning the rise in obesity and type 2 diabetes requires a range of coordinated cross-government actions to:

- promote healthy eating and physical exercise by persuading people to change their behaviour and providing programs to help them do this
- control exposure to these risk factors by integrating health concerns with public policies with respect to regulation (for example food labelling) and subsidies (for example by providing incentives for community development projects)
- make sure that local environments integrate access to better nutrition and more exercise into the way people go about their day-to-day activities.

Forming and implementing this type of comprehensive approach to prevention presents special challenges to governments where objectives, programs and funding are aligned with lead agency responsibilities. Lead agencies must overcome barriers which make it difficult to plan and collaborate across portfolios.

These barriers include:

- different drivers and objectives which will lead to some agencies placing a lower priority on their contribution to a collaborative plan
- the difficulties in driving collaborative planning, implementation and evaluation through existing cross-agency governance structures
- established programs and funding allocations limiting the flexibility to redirect resources to the priority actions identified from a whole-of-government perspective
- established funding models which make it easier to treat, rather than prevent, chronic disease.

The plan recognised the challenges of working within the current arrangements and raised the possibility of moving to a governance model which could more effectively address obesity.

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[12] Department of Premier and Cabinet and Department of Treasury and Finance 2007, *Council of Australian Governments' National Reform Agenda 2006, Victoria's Plan to Address the Growing Impact of Obesity and Type 2 Diabetes,* Department of Premier and Cabinet, Melbourne.

The plan illustrated how potential improvements in health outcomes could be driven by better governance arrangements through the following examples:

- the Victorian Transport Accident Commission (TAC) is the single fund holder for the prevention and treatment of road accidents in Victoria. It has a strong incentive to invest in effective accident prevention and can fund a range of complementary programs from a single funding source
- VicHealth has invested in health promotion over the last 20 years. A major strength is its ability to make independent decisions about policy and the programs it funds outside of the political environment
- the Canadian Public Health Agency provides strong leadership for the analysis and prevention of chronic disease.

4.3.4 Room to improve coordination across local and lead agencies

Coordination of programs from a local agency perspective

There were programs with similar health promotion aims run by several lead agencies. For example, DVC, VicHealth, the Department of Infrastructure (DoI) and VicRoads all have programs which encourage active transport for school children or fund facilities to support this type of transport. Some of this activity was coordinated, for example where VicHealth and DoI had partnered to create some *Walking School Bus* programs.

However, these programs were often not linked and imposed an additional administrative burden on local agencies, as each funding agency required a separate application to meet its own criteria and priorities.

There were some examples where opportunities had been lost to link complementary local activities to centrally planned programs. For example, in Geelong and Macedon Ranges, local agencies would have capitalised on the *GFYL* advertisements in the local press if they had known about them beforehand.

GFYL has since developed a draft communications strategy. The *GFYL* secretariat plans to advise relevant local agencies and non-government organisations of media campaigns in advance through quarterly communications working group meetings and annual meetings with local providers. It is important that the communications strategy is finalised in consultation with relevant local stakeholders and that the process is sufficiently detailed to enable these organisations to understand how these communications will work. *GFYL* then needs to put feedback mechanisms in place to make sure that these processes deliver the required information to those who need it.

Coordination issues across lead agencies

Part 4.3.3 describes the barriers which made it difficult to effectively coordinate a whole-of-government plan across lead agency boundaries.

The *GFYL* secretariat was formed to better coordinate programs across lead agencies. There were some examples where lead agencies had recognised the need to better coordinate programs and had started to do this.

- Both DVC and VicHealth invest in community sport and recreation with similar programs to encourage physical activity. These agencies now discuss applications and coordinate the allocation of grants in the light of these discussions.
- In 2006, DVC committed $150 000 to work across government and with non-government organisations to better coordinate programs to promote walking and cycling. DVC chaired a meeting of the lead agencies responsible for walking and cycling programs in March 2007. The key stakeholders agreed to map current programs and to research the factors which promote or prevent integration, for a sample of local government areas. This research will help to better coordinate programs at a statewide level. This initiative aims to develop a model for better integration that will be piloted at the local level.

These are encouraging developments. In particular, the work on walking and cycling across government could provide the means to develop a joined-up strategy to plan, implement and evaluate walking, cycling and active transport programs.

However, different priorities of agencies and the inflexibility of current funding models mean that further work is needed to develop a coordinated and effective plan to tackle these risk factors. The lead agencies promoting healthier lifestyles - DHS, VicHealth and DVC, need to better understand these barriers. This will provide government with the basis to decide on the governance changes needed to drive an effective whole-of-government approach.

4.4 Current funding models limit the ability of agencies to properly plan, coordinate and sustain programs

4.4.1 Program funding requirements made it difficult to implement local priorities

Addressing obesity requires a range of complementary activities to address the key risk factors and achieve healthier outcomes. These include programs to encourage people to change their behaviour, together with other programs to remove environmental and social barriers to change. The effective balance of activities needs to be refined in the light of evidence on the program impacts.

There was little evidence to show that program funding across government had been planned and coordinated to deliver a balanced range of activities in support of evidence-based priorities.

The requirements and allocation of funding to programs created some problems for local agencies as they tried to channel resources into locally determined priorities. There were specific examples where local agencies did not implement priority activities because the program funding requirements did not allow them to do this.

For example, programs to promote physical activity were much more frequent and widespread among local agencies than programs to promote healthy eating. Only 2 councils (Dandenong and Whittlesea) had healthy eating strategies for the local community, although all councils visited recognised the importance of healthy eating. The balance of activities was affected by the funds made available by lead agencies for these different activities. These allocations were the result of mostly separate funding decisions taken across central government.

The proposed plan to tackle obesity and type 2 diabetes has the potential to provide a more balanced approach. It includes a range of complementary actions at the State and Commonwealth level to address these problems. The plan acknowledges the need to build the evidence base and to identify what works best and then to adapt the program in the light of this knowledge.

4.4.2 Sustaining programs beyond an initial funding term

In most cases, program funding lasted for between one and 4 years, and did not offer a clear pathway to continue funding after the term expired. It was common practice for lead agencies to fully fund programs for a fixed period with a reduction in funding after this period. Usually, local agencies were required to “match” this funding shortfall and demonstrate their ability to sustain the program over a longer time period.

The onus then is on local agencies to develop sufficient capacity to continue the program as a lead agency reduces or ceases funding. Most local agencies have limited capacity to source the funding shortfall without diverting resources from other activities. In some cases, this will lead to the cessation of successful programs.

The following examples illustrate this:

- In Geelong, DHS funded the *Kids GFYL* program for 2 years. In the third year, (2007-2008) the council has to provide 50 per cent ($25 000) of program funding in addition to providing ongoing project support, such as management and administrative costs, for the life of the program. Council will need to divert funding from other activities to effectively implement project priorities.
- In East Gippsland Shire, the *Walking School Bus* program was a success and expanded to include a *Riding School Bus* program. Although VicHealth extended the funding period, it reduced the amount of funding. The council has partly covered the shortfall this year, but is unlikely to do next year and the program will come to an end.

There were some examples where agencies provided funding to create programs that would be sustained when lead funding stopped. DVC, for example, provided seed funding for local walking clubs in Central Goldfields and Macedon Ranges Shires through community walking grants. Sustaining these activities relied on motivated volunteers continuing to lead these activities beyond the funding term. However, most health promotion programs are not sustainable without at least some ongoing funding support.

The short-term nature of most program funding made it difficult to attract and retain high calibre staff to manage these programs. The administration of often small grants imposed a significant burden on these staff. For example, the time required to apply for, administer and report back on a $10 000 community walking grant, was large in relation to the resource provided. DVC has started to address this following the evaluation of the *Community Walking Grants* program. DVC has streamlined the administration and reporting processes established for grant recipients and provided larger grants ($30 000) under the new *Walk Together Grants* program. This will help projects to establish walking groups which are sustained beyond the life of the funding.

4.4.3 Challenges and limitations of current funding models

DHS has recognised the validity of these funding issues and has taken positive steps to address some of these. DHS provided PCPs with recurrent funding for health promotion. DHS also require CHSs and women's health agencies to allocate a fixed percentage of their recurrent funding to health promotion. This has helped these agencies to improve their health promotion planning and to sustain a range of health promotion activities.

Despite these changes, local agencies rely on non-recurrent funding to resource activities beyond their recurrent funding base. DHS acknowledges the challenges of short-term, non-recurrent funding and is proposing to move non-recurrent program funding such as the *Good Practice Program* and Capacity Building funds, to a longer-term funding model.

Councils have a legislative responsibility to prepare a Municipal Public Health Plan and this activity competes with councils' other responsibilities for available funds. The health promotion activities of councils remain largely dependent on securing discretionary program funding.

Lead agencies are also constrained in terms of their funding options. For example, under the *Tobacco Act*, VicHealth must allocate at least 30 per cent of its funding to sports organisations and at least 30 per cent to health promotion activities. Furthermore, its funding through DHS is provided through a 3-year service agreement which, while this allows for periodic reviews, also limits its capacity to make longer-term funding commitments. The provision of fixed-term budget allocations also limited the flexibility of other departments to support projects over a longer time period.

4.5 Program evaluations, for the most part, did not provide the information needed to understand whether plans had been effective

4.5.1 What do we mean by evaluation?

This report has drawn on DHS' publications to describe what evaluation means when applied to health promotion.

Figure 4C
What do we mean by evaluation?

The purpose of evaluation is to determine how well individual strategies and an overall program are working through measurement, observation and comparison with some standard or target. The audit refers to the following types of evaluation:

- "process" evaluation measures all aspects of the process of delivering a strategy including: implementing actions as intended; and understanding the coverage ("reach") and the quality of these actions
- "impact" evaluation measures effects of a strategy on people and environments. First level impacts include measurable changes in people's knowledge, skills and attitudes. Second level impacts include changes in personal behaviours, environments and following these, changes in risk indicators such as a person's weight, body mass index and cholesterol levels
- "outcome" evaluation measures the longer-term effects of strategies on overall program goals to reduce the prevalence of preventable chronic disease. These effects are usually expressed as changes in measures of wellbeing, including mortality, morbidity, disability and quality of life. It is more difficult to measure these outcomes because they are affected by a range of factors beyond our interventions and are often only observable over a longer time period.

Source: Adapted from *DHS Planning for effective health promotion, May 2005; Measuring health promotion impacts; A guide to impact evaluation in integrated health promotion.*

4.5.2 Limiting evaluations to measures of the "process"

All the councils, PCPs and CHSs that were examined included evaluation measures within their plans and reported against these. However, these measures seldom went beyond verifying that strategies had been implemented and describing the number and type of people the strategy had reached.

Most of the centrally funded programs required local agencies to measure aspects of the process, often as evidence that funds had been used as intended. For example:

- CHSs routinely reported service hours to DHS but rarely provided information on program impacts.
- For the *Seniors GFYL* program, DVC required PCPs to report against process measures such as "total number of seniors not previously active". The evaluation did not measure the impact on participants' understanding of healthy exercise requirements or their changes to levels of physical activity.

Councils are required by the Health Act to evaluate their Municipal Public Health Plans. Plans to do this were not evident at the 7 councils visited.

4.5.3 Some evaluations included program impacts

There were examples where evaluations included some program impacts. These are described Figure 4D.

Figure 4D
Examples of evaluations which included program impacts

Agency	
Barwon Primary Care Forum (Geelong)	The *10 000 Steps* Walking Program measured the changes in daily walking activity and attitudes to exercise over a 16-week period.
Macedon Ranges and Central Goldfields Shire Councils	The Pedometer Challenges in both shires measured the increase in activity, and the motivating factors for participants to join and continue with the program.
Plenty Valley CHS (Whittlesea) and Whittlesea City Council	Measured the body mass index (BMI) of children at their 3.5 year development check at Maternal and Child Health Centres. This provided a baseline which will help judge the success of programs for this age group.
VicHealth	Over the past 3 years, VicHealth has included some impact measures to help understand the effectiveness of its *Sport and Active Recreation* and *Walking School Bus* programs. This involved funded agencies reporting on participants' understanding of the health benefits of exercise and changes to policies and practices.
DHS and Deakin University	The *'Be Active, Eat Well'* project. DHS and Deakin University defined an evaluation framework and are measuring the impact on behaviour and risk factors, such as weight, height and BMI.
Department of Infrastructure	The *TravelSMART* Alamein project measured the level of change in travel behaviour following implementation of strategies to reduce car use and promote active transport.

Note: Examples include those from the audit review of lead agencies and, hence, they refer to council areas not included in our detailed audit of local agencies.
Source: Victoria Auditor-General's Office.

DHS and DVC used qualitative methods to evaluate programs which included:

- the DHS narrative evaluation action research (NEAR) method which was used by the DHS North and West Metropolitan region to describe what was done, how well it worked and how the results will be used for future planning and action.
- a description of projects outputs and achievements by each local agency for the *Seniors GFYL* program (DVC) to identify issues and barriers to implementation, program highlights and key learnings.

DVC has started qualitative evaluations of Sport and Recreation Victoria's (SRV) *Physical Activity Grant* and *Community Walking Grant* programs to identify and promote good practice models.

These approaches prompt agencies to think about the effectiveness of health promotion activities and how they might be improved. However, it was unclear how these lessons had been captured and used to inform the direction of future programs. These qualitative measures need to be complemented by the measurement of quantitative indicators of program impact.

The *GFYL* evaluation framework was endorsed by ministers in March 2007. It is intended that the framework will provide a mechanism for collating information and developing consistent indicators across individual programs in the *GFYL* strategic plan.

4.5.4 Moving evaluation beyond process measurement

There were barriers which made it difficult for local agencies to move their evaluations beyond process measurement. These barriers included:

- access to skilled evaluation resources
- insufficient budgeted resources to go beyond the collection of process indicators
- the absence of detailed evaluation frameworks and “hands-on” guidance.

The planning, design and implementation of evaluation frameworks require appropriately skilled and experienced staff. Most local agencies do not have access to people with the requisite skills. DHS has recognised the need to develop evaluation skills and has invested in training people in the NEAR qualitative evaluation technique, and through one-day evaluation forums conducted by Deakin University.

Most local agencies found the level of funding did not allow them to conduct evaluation beyond the process measures needed for acquittal purposes. Funding was usually insufficient to allow the more in-depth evaluation of program impacts.

However, there were examples where agencies with skilled staff had found innovative ways to expand the scope of their evaluations and had committed additional funding to do this. For example:

- Plenty Valley CHS (in Whittlesea) and Whitehorse CHS partnered with universities, respectively, to develop baseline impact indicators and to jointly fund a “health evaluator” position
- the Barwon Primary Care Forum (Geelong) and the Plenty Valley CHS (in Whittlesea) had improved access to baseline data by sharing the cost of data collection with local agencies (Barwon) or setting up a research and analysis function (Plenty Valley).

For the most part, lead agencies required the reporting of process measures so that they could be sure that the funds had been spent as intended. To go beyond this, local agencies need clear and consistent evaluation frameworks and “hands on” guidance showing them how to apply these frameworks.

Lead agencies need to design these frameworks and provide support and guidance so that they are properly applied by local agencies. They also need information to be able to tell how well each application has contributed to the program objective.

A practical approach to achieving these program evaluation aims may be summarised in the following steps:

- Formulate a detailed evaluation plan before starting the program.
- Develop evaluation indicators at the same time as the program objectives to ensure they provide the information needed to measure progress.
- Invest more heavily in evaluation for the early (pilot) applications of the program by applying a detailed evaluation framework to understand the impacts and their underlying causes.
- Roll out the program beyond the pilot with a consistent and simplified set of indicators.
- Invest in training and guidance material that will provide agencies with a practical understanding of how to complete the evaluation and why it is important to do so.
- Aggregate the program results, report on the impacts and investigate cases where the impacts vary from what was expected.
- Use the information to continuously improve the program.

DHS and DVC recognised the need to improve the evaluation of the programs they fund and in 2006, DVC commissioned a mid-term evaluation of the *Seniors GFYL* program[13]. This evaluation supported the audit's findings and identified the difficulties in aggregating and comparing results because of incomplete and inconsistent data. As a result, DVC has developed a new evaluation framework to assess the program at its completion and this incorporates measures of perceived individual benefit and changes in physical activity levels.

RESPONSE by Chief Executive Officer, Whitehorse Community Health Service

Section 4.1.4

The description of the PCP's role in bringing different organisations together would be more accurate if it identified that it is a DHS requirement for Community Health Services in their health promotion plans and PCP's in their catchment plan to have a joint priority. In the Inner East PCP catchment, the priority is healthy weight in primary/pre school children and the PCP supported each of the initiatives in the four local government areas not just a pilot project in the Whitehorse LGA.

Sections 4.3.3 and 4.4.1

The issue of better coordination across local and lead agencies and particularly the development of systems and processes for a whole of government approach to obesity prevention is critical to the success of future health promotion action in Victoria.

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[13] Department for Victorian Communities 2006, *Final Report, Mid-Term Evaluation of Seniors Go For Your Life*, prepared by The Nucleus Group, Department for Victorian Communities, Melbourne.

RESPONSE by Chief Executive Officer, Whitehorse Community Health Service - continued

Leadership in the form of funding for specific evidence based initiatives to prevent obesity is required from a whole of government approach such as that described in the GFYL initiative (Section 7). This whole of government approach is not obvious at local agency level and needs to be strengthened though public commitment to joint action and through clear identification of the role of the various government departments in obesity prevention. This would include joint planning across relevant government departments, such as regulation, legislation and policies. Evidence based frameworks for action which connect to the broader whole of government approach need to be developed by the relevant funding bodies (DHS, DVC, VicHealth and others) to be rolled out through the various sectors in respective plans at the local level: CHS, PCPs, councils. Such an approach would provide a model for inter-sectoral action at local agency level and strongly support agencies to plan and work together to implement best practice health promotion interventions for obesity prevention.

Sections 4.4.2 and 4.4.3

Project based funding for obesity prevention (or other health promotion work) is not a realistic approach to the long-term, environmental, social, political and cultural change that is required to have a positive impact on obesity into the future. The issue of sustainable funding could be addressed through strengthening the whole of government approach and articulating clearly the role that different government departments, regional and local agencies have in preventing obesity. Funding for the evidence based frameworks could be attached to councils' Municipal Public Health Planning requirements, PCP catchment planning & Community Health, health promotion plans (and others) so that the funding is ongoing and action sustainable and not short-term project based.

Sections 4.5.1

Local agency capacity to plan, implement and act on impact evaluation is extremely limited. Effective impact evaluation requires specialist knowledge and skills that may be unrealistic for staff working in health promotion roles at local agency level. Evaluation not only requires skills in writing measurable objectives and indicators but also in data collection, analysis and report writing as well as skills in translating results into ongoing action.

To support best practice evaluation of the impact of health promotion action, a significant investment is required to support links with the higher education sector to lead evaluation of locally based health promotion initiatives. A whole of government health promotion framework for obesity prevention could have built–in evaluation indicators, data collection and analysis tools and clear direction in using and communicating evaluation results to inform future action.

5 Health promotion for Aboriginal people

At a glance

Background

This part of the report, examines the approach to health promotion for Aboriginal people by examining the initiatives funded under the *Fairer Victoria* policy.

Key findings

- The *Fairer Victoria* policy recognises the need to further improve the prevention and management of chronic disease among Aboriginal people**.**
- The Department of Human Services (DHS) and some local agencies have previously developed plans aimed at improving the health of Aboriginal people.
- Existing plans to prevent chronic disease among Aboriginal people have been strengthened through targeted programs.
- Local agencies had made some progress in developing better coordinated plans. However, there was room to improve these plans and incorporate reporting and evaluation frameworks to understand the impacts of local plans.
- There is room to further improve the approach to promoting the health of Aboriginal people by:
  - improving the quality and comprehensiveness of the Aboriginal Health Promotion and Chronic Care (AHPACC) plans
  - applying evaluation frameworks that provide an understanding of the plan impacts
  - creating a reporting framework that allows DHS to clearly understand the plans' impacts.

5.1 Need to further improve the prevention and management of chronic disease among Aboriginal people

In its *Fairer Victoria* policy, the government identified the improvement in the health and wellbeing of Aboriginal people and other disadvantaged people as a priority. Aboriginal people are disproportionately affected by preventable chronic disease and are more exposed to the risks underpinned by unhealthy eating and physical inactivity.

5.2 DHS and some local agencies have previously developed plans aimed at improving the health of Aboriginal people

All 6 DHS regions visited had Aboriginal Service Plans. These plans aimed to achieve a reduction in health inequality between Aboriginal people and other Victorians through better health care and the prevention of chronic disease.

The local government areas included in this audit with higher concentrations of Aboriginal people (Dandenong, Whittlesea and East Gippsland) had established specific health promotion initiatives. These included strategies to encourage physical activity and healthy eating to tackle chronic disease among Aboriginal people.

The Aboriginal Service Plans set out the regional strategy to address a range of issues affecting Aboriginal people including chronic disease and the level of poor health among sections of the Aboriginal community.

5.3 Existing plans to prevent chronic disease among Aboriginal people have been strengthened

As part of the *Fairer Victoria* policy, DHS set up an AHPACC program with funding for 4 years from 2005-06. The program aims to help Aboriginal organisations and other local health agencies to better plan, deliver and evaluate health promotion programs. There are 9 AHPACC-funded areas across Victoria, including Dandenong, Whittlesea, Whitehorse and East Gippsland.

The local Aboriginal Community Controlled Organisations (ACCHOs) and community health services (CHSs) had to:

- build strong partnerships across those parts of the community with an interest in promoting better health among Aboriginal people
- develop a plan to better address chronic disease and build local capacity so that the plan could be successfully implemented
- implement the plan and develop local evaluations to understand the impact of the plan elements. To help local agencies do this, DHS committed to provide a strategic evaluation framework as a guide for local evaluations
- provide regular reports on progress.

5.4 Progress by local agencies in developing better coordinated plans

Plans encompassing the East Gippsland, Whittlesea, Dandenong and Whitehorse council areas were examined. All these areas had developed AHPACC-funded plans. These plans made use of existing structures and programs, and had been developed in consultation with relevant local and state organisations.

All the areas recognised the complexity of the task and had developed initial 12 to 18 month plans to:

- build better partnerships and develop a local and regional capacity to plan for, and implement, programs
- set up the governance and management structures for the longer term
- recruit and train people who could work effectively with Aboriginal people to promote better health.

The planning for East Gippsland had gone further with the development of a 3-year plan to improve chronic disease management and to evaluate the impacts of the area's plan.

East Gippsland's planning was not only further advanced but also more comprehensive and detailed. During the initial planning period, the program partners had committed resources to:

- collect baseline information on the population and the risk factors driving chronic disease
- develop an evaluation framework to evaluate the plan actions in terms of health impacts and outcomes.

In East Gippsland, the agencies involved secured additional funding by combining resources from the AHPACC program and the Commonwealth *Healthy for Life* program[1], and had integrated the complementary objectives of these programs. The additional funding had helped the agencies collect baseline data.

Improving the quality and comprehensiveness of the AHPACC plans

The East Gippsland plan was well-structured, detailed, costed and with definite timelines. The plan was founded on a detailed baseline assessment of current practices, population characteristics and chronic disease risks. The plan had a clear approach to evaluating the impacts of activities. The other areas need to follow this example in formulating their longer-term plans.

Other plans reviewed were less advanced in terms of defining an evaluation framework and the baseline data needed to track impacts because they were at an earlier stage of development. DHS had committed to supply local areas with a strategic evaluation framework as a foundation for local evaluation frameworks. This is planned for completion by the end of May 2007 and will need to provide practical, “hands-on” guidance to assessing the impacts and outcomes of these plans.

However, DHS acknowledged that the program in some areas was less well-established and one of the key challenges faced by agencies was recruiting and training staff to implement the plan. For some areas, it has taken some time to recruit and employ suitable staff.

5.4.1 Creating a reporting and evaluation framework that allows DHS to clearly understand the plans’ impacts

AHPACC implementation plans need to be revised and updated every 12 months. Local agencies are required to report to DHS as follows:

- 6-monthly reports in the first 12 months of the program which could have taken the form of a structured discussion
- 12-monthly reports describing achievements for the period which inform a range of DHS reports.

There was evidence of some limited reporting by AHPACC agencies of service hours and client numbers, and an example of a 6-monthly report.

[1] Commonwealth Government program, delivered through the Office for Aboriginal and Torres Strait Islander Health (OATSIH) aimed at improving the health of mothers and children and the quality of life for people with a chronic condition.

DHS acknowledged that the reporting and evaluation processes were not well-developed. However, planned program reporting in the short-term included:

- commencement of narrative reporting by AHPACC workers
- 6-monthly reports from each area in the short-term
- roll-out of the evaluation framework to local agencies in June/July 2007. This is critical in defining how local agencies will measure the impacts of their plans on the health of Aboriginal people.

Applying evaluation frameworks to understand the impacts of plans

All the plans need to develop evaluations that inform on their impacts on the health and wellbeing of Aboriginal people. A well-founded strategic evaluation framework should help local areas build and apply consistent and local, evaluation frameworks.

RESPONSE provided by Secretary, Department of Human Services

The report has identified some of the key challenges for the AHPACC program. Reporting and evaluation processes will continue to be developed throughout the life of the program, including formative local and statewide evaluations and collection of relevant client service data.

All Partnerships have now submitted implementation plans of a good standard. As noted in the report, the East Gippsland plan is well developed, targets a broad range of areas and provides a much greater level of detail of strategies than some other plans. The plans have been developed by the local partners and reflect the capacity of the agencies involved and the level of development of the partnership. This is indicative of the resourcing available to partner agencies, the history of local service development, and the experience of the partners in providing health services to their local Aboriginal populations.

6 Health promotion for school students

At a glance

Background

Schools are very important settings for encouraging children to be physically active and to eat healthy food. Increasing trends in physical inactivity, unhealthy eating and obesity among school-aged children are a source of great concern. Health promotion activities were examined at a primary school and secondary school in each of the 7 local council areas we reviewed.

Key findings

- Schools planned and delivered a range of physical activity and healthy eating activities through:
  - the school curriculum
  - the secondary school nursing plans
  - programs developed by individual schools, and sometimes in partnership with local agencies
  - government-sponsored and statewide initiatives.
- There is room to further improve planning and delivery of health promotion in schools by:
  - improving the monitoring of risk factors
  - forming plans based on what works best
  - better coordinating plans and activities to address these risk factors
  - evaluating the impacts of programs to understand their effectiveness.
- Currently, the extent to which school children are encouraged to develop healthy habits varies across schools. Apart from the minimum requirements of the curriculum, the exposure to health promotion varies by school.
- The agencies responsible for health promotion activities in schools need to implement these improvements through a statewide plan to tackle obesity.

6.1 Planning and delivering health promotion in schools

Health promotion activities encouraging physical activity and healthy eating in schools were planned and delivered through:

- the school curriculum
- the secondary school nursing plans
- programs developed by individual schools and sometimes in partnership with local agencies
- government-sponsored, statewide initiatives.

6.1.1 Physical activity and health education through the school curriculum

In 1993, a Department of Education (DoE) policy introduced timetable requirements for physical and sports education[1] for Prep to Year 10 students in all Victorian schools. These were restated in 2002 in a DoE circular[2], and Figure 6A summarises the details.

Figure 6A
Prescribed curriculum times for physical education and sport

Year level	Prescribed minutes per week
Prep to Year 2	100-150 minutes per week (20-30 minutes daily)
Year 3 to Year 6	180 minutes per week with at least 50 per cent allocated to physical education
Year 7 to Year 10	200 minutes per week, with a minimum of 100 minutes of physical education, and 100 minutes of sports per week
Year 11 to Year 12	Recommended duration not specified

Source: Department of Education.

In 2006, the Australian Council for Health, Physical Education and Recreation (ACHPER) Victoria, completed a survey on physical education and sport in 150 primary and 74 secondary schools in Victoria. Among other things, the survey asked schools about the average number of minutes per week students spent on physical education and sports. The survey found that across all schools the average times devoted to these activities fell below the minimum levels for students between Prep and Year 12[3].

[1] Executive Memorandum (No. 764) 1993, issued to General Managers and Principals of all Victorian schools, Department of Education, Melbourne.

[2] Department of Education Circular 361/2002, detailing mandated times for physical and sport education.

[3] Australian Council for Health, Physical Education and Recreation conference, 30 November and 1 December 2006, Melbourne.

DoE plans to implement a School Compliance Checklist in 2007 to better monitor how well schools comply with these mandated activity times.

The curriculum provided students with some information on healthy eating and the need for exercise through subjects such as health education, food technology (home economics) and science. Two of the secondary schools visited (in Whittlesea and Macedon Ranges) had better aligned the material on health and nutrition across these subjects.

6.1.2 Promotion of better health through the DHS-funded school nurse program

A total of 199 of the 311 Victorian secondary schools have a part-time DHS-funded nurse. Of the 7 schools visited by the audit team, 6 ran the school nurse program. School nurses develop an annual plan to promote better health formed around the 3 priorities thought to be of most relevance to each school.

Plans for 3 of the 6 schools with a DHS-funded nurse, visited in Geelong, Dandenong and Macedon Ranges included physical activity and healthy eating within their top 3 priorities.

We found that for 4 of the 6 schools within the program, the school nurse worked closely with the school principal and welfare staff to determine priorities and formulate a plan. In the other 2 schools, the nurse and the school welfare staff worked more independently and this led to plans that were less collaborative.

The program only funds the nurse's salary. The 2003 evaluation found that the absence of dedicated funding meant that it was difficult to implement actions which needed resources beyond the nurse's time. However, in schools where there was good cooperation between the nurse and the school welfare staff, we found nurses were often able to secure funding from other sources to implement some of the planned actions.

Schools measured the success of their annual action plans through student observation, feedback, surveys and quizzes to determine student knowledge and understanding. It was difficult to use this information to gain a statewide view of the program. This information was not used to understand the strengths and weaknesses of the program and to improve performance.

RESPONSE provided by Secretary, Department of Human Services

Following the evaluation of the Secondary School Nursing Program in 2003 two supporting documents were published in 2006 to better support nurses in their role - Secondary School Nursing Professional Practice Standards and Secondary School Nursing Program Standards. The Department will continue to work with the Department of Education to enhance the existing partnership and regularly meet with Nurse Managers to identify priorities for the program.

6.1.3 Encouragement of physical activity and healthy eating beyond the curriculum

All the schools visited by the audit team recognised the need to provide physical activity opportunities and promote healthy eating by:

- providing extra-curricula opportunities for physical activity
- encouraging healthier canteen menus
- partnering with other local agencies to run programs to encourage healthy lifestyles
- working to remove the barriers to physical activity by providing access to good quality facilities.

Extra-curricula physical activity

The schools examined encouraged students to participate in a range of structured and unstructured physical activities and provided opportunities to be involved in competitive sport. For example, students at the primary schools in Dandenong and Geelong ran laps around the school 2-3 times a week. Other primary schools had raised funds through sponsored walkathons (Geelong) and an annual cross-country run (Macedon Ranges).

Healthier canteen choices

All schools had introduced healthier food choices to their canteen menus and had reduced less healthy foods. Primary schools in Whittlesea, Macedon Ranges and Geelong had gone further in promoting a healthy eating culture by introducing water drinking policies, providing fresh fruit and setting up breakfast clubs. Some schools relied on non-government support to fund breakfast clubs.

Partnership programs with other local agencies

There were several examples where schools had partnered with lead and local agencies to encourage healthier lifestyles:

- Primary schools in Dandenong, Whittlesea and East Gippsland operated the *Walking School Bus* program with VicHealth and *TravelSmart* with the Department of Infrastructure (DoI) operated in Dandenong.
- Newcomb Secondary College in Geelong was part of the *It's Your Move* partnership project with DHS and Deakin University covering 5 schools in Geelong.

Several agencies partnered schools to run active transport programs such as, VicHealth (*Walking School Bus*), DoI (*TravelSmart*) and Bicycle Victoria (*Ride2School*). Local councils and VicRoads played an important role in providing facilities such as bike paths and crossings to facilitate safe and direct walking and cycling routes to schools. DVC through Sport and Recreation Victoria (SRV) is providing $400 000 over 4 years for the *Go For Your Life Bike Shed Seeding Grants* which provide for the construction of new storage facilities or the improvement of existing storage facilities.

There was little in the way of coordination between often similar programs. In some cases, this made it more difficult to expand successful programs. For example, schools in East Gippsland and Dandenong wanted to expand their *Walking School Bus* programs to include a cycling element and found this difficult to do so. VicHealth sought to address this by introducing a new initiative, *Peddle Pods*, delivered through Bicycle Victoria. East Gippsland had been successful in securing funding for this program. For the most part, individual programs set priorities and allocated funding mostly without reference to other programs. These agencies are working with the Department for Victorian Communities to improve the coordination of walking and cycling programs.

Most initiatives were not resourced and structured to evaluate their impacts on attitudes, behaviours and the indicators of risk in relation to physical activity and healthy eating. However, there were some examples where initiatives were subject to a structured and comprehensive evaluation. For example, the *It's Your Move* project (DHS/Deakin University and 5 schools in Geelong) is measuring impacts and outcomes as part of the project evaluation.

Providing access to good quality facilities

Schools recognised the importance of creating an environment which encouraged physical activity by having:

- good sporting and recreational facilities near to the school
- safe and direct walking and cycling routes linking the school with local neighbourhoods.

The quality of these facilities varied across the schools visited. For example, at Kyneton (Macedon Ranges), the primary school had only one oval which was in urgent need of an upgrade and the closest public open space was 1.5 kilometres away. The school had only recently secured funding to upgrade these limited facilities. Kyneton students had access to outdoor pools in Kyneton and Woodend, but the closest indoor pool was 33 kilometres away in Gisborne.

In contrast, Findon primary school (Whittlesea) had 3 good quality ovals within the school grounds and was upgrading its netball and basketball courts by installing synthetic grass. Findon also made use of a nearby reserve.

6.1.4 Statewide initiatives to encourage healthier eating

The risks of increased levels of obesity and being overweight among young people have been responded to by introducing some healthy eating initiatives. These include:

- banning the sale of soft (sugar laden) drinks in schools by the start of 2007
- issuing guidelines for school canteens and setting up an advisory service to encourage a healthier menu, with a ban on selling confectionary by the beginning of 2009
- funding primary schools to provide a free piece of fruit once a week for students in Prep, Year 1 and Year 2 in 2007.

In many cases, schools have been moving towards healthier food options and these measures will help them along this path.

The documentation on these initiatives did not make it clear how DoE will:

- determine whether these measures have been implemented as intended
- monitor the potential barriers to implementation such as the impacts of the canteen guidelines on the financial viability of school canteens
- evaluate the effectiveness of these measures in influencing children's eating habits and their health. The *Healthy Canteen Kit* suggested that schools evaluate the success of these changes, but did not provide sufficient guidance for them to do this in a robust and consistent way.

These initiatives have not been applied in a way in which we are likely to understand their impacts on healthy eating within schools.

6.2 Improving the planning, delivery and evaluation of health promotion in schools

Schools are very important settings for encouraging children to be physically active and to eat healthy food. Increasing trends in these risk factors and obesity among school-aged children are a source of great concern.

Currently, the extent to which school children are encouraged to develop healthy habits varies across schools. Children are likely to receive far greater encouragement to choose healthy options in schools which have:

- access to good facilities
- a principal who prioritises health promotion
- good connections to supportive local agencies.

Many programs aimed to improve the health of school children. However, there was considerable room to improve health promotion in schools. Specifically, there is a need to:

- build an objective understanding of these risk factors and obesity among school-aged children to understand the underlying causes of obesity
- formulate plans based on what works best to address these issues
- better coordinate plans and activities to address physical inactivity and unhealthy eating, especially those with similar objectives
- ensure that the impacts of plans are evaluated to understand their effectiveness
- use the evidence on program impacts to drive and update plans.

The agencies responsible for health promotion activities in schools need to implement these improvements through a whole-of-state plan to tackle obesity in schools.

7 Strengthening the approach to health promotion

At a glance

Background

This part of the report focuses on where the approach to health promotion can be strengthened to tackle the risks associated with unhealthy eating and physical inactivity.

Key findings

- The evidence base to guide Victoria's investment in health promotion needs to be built and maintained by:
  - building a better understanding of the risks and outcomes of unhealthy eating and physical inactivity
  - understanding existing evidence on what programs work best to achieve these changes
  - consistently evaluating program impacts of health promotion programs on these risk factors.
- A strategic plan to address obesity by promoting healthy eating and physical activity has been established. While this plan provides a logical structure, it needs to go further by defining specific targets and filling the gaps identified.
- The *Go For Your Life (GFYL)* initiative was set up to coordinate action on obesity. To date, *GFYL* has focused on pulling existing initiatives into a consistent framework and encouraging cross-agency coordination.
- It is important that the governance arrangements are reviewed to determine if they are adequate to guide the initiative towards the intended outcomes in the longer-term.

Key recommendations

7.1 That the Department of Human Services (DHS) designs and implements an ongoing approach to data collection and monitoring that will inform the plans of lead and local agencies through an objective understanding of obesity-related risk factors, and the consequent health and wellbeing risks and outcomes.

At a glance - *continued*

Key recommendations - *continued*

7.2 That DHS, VicHealth and the Department for Victorian Communities (DVC) work to improve agencies' understanding of the evidence on program effectiveness by setting up a structured approach to:

- review the existing evidence and distil guidance on the effectiveness of programs to address the risk factors underpinning obesity
- identify the important gaps in our understanding and implement a plan to address these gaps
- update guidance on program effectiveness in the light of further research and the ongoing evaluation of programs in Victoria
- put in place mechanisms to communicate this guidance across central government and to the local agencies responsible for planning health promotion programs.

7.3 That DHS, VicHealth, DVC and the Department of Education (DoE) collaboratively improve the evaluation of the health promotion projects they fund to address unhealthy eating, physical inactivity and obesity by:

- designing evaluation frameworks to measure the impacts of programs on these risk factors
- working with other lead agencies to use consistent indicators of impact across similar programs
- providing practical guidance and training to local agencies showing them how to apply these frameworks
- using this information to report on the impacts of programs.

7.4 That local councils regularly evaluate Municipal Public Health Plans and, in the design and scope of the evaluation, include information to understand how these plans have achieved their objectives.

7.5 That the *GFYL* secretariat coordinates the development of a comprehensive plan to address unhealthy eating, physical inactivity and obesity for Victoria. The plan needs to:

- use the existing evidence to set specific objectives for each population group
- define a coordinated and costed program to achieve these objectives
- provide detailed evaluation and reporting frameworks to ensure that the impacts of projects on the program objectives are clearly understood
- document the mechanisms for adjusting the plan in the light of the emerging evidence on effectiveness.

7.6 That DHS reviews the current *GFYL* governance arrangements and makes recommendations on the arrangements needed to deliver effective whole-of-government programs to reduce obesity. In conducting the review DHS should consult the other lead agencies working in this area and seek input from the State Services Authority (SSA) in relation to good practice governance arrangements.

7.1 Introduction

The preceding parts of this report have illustrated the challenge facing Victoria in addressing the risks posed by unhealthy eating and physical inactivity. The impacts of obesity-related risk factors on the Victorian population, health expenditure and the economy are already significant and are on an upward trend.

Some positive steps have been taken to address these risks and there are plans to do more. However, to date, the combined efforts of government have not significantly slowed the increase in obesity underpinning the rise in preventable chronic disease.

In this part of the report we describe how the approach to promoting healthy eating and physical activity needs to be strengthened in terms of:

- building and maintaining the evidence base to guide the State's investment to reduce obesity
- improving the planning and coordination of programs to address unhealthy eating and physical inactivity.

7.2 Building and maintaining the evidence base to guide the State's investment in health promotion

The Victorian Government's investment in the mix of healthy eating and physical activity programs needs to be channelled to effectively address obesity. To do this, agencies need to:

- build a better understanding of the risks and outcomes of unhealthy eating and physical inactivity
- collate and better understand the existing evidence on what programs work best to achieve these changes
- consistently evaluate the impacts of health promotion programs on these risk factors.

7.2.1 Building a better understanding of the risks and outcomes of unhealthy eating and physical inactivity

There were gaps in the information on obesity risk factors, particularly at the level that would help inform local agency planning. It is important to have an objective and ongoing appreciation of these risks and the pattern of obesity which they underpin.

DHS plans to pilot and roll-out a health monitor survey to better understand the eating habits, physical activity and related biomedical health indicators of Victorians. This is an encouraging development and DHS needs to follow through with these plans.

DHS is best positioned, with its specialist surveillance skills, to improve the information available to lead and local agencies to inform their planning. In doing this, DHS needs to understand the needs and views of the other agencies involved in health promotion.

Recommendation

7.1 That DHS designs and implements an ongoing approach to data collection and monitoring that will inform the plans of lead and local agencies through an objective understanding of obesity-related risk factors, and the consequent health and wellbeing risks and outcomes.

7.2.2 Understanding the existing evidence on what programs work best to achieve these changes

DHS, VicHealth, DVC and other organisations, for example universities, have all contributed to an improved understanding in this area. However, there are gaps in the evidence base and this made it more difficult for agencies to link their plans to the information about what programs work best.

DHS, VicHealth and DVC need to work together to address these gaps. In doing this, they will need to involve university departments and local agencies working in this area.

Recommendation

7.2 That DHS, VicHealth and DVC work to improve agencies' understanding of the evidence on program effectiveness by setting up a structured approach to:

- review the existing evidence and distil guidance on the effectiveness of programs to address the risk factors underpinning obesity
- identify the important gaps in our understanding and implement a plan to address these gaps
- update guidance on program effectiveness in the light of further research and the ongoing evaluation of programs in Victoria
- put in place mechanisms to communicate this guidance across central government and to the local agencies responsible for planning health promotion programs.

7.2.3 Consistently evaluating the impacts of health promotion programs on these risk factors

The approach to program evaluation for the health promotion programs we examined lacked consistency. Most evaluations did not go beyond the process measures most commonly required as evidence that agencies had spent funds on planned activities. Occasionally, we came across an evaluation designed to measure the impacts of a program on these risk factors and obesity.

Given the significance of obesity in Victoria, it is critical that agencies understand how well programs have achieved their objectives. Evaluation frameworks and "hands-on" guidance, training and ongoing support to help local agencies apply these frameworks to expand the scope of their evaluations are needed.

In addition, evaluation frameworks must balance the need to understand the impacts with the resources required to do this. A practical approach is required, investing more in evaluating and proving pilot programs, while requiring the collection of a restricted set of impact indicators in the program roll-out.

RESPONSE by Chief Executive Officer, Whitehorse Community Health Service

Evaluation of health promotion impacts and the use of evidence based approaches are clearly aligned and this understanding needs to be strengthened through future frameworks such as those described. Like evaluation, successfully using evidence based approaches in health promotion requires particular knowledge and skills to source evidence, analyse evidence, contextualise evidence to local areas and to translate evidence into practice. Aligning with the higher education sector to achieve this will support local agencies in connecting practice to theory and academic institutions in connecting theory to practice, particularly in relation to contextualising and translating evidence into practice and helping to inform future research. DHS could consider funding a number of demonstration projects to establish organisational models that systematise evaluation and evidence based practice within the community health setting, as they have with the funding for early intervention in chronic disease models in community health.

Recommendations

7.3 That DHS, VicHealth, DVC and DoE collaboratively improve the evaluation of the health promotion projects they fund to address unhealthy eating, physical inactivity and obesity by:

- designing evaluation frameworks to measure the impacts of programs on these risk factors
- working with other lead agencies to use consistent indicators of impact across similar programs
- providing practical guidance and training to local agencies showing them how to apply these frameworks
- using this information to report on the impacts of programs.

7.4 That local councils regularly evaluate Municipal Public Health Plans and, in the design and scope of the evaluation, include information to understand how these plans have achieved their objectives.

7.3 Improving the planning and coordination of programs to address unhealthy eating and physical inactivity

7.3.1 Plans to tackle obesity and the ways in which these could be improved

The *Go For Your Life* (*GFYL*) initiative has been established as a whole-of-government endeavour to improve the health and wellbeing of Victorians through increased healthy eating and physical activity. The *GFYL* governance structure has been designed to promote a coordinated approach across government, with a minister's forum, a senior officers group, an interdepartmental committee and an ambassadors group with community representation. The *GFYL* secretariat administers the initiative.

The *GFYL* strategic plan covers the period 2006 to 2010. It clearly describes the initiative's vision, medium-term goal, objectives and key measures of success. The strategic plan provides a structure for gathering and coordinating a range of existing initiatives under 5 population groups (children under 5, young people and their families, adults, senior Victorians and high-risk population groups).

The plan also flagged specific *GFYL* projects to develop an evaluation framework, to collect base data on impacts and outcomes, and to develop a communications strategy.

The *GFYL* plan provided a coherent structure and common branding for a wide range of existing programs. The *GFYL* secretariat is working to better coordinate and maximise the impact of these programs. In the medium-term, *GFYL* aims to measure the success of these objectives in addressing obesity.

However, the planning needs to go further for this to form the basis for effective action to address these risks. For each population group, the plan needs to:

- collate the existing information on the risks and health outcomes and describe the additional information needed to understand the nature of these risks
- set healthy eating and physical activity targets in line with the *GFYL* objectives
- define a coherent, joined-up and costed set of programs to achieve these targets, together with implementation timelines and responsible agencies
- provide a detailed evaluation and reporting framework for measuring progress towards these targets and the consequent health outcomes
- document the mechanisms for managing and adjusting the plan in the light of the monitoring and evaluation results.

Recommendation

7.5 That the *GFYL* secretariat coordinates the development of a comprehensive plan to address unhealthy eating, physical inactivity and obesity for Victoria. The plan needs to:

- use the existing evidence to set specific objectives for each population group
- define a coordinated and costed program to achieve these objectives
- provide detailed evaluation and reporting frameworks to ensure that the impacts of projects on the program objectives are clearly understood
- document the mechanisms for adjusting the plan in the light of the emerging evidence on effectiveness.

7.3.2 Putting in place a governance structure capable of addressing the risk factors driving the rise in obesity

Working effectively across departmental and agency boundaries presents special challenges to government. The governance structure must help agencies overcome barriers which make it difficult to plan and collaborate across portfolios. These barriers include:

- different drivers and objectives which will lead to some agencies placing a lower priority on their contribution to a collaborative plan
- the difficulties in driving collaborative planning, implementation and evaluation through existing cross-agency governance structures
- established programs and funding allocations limiting the flexibility to redirect resources to the priority actions identified from a whole-of-government perspective
- established funding models which make it easier to treat, rather than prevent chronic disease, and limit the agencies' ability to sustain funding to programs in the longer-term.

Success in addressing the risk factors leading to obesity requires a governance structure which can overcome these barriers.

The government set up *GFYL* as the whole-of-government initiative to coordinate action on obesity. So far, *GFYL* has focused on pulling existing initiatives into a consistent framework and encouraging cross-agency coordination.

To effectively address obesity going forward, *GFYL* will need to:

- set specific objectives and targets relating to healthy eating for each of its target population groups
- devise a program that builds on existing programs to deliver these objectives
- provide ongoing measures of success
- have the flexibility to reallocate or expand resources in response to the emerging evidence on performance and the target outcomes.

It is critical that the governance arrangements are capable of driving effective outcomes. With this in mind, Government needs to review the existing governance arrangements to determine if they can deliver on these requirements.

Recommendation

7.6 That DHS reviews the current *GFYL* governance arrangements and makes recommendations on the arrangements needed to deliver effective whole-of-government programs to reduce obesity. In conducting the review DHS should consult with the other lead agencies working in this area and seek input from State Services Authority in relation to good practice governance arrangements.

Appendix A. Audit assistance

Audited agencies

We interviewed key staff about initiatives which focused on promoting healthy eating and physical activity at the following lead and local agencies.

Statewide lead agencies

- Department for Victorian Communities
- Department of Education
- Department of Human Services
- Department of Infrastructure
- Department of Premier and Cabinet
- Department of Sustainability and Environment
- Department of Treasury and Finance
- VicHealth
- VicRoads.

Local agencies in Greater Dandenong

- Carwatha College P-12
- Greater Dandenong City Council
- Greater Dandenong Community Health Service
- South East Primary Care Partnership
- Southern Metropolitan (DHS region)
- Southvale Primary School.

Local agencies in Greater Geelong

- Barwon Health
- Barwon Primary Care Forum
- Barwon South Western Region (DHS region)
- City of Greater Geelong
- Mandama Primary School
- Newcomb Secondary College and *Its Your Move* Project.

Local agencies in Whitehorse

- City of Whitehorse
- Eastern Metropolitan (DHS region)
- Inner East Primary Care Partnership
- Koonung Secondary College
- Mount Pleasant Primary School
- Whitehorse Community Health Service.

Local agencies in Whittlesea

- City of Whittlesea
- Findon Primary School
- Lalor Secondary College
- Plenty Valley Community Health Service
- North Central Metropolitan Primary Care Partnership
- North West Metropolitan (DHS region).

Local agencies in Central Goldfields

- Central Goldfields Shire Council
- Central Victorian Health Alliance – covers the Central Goldfields and Macedon Ranges Shires
- Loddon Mallee (DHS region) – covers the Central Goldfields and Macedon Ranges Shires
- Maryborough College P-12
- Maryborough District Health Service.

Local agencies in Macedon Ranges

- Cobaw Community Health Service
- Kyneton Primary School
- Kyneton Secondary College
- Macedon Ranges Shire Council.

Local agencies in East Gippsland

- Bairnsdale Junior Secondary School
- Bairnsdale West Primary School
- East Gippsland Primary Care Partnership
- East Gippsland Shire Council
- Gippsland (DHS region)
- Gippsland East and Gippsland Aboriginal Co-operative Limited
- Gippsland Lakes Community Health Service.

Assistance to the audit team

The following people and organisations were consulted to obtain information about the risks associated with unhealthy eating and physical inactivity, and the delivery of healthy eating and physical activity initiatives at a statewide and local level.

- Australian Council for Health, Physical Education and Recreation (Victoria)
- Diabetes Australia - Victoria
- General Practitioners Association of Geelong
- Kinect Australia
- Maribyrnong City Council
- Monash University – Centre for Health Economics
- Moreland City Council
- Municipal Association of Victoria
- National Heart Foundation (Victoria)
- National Public Health Partnership
- Northern Division of General Practitioners
- The Cancer Council Victoria
- Victorian Aboriginal Community Controlled Health Organisation.

Specialist support was provided by a reference committee, comprising Professor Vivian Lin, Professor of Public Health, School of Public Health, La Trobe University; Ms Liz Furler, Executive Director, TRACsa: Trauma and Injury Recovery, Adelaide; and Mr Nigel Dawson, Creative Director, Grey Worldwide.

We thank all those involved in the audit and found their contributions most valuable.

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