Implementation Plan for Healthy Workers

NATIONAL PARTNERSHIP AGREEMENT ON PREVENTIVE HEALTH

NOTE: The Australian Government may publish all or components of this jurisdictional implementation plan, following initial consultation with the jurisdiction, without notice in public documents pertaining to the National Partnership Agreement.

PRELIMINARIES

1. This Implementation Plan is created subject to the provisions of the National Partnership Agreement on Preventive Health and should be read in conjunction with that Agreement. The objective in the National Partnership is to address the rising prevalence of lifestyle related chronic diseases, by:

   1.1 laying the foundations for healthy behaviours in the daily lives of Australians through social marketing efforts and the national roll out of programs supporting healthy lifestyles; and

   1.2 supporting these programs and the subsequent evolution of policy with the enabling infrastructure for evidence-based policy design and coordinated implementation.

   The measures funded through this Agreement include provisions for the particular needs of socio-economically disadvantaged Australians, and those, especially young women, who are vulnerable to eating disorders.

2. The Healthy Workers initiative provides funding to support implementation of healthy lifestyle programs in workplaces, with workers, their families and communities.

3. Under the Healthy Workers initiative jurisdictions are responsible for developing programs that may include a range of different activities. Some of these activities may be grouped according to similarities.

TERMS OF THIS IMPLEMENTATION PLAN

4. This Implementation Plan will commence as soon as it is agreed between the Commonwealth of Australia, represented by the Minister for Health, and the State of Victoria, represented by the Hon. David Davis MLC, Minister for Health (known as the Parties to this Implementation Plan).

5. This Implementation Plan may be varied by written agreement between authorised delegates.

6. This Implementation Plan will cease on completion or termination of the National Partnership, including the acceptance of final performance reporting and processing of final payments against performance benchmarks specified in this Implementation Plan.

7. The parties to this Implementation Plan do not intend any of the provisions to be legally enforceable. However, that does not lessen the parties' commitment to this Implementation Plan.

FINANCIAL ARRANGEMENTS

8. The maximum possible financial contribution to be provided by the Commonwealth as facilitation payments for the Healthy Workers initiative is $52.85 million.

9. The maximum possible financial contribution to be provided by the Commonwealth as reward payments for the National Partnership is $37.43 million. Reward payments will be made following the COAG Reform Council's assessment of Victoria's achievement against the seven performance benchmarks specified in the National Partnership. Facilitation and reward payments will be payable in accordance with Table 1 from July 2011 to 2018 in accordance with the National Partnership. All payments are exclusive of GST.

Table 1: Facilitation and Reward Payment Schedule ($ million)

Facilitation Payment for Healthy Workers initiative		Due date	Amount
(i)	Facilitation payment	July 2011	$8.25
(ii)	Facilitation payment	June 2012	$9.43
(iii)	Facilitation payment	July 2012	$5.17
(iv)	Facilitation payment	July 2013	$6.00
(v)	Facilitation payment	July 2014	$6.00
(vi)	Facilitation payment	July 2015	$6.00
(vii)	Facilitation payment	July 2016	$6.00
(viii)	Facilitation payment	July 2017	$6.01
Reward Payment for NPAPH		Due date	Amount
(ix)	Reward payment	2016-2017	$18.72
(x)	Reward payment	2017-2018	$18.72

OVERALL BUDGET

10. The overall program budget (exclusive of GST) is set out in Table 2.

Table 2: Overall program budget ($ million)

Expenditure item		2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	Total
(i)	Health promoting workplaces & workforces	0.500	1.250	1.363	1.460	1.626	1.327	1.340	8.866
(ii)	Healthy workplaces & workers as part of communities	2.848	7.068	7.886	7.802	6.210	6.080	6.093	43.987
TOTAL		$3.348	$8.318	$9.249	$9.262	$7.836	$7.407	$7.433	$52.853

Note: A facilitation payment (Healthy Workers and Healthy Children) on the 29 June 2012 of $20 million will be allocated across 2013-18 to matched planned expenditure.

11. Having regard to the estimated costs of program and associated activities specified in the overall program budget, the State will not be required to pay a refund to the Commonwealth if the actual cost of the program is less than the agreed estimated cost. Similarly, the State bears all risk should the costs of the program and/or a project(s) exceeds the estimated costs. The Parties acknowledge that this arrangement provides the maximum incentive for the State to deliver projects cost-effectively and efficiently.

PROGRAM OVERVIEW AND OBJECTIVE

12. **Program name:** Healthy workers, workplaces and communities

13. The objective in this program is to support health promoting workplaces, workforces and communities to increase fruit and vegetable consumption and physical activity rates, and decrease smoking and alcohol consumption rates in workers and their families.

14. Healthy workers, workplaces and communities is inclusive of the following activities. These activities build on and continue the work already commenced and approved under the National Partnership to create a dynamic and integrated preventive health system at a statewide and local level.

    Activity 1: Health promoting workplaces and workforces

    Activity 2: Healthy workplaces and workers as part of communities (Healthy Together Communities - HTC)

15. The senior contact officer for this program is Dr Shelley Bowen, Senior Public Health Advisor, Department of Health Victoria (t: 03 9096 5209 e: shelley.bowen@health.vic.gov.au).

ACTIVITY DETAILS

16. **Activity 1:** Health promoting workplaces and workforces

17. **Overview:** The Department of Health is building a dynamic health and wellbeing system in Victoria to support healthy choices where people live, learn, work and play. A range of statewide initiatives (see below) will be supported through existing statewide policies and strategies including the *Victorian Public Health and Wellbeing Plan 2011 – 2015*, the *Victorian Aboriginal Nutrition and Physical Activity Strategy*, and the *Victorian Healthy Eating Enterprise* (VHEE) which aims to build a vibrant healthy eating culture in Victoria. A Healthy Food Charter aims to ensure consistency of healthy eating messages across VHEE initiatives.

    Further, 'health promoting workplaces and workforces' is complemented by the activities of Worksafe's WorkHealth program which includes WorkHealth checks, health coaching for medium to high risk individuals, 'how to' tools and resources and workplace health promotion grants.

    Statewide initiatives include:

    - The **Healthy Together Achievement Program** (Achievement Program) sets out an approach for how businesses can create a health promoting workplace. The Achievement Program process allows workplaces to consider what existing health and wellbeing policies and activities are in place and how to build on these to work towards best practice health promotion. It supports workplaces to meet benchmarks for healthy eating, physical activity, tobacco and alcohol use. Workplaces/workforces will be recognised when benchmarks for a priority has been achieved.

      Workplaces/workforces will receive guidance to support implementation through 'how to' tools and resources, phone enquiry line and email advice, professional development, online network and website.

    - The **Healthy Together Healthy Eating Advisory Service** (HEAS) provides healthy eating and nutrition advice and menu assessment services to schools, early childhood services, workplaces and hospitals. The service supports settings to work towards achieving the healthy eating benchmark of the Achievement Program. It will provide workplaces with phone and email healthy eating and nutrition advice, menu, catering and vending machine assessments, healthy recipes and food ideas, support and training for health professionals and food service staff, policy development advice and a range of resources via a website. It will also support Victorian hospitals in implementing the *Healthy Choices: food and drink guidelines for Victorian public hospitals.*

    - The provision of **Healthy Living Programs and Strategies** designed for workers and families such as healthy living web 2.0, for example online tools and advice to support healthy living through the Better Health Channel and Jamie's Ministry of Food (fixed kitchen).

    - A statewide **social marketing campaign** focused on increasing the fruit and vegetable consumption and physical activity of families.

18. **Outputs:**

Output	**Quantity**	**Quality**	**Timeframe**
Number of workplaces participating in the Achievement Program	20% of medium to large workplaces	See evaluation, outcomes & performance benchmark measurement.	2017-18

19. **Outcomes:**

Activity	**Long term outcomes (2017/18) ***
Activity 1: Health promoting workplaces and workforces	• Proportion of adults at healthy weight returned to 2008 baseline. • Increase in daily serves of fruits and vegetables consumed by adults to meet targets • Increase in proportion of adults participating in moderate physical activity each day by 15 per cent

20. **Rationale:** Victoria is taking an innovative systems-building approach to prevention. It is utilising systems theory to establish the building blocks of a preventive health system and design comprehensive initiatives that target all levels of the system.

A social ecological systems model lies at the heart of Victoria's prevention strategy, supporting a range of complementary health promoting initiatives which are supported by appropriate policies and programs delivered at different levels within the system: statewide, settings and communities.

The initiatives detailed are evidence based and shift effort from less effective approaches (fragmented short-term projects) to those that have the potential for greater population impact. The Achievement Program is based on the World Health Organization's Healthy Workplaces model and shows four areas of a work environment that impact on employee health. It also outlines a set of principles that should be considered to create and sustain a healthy work environment.

Workplaces are complex ecological systems (Hawe et al 2009) requiring matched investment in organisational capacity and capability as well as multiple health promotion interventions. The most promising approaches to preventing chronic disease among workers and resulting in a productive workplace are those that achieve a balance between encouraging healthy behaviour among employees and addressing underlying workplace and organisational factors (Anderson et al, 2009; Robroek et al, 2009). This creates a supportive environment where workers are better able to make healthy choices. This means that the focus is broader than individual attitudes and behaviour, and also aims to address the workplace environment. The World Health Organisation's Healthy Workplaces Model for Action describes the four key areas that can be influenced in healthy workplace initiatives: the physical work environment; the psychosocial work environment; personal health resources; enterprise involvement in the community (WHO, 2010).

References:

Anderson, LM. et al. The Effectiveness of Worksite Nutrition and Physical Activity Interventions for Controlling Employee Overweight and Obesity: A Systematic Review. American Journal of Preventive Medicine 2009; 37(4).

Hawe P, Shiell A, Riley T. Theorising interventions as events in systems. American Journal of Community Psychology, 2009, 43:267-276.

Robroek et al (2009) Determinants of participation in worksite health promotion programmes: a systematic review. International Journal of Behavioral Nutrition and Physical Activity 2009, 6:26.

World Health Organisation (2010). Healthy workplaces: a model for action for employers, workers, policy-makers and practitioners
www.who.int/occupational_health/.../healthy_workplaces_model.pdf

21. **Contribution to performance benchmarks:** See logic map attached (attachment A).

22. **Policy consistency:** *NPAPH and Healthy Workers Scoping Statement and Guiding Policy Principles (Attachment B).*

    The health promoting workplace program is consistent with the objectives of the NPAPH to improve nutrition, increase levels of physical activity, reducing harmful/hazardous consumption of alcohol and smoking cessation. It is also consistent with the outputs, scope and policy principles of the Healthy Workers initiative as detailed in the Healthy Workers Scoping Statement and Guiding Policy Principles.

    This activity is consistent with broader Victorian preventive health reforms, policies and specific directions in workplace health in Victoria.

23. **Target group(s):** A total of 495,516 small to large (21,236 medium to large) private businesses are registered in Victoria (2012). Medium to large businesses comprise 20 plus employees.

24. **Stakeholder engagement:** The initiatives build on and continue the work already commenced and approved under the National Partnership. A broad range of stakeholders were consulted and engaged in the development of the initiatives.

    The Department of Health has a range of mechanisms for engaging with key stakeholders on the workplace health agenda. Two committees related to work and health meet regularly and involve key stakeholders and other government departments. These are led by other agencies and include the WorkHealth Advisory Group (WAG) and the VicHealth Participation/Workplace Health Advisory Committee. The Department of Health are a member of these groups and has a standing item/regular reporting item on the NPAPH on their agendas.

    A Partnership and Engagement Strategy has been developed to ensure a stronger engagement and collaboration with partners and key stakeholders to align policy and programs and deliver shared goals to shape the prevention system in Victoria and deliver better health outcomes.

25. **Risk identification and management:**

Risk	**Level**	**Mitigation strategy**	**Responsibility/timeline**
The engagement of workplaces in the Achievement Program	M	The Achievement Program developed through extensive stakeholder consultation. External agency contracted to undertake communication and engagement and support workplaces to implement the Achievement Program (website, e-newsletters, networks, forums etc). Communication and engagement strategy developed and updated regularly.	Prevention and Population Health Branch (PPHB)
NGOs continuing to work in a traditional programmatic approach	M	Whole system methods established to support statewide NGOs as part of a system (eg meeting differently). Ongoing feedback and assessment at state and local level (eg system inventory and assessment).	PPHB and the Centre of Excellence in Intervention and Prevention Science (CEIPS)

26. **Evaluation:**

Activity	**Methodology**	**Timeframe**
Activity 1: Health promoting workplaces and workforces As Healthy Workers activities are collectively intended to contribute to outcomes shared by all other NPAPH initiatives, the evaluation of Healthy Workers Victoria will necessarily be a component of a broader Victorian evaluation strategy and will contribute to it.	In addition to the 2008 and 2011 Victorian Population Health Survey (VPHS)-LGA behavioural measures, a baseline survey (CATI), will cover key behavioural mediator variables (not currently measured) such as awareness, attitudes, self-efficacy and intentions. These measures will be taken in Healthy Together Communities (HTC) and selected comparison communities, to create a quasi-experimental design, to allow for assessment of both between area and within area effects between 2012 and 2015. Process review and discrete program level evaluation in the HTC areas have been designed to provide lessons learnt/ insights. Supplementary workplace Achievement Program data is being investigated.	2008 and 2011 behaviour change baseline using VPHS-LGA. Larger area worker profiles will be investigated for initiative evaluation utility. 2014 and 2017 post-test using VPHS-LGA 2012 baseline mediator CATI survey in HTC areas and comparison areas. 2015 post-test mediator CATI survey in HTC areas and comparison areas. 2011-2017 qualitative process review and case studies (a component of a community-wide evaluation to be undertaken with HTC areas) 2016/2017 evaluation report and peer-reviewed publications Supplementary workplace Achievement Program evaluation data collected in HTCs and statewide.

27. **Infrastructure:** Not applicable. Infrastructure funded under the NPAPH has been detailed under each activity.

28. **Implementation schedule:**

Table 3: Implementation schedule

Deliverables and milestones		Due Date
(i)	Engagement and support of workplaces and industry in the Achievement Program including provision of resources, advice and network	Annual reporting by 31 August 2012, 2013, 2014, 2015, 2016, 2017, and 2018
(ii)	Engagement and support provided to workplaces by the Healthy Together Healthy Eating Advisory Service	Annual reporting by 31 August 2012, 2013, 2014, 2015, 2016, 2017, and 2018
(iii)	Healthy Living Programs and Strategies provided	Annual reporting by 31 August 2012, 2013, 2014, 2015, 2016, 2017, and 2018
(iv)	Social marketing campaign delivered	Annual reporting by 31 August 2012, 2013, 2014, 2015, 2016, 2017, and 2018

29. **Responsible officer and contact details:** Dr Shelley Bowen, Senior Public Health Advisor, Department of Health Victoria (t: 03 9096 5209 e: shelley.bowen@health.vic.gov.au).

30. **Activity budget:**

Table 4: Activity project budget ($ million)

Expenditure item	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	Total
(i) Healthy Together Achievement Program								
(ii) Healthy Living Programs and Strategies								
(iii) Social marketing campaign								
(iv) Evaluation								
TOTAL	0.500	1.250	1.363	1.460	1.626	1.327	1.340	8.866

31. **Activity 2:** Healthy workplaces and workers as part of communities (Healthy Together Communities - HTC). Note: HTC was previously delivered under the Prevention Community Model banner.

32. **Overview:** The HTC strategy is defined as a whole of community and complex community level system building effort to raise the profile of and demand for good health. Its business is to create multiple health promoting environments. The HTC strategy is surrounded and supported by a multi-level prevention system building effort across Victoria.

The HTC strategy brings together local stakeholders and communities to develop local solutions to promote health and wellbeing by using local partnerships and a skilled health promotion workforce to design and deliver tailored programs and initiatives. This involves working with local communities, schools and workplaces to take action on health ie improving people's health where they live, learn, work and play.

HTC builds on existing health promotion efforts in a select number of communities through the provision of:

- A new prevention workforce and leadership and workforce development strategy
- Tailored interventions at the community level, including healthy living programs that encourage community participation in prevention, as well as strategies that create environments that encourage and support healthy living such as Healthy Together Health Champions, Jamie's Ministry of Food mobile kitchen, Healthy Food Connect, Healthy Food Recovery, Healthy Eating and Food Literacy in Secondary Schools and Healthy by Design.
- Innovative local community engagement and social marketing (healthy eating and physical activity messages)
- Statewide initiatives and social marketing to support healthy lifestyles eg Healthy Together Achievement Program and Healthy Together Healthy Eating Advisory Service
- Research and evaluation support via the Centre of Excellence in Intervention and Prevention Science (CEIPS)

The Working together towards healthier communities: Joint statement of commitment to prevention (www.health.vic.gov.au/prevention) articulates the agreement between all levels of government to participate in the implementation of the HTC strategy.

Operating across the municipalities of Hume, Wyndham, Whittlesea, Knox, Greater Dandenong, Cardinia Shire, Mildura, Greater Bendigo, Wodonga, Latrobe, Greater Geelong, Ararat, Pyrenees and Central Goldfields, Healthy Together Communities will reach approximately 1.3 million Victorians, 520 schools, 938 early childhood services and 4,409 medium to large workplaces.

33. **Outputs:**

Output	**Quantity**	**Quality**	**Timeframe**
Activity 2: Healthy workplaces and workers as part of communities (HTC)	Extension of 12 prevention areas (across 14 local government areas).	See evaluation, outcomes & performance benchmark measurement.	2017/18

34. **Outcomes:**

Activity	**Long term outcomes (2017/18) ***
Activity 2: Healthy workplaces and workers as part of communities (HTC)	• Proportion of adult at healthy weight returned to 2008 baseline. • Increase in daily serves of fruits and vegetables consumed by adults to meet targets • Increase in proportion of adults participating in moderate physical activity each day by 15 per cent

* see NPAPH Performance Benchmarks for details

35. **Rationale:** Victoria is taking an innovative systems-building approach to prevention. It is utilising systems theory to establish the building blocks of a preventive health system and design comprehensive initiatives that target all levels of the system: statewide, settings and communities.

The HTC approach is a whole of community and complex community level system building effort. This approach recognises that workplaces are one setting within a community to improve individual workers' health and action within a workplace must be replicated across the community. It acknowledges that workers are also parents, grandparents and family members, and reinforcing health promoting approaches across a range of settings will have greater effect.

The UK Foresight report on obesity defines this as failing to address the systemic drivers of chronic disease in a concerted and coordinated manner and what is required is a 'whole of systems' approach (Foresight, 2007). For example, action in one part of the system (eg encouraging employees to have a healthy lunch) can be undermined by the actions in other parts of the system (eg price of fast food located close to the workplace).

The approach recognises the capacity of medium to large workplaces to adopt a health promoting organisation approach (the Achievement Program). Small businesses have long been recognised as offering specific challenges to engaging workers in health promotion (Goertzal, 2008). There are a number of barriers in small businesses that mean that many primary prevention interventions in the workplace setting is not a possibility. The Victorian business community is dominated by small business. Therefore, a broad approach that steps beyond the workplace is required to comprehensively improve the health of Victorian workers. It is timely to consider how workplace health promotion best applies to small and medium-sized enterprises who are part of a community, and possibly better able to take up interventions *offered across the communit*y rather than always within the four walls of the workplace.

For example, an employee may want to take part in a lifestyle modification program offered at a community health centre or access healthy cooking classes to develop further skills and knowledge through Jamie's Ministry of Food. Further, by taking a whole of community approach, this employee would be exposed to local social marketing campaigns across their community promoting healthy eating, be able to purchase healthy food options in their community and know which options are healthy through a local menu disclosure program. This approach means that the employee's family will also be exposed to these messages and programs to support the employee in making healthy choices.

The HTC strategy builds on community-level interventions in preventive health across Australia and internationally such as *Colac Be Active Eat Well* in Victoria (Sanigorski et al, 2008), *EPODE* in France (Roman et al, 2009), *OPAL* (Obesity Prevention and Lifestyle) in South Australia, *Healthy Weight, Healthy Lives* in the UK and *Communities Putting Prevention to Work* in the USA.

The Victorian Department of Health (Centre for Allied Health, 2009) commissioned a rapid review of the research evidence on community level interventions to reduce obesity which supports their effectiveness when based on the following core elements: integrated and comprehensive programs, across multiple settings; using multiple interventions, targeting change at the individual, group and organisation levels; involving the community in planning, implementation and evaluation and; using multiple individual-level intervention strategies.

The HTC strategy has been developed in recognition that local governments have a legislated responsibility for the health and wellbeing of their community and are ideally placed to lead local policies that influence the many determinants of health. Further, experience has shown that spreading resources too thinly over too short a period of time has little impact (Hawe et al, 2009; Foresight, 2007). Victoria's prevention effort is therefore focused on providing a concentrated, well-resourced prevention effort in selected communities to build a preventive health system at the local level.

References:

The Centre for Allied Health Evidence. 2009. Community-based interventions: A rapid review. A technical report prepared for Department of Health, Victoria.

Cross-Government Obesity Unit, Department of Health and Department of Children, Schools and Families. 2008. Healthy Weight, Healthy Lives: a Cross –Government Strategy for England. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_084024.pdf

Foresight. 2007. Tackling obesities: future choices-project report. London: The Stationery Office. http://www.bis.gov.uk/foresight/our-work/projects/published-projects/tackling-obesities/reports-and-publications

Hawe P, Shiell A, Riley T. Theorising interventions as events in the systems. American Journal of Community Psychology 2009; 43: 267-276.

Goetzel RZ, Ozminkowski RJ. The health and cost benefits of worksite health promotion programs. Annual Review of Public Health 2008;29: 303-23.

Roman M, Lommez A, Tafflet M, Basdevant A, Oppeert JM, Bresson JL, Duciemetiere P, Charles MA, Borys JM. Downward trends in the prevalence of childhood overweight in the seeting of 12 year school and community-based programmes. Public Health Nutrition 2009 12 (10) 1735-42.

Sanigorski AM, Bell AC, Kremer PF, Cuttler R, Swinburn BA. Reducing unhealthy weight gain in children through community capacity-building: results of a quasi-experimental intervention program, Be Active Eat Well. International Journal of Obesity. 2008; 79: 1-8.

US Department of Health and Human Services. 2010. Communities Putting Prevention to Work. www.cdc.gov/chronicdisease/recovery/

36. **Contribution to performance benchmarks:** See logic map attached (attachment A).

37. **Policy consistency:** *NPAPH and Healthy Workers Scoping Statement and Guiding Policy Principles (Attachment B).*

Health promoting workplaces and workforces is consistent with the objectives of the NPAPH to improve nutrition and increase levels of physical activity in workers. It is also consistent with the outputs, scope and policy principles of the Healthy Workers initiative as detailed in the Healthy Workers Scoping Statement and Guiding Policy Principles.

This activity is consistent with broader Victorian preventive health reforms, preventive health policies and specific directions in healthy workers.

38. **Target group(s):** The HTC strategy funds 14 Local Government Areas (or 12 Prevention Areas) and reaches approximately 1.3 million Victorians, comprising approximately 520 schools, 938 early childhood services, and 4,409 medium-large workplaces/businesses (20 plus employees).

39. **Stakeholder engagement:** The initiatives build on and continue the work already commenced and approved under the National Partnership. Extensive engagement and consultation of key stakeholders was undertaken in the development of the HTC strategy.

    A Partnership and Engagement Strategy has been developed to ensure a stronger engagement and collaboration with partners and key stakeholders to align policy and programs and deliver shared goals to shape the prevention system in Victoria and deliver better health outcomes.

40. **Risk identification and management:**

Risk	**Level**	**Mitigation strategy**	**Responsibility/timeline**
Staff turnover and knowledge retention	L	Knowledge retained in prevention team. Documented knowledge in system inventory and assessments, event logs and case studies.	PPHB, CEIPS and HTCs
Continuing to work in a traditional programmatic approach	M	Whole system methods established to support HTC workforce to think and act systems (eg networks of practice, workforce development, leadership for prevention initiative). DH participating on all HTC governance groups to ensure integrity. Ongoing feedback and assessment at state and local level (eg system inventory and assessment).	PPHB, CEIPS and HTCs

41. **Evaluation:**

Activity	**Methodology**	**Timeframe**
Activity 2: Healthy workplaces and workers as part of communities (HTC) As Healthy Workers activities are collectively intended to contribute to outcomes shared by all other NPAPH initiatives, the evaluation of Healthy Workers Victoria will necessarily be a component of a broader Victorian evaluation strategy and will contribute to it.	In addition to the existing 2008 and 2011 VPHS-LGA behavioural measures of adults and parents, a baseline survey in 2012 (CATI), will cover key behavioural mediator variables (not currently measured) such as attitudes, self-efficacy and intentions. These measures will be taken in HTC communities and selected comparison communities, to create a quasi-experimental design, to allow for assessment of both between area and within area effects between 2012 and 2015. Process review and discrete program level evaluation in the HTC areas have been designed to provide lessons learnt/ insights. Supplementary workplace Achievement Program data is being investigated.	2008 and 2011 behaviour change baseline using VPHS-LGA. Larger area worker profiles will be investigated for initiative evaluation utility. 2014 and 2017 post-test using VPHS-LGA 2012 baseline mediator CATI survey in HTC areas and comparison areas. 2015 post-test mediator CATI survey in HTC areas and comparison areas. 2011-2017 qualitative process review and case studies (a component of a community-wide evaluation to be undertaken with HTC areas) 2016/2017 evaluation report and peer-reviewed publications Supplementary workplace Achievement Program evaluation data collected in HTCs and statewide.

42. **Infrastructure:** Not applicable. Infrastructure funded under the NPAPH has been detailed under each activity.

43. **Implementation schedule:**

Table 3: Implementation schedule

Deliverables and milestones	Due Date
(i) Prevention workforce engaged and maintained	Annual reporting by 31 August 2012, 2013, 2014, 2015, 2016, 2017 and 2018
(ii) Leadership and workforce development strategies delivered	Annual reporting by 31 August 2012, 2013, 2014, 2015, 2016, 2017 and 2018
(iii) Healthy Living Programs and Strategies provided	Annual reporting by 31 August 2012, 2013, 2014, 2015, 2016, 2017 and 2018
(iv) Local community engagement and social marketing delivered	Annual reporting by 31 August 2012, 2013, 2014, 2015, 2016, 2017 and 2018

44. **Responsible officer and contact details:** Dr Shelley Bowen, Senior Public Health Advisor, Department of Health Victoria (t: 03 9096 5209 e: shelley.bowen@health.vic.gov.au).

45. **Activity budget:**

Table 4: Activity project budget ($ million)

Expenditure item	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	Total
(i) Prevention workforce								
(ii) Leadership and workforce development								
(iv) Healthy Living Programs and Strategies								
(iii) Community engagement and social marketing								
(iv) Evaluation								
TOTAL	2.848	7.068	7.886	7.802	6.210	6.080	6.093	43.987

ROLES AND RESPONSIBILITIES

Role of the Commonwealth

46. The Commonwealth is responsible for reviewing the State's performance against the program and activity outputs and outcomes specified in this Implementation Plan and providing any consequential financial contribution to the State for that performance.

Role of the State

47. The State is responsible for all aspects of program implementation, including:

    (a) fully funding the program, after accounting for financial contributions from the Commonwealth and any third party;

    (b) completing the program in a timely and professional manner in accordance with this Implementation Plan; and

    (c) meeting all conditions of the National Partnership including providing detailed annual report against milestones and timelines contained in this Implementation Plan, performance reports against the National Partnership benchmarks, and a final program report included in the last annual report that captures lessons learnt and summarises the evaluation outcome.

48. The State agrees to participate in the Implementation Working Group and the Healthies Steering Committee or other national participation requirements convened by the Commonwealth to monitor and oversee the implementation of the initiative, if relevant.

PERFORMANCE REPORTING

49. The State will provide performance reports to the Commonwealth to demonstrate its achievement against the following performance benchmarks as appropriate to the initiative at 30 June 2016 and 31 December 2017:

    a) Increase in proportion of children at unhealthy weight held at less than five per cent from baseline for each state by 2016; proportion of children at healthy weight returned to baseline level by 2018.

    b) Increase in mean number of daily serves of fruits and vegetables consumed by children by at least 0.2 for fruits and 0.5 for vegetables from baseline for each State by 2016; 0.6 for fruits and 1.5 for vegetables by 2018.

    c) Increase in proportion of children participating in at least 60 minutes of moderate physical activity every day from baseline for each State by five per cent by 2016; by 15 per cent by 2018.

    d) Increase in proportion of adults at unhealthy weight held at less than five per cent from baseline for each state by 2016; proportion of adults at healthy weight returned to baseline level by 2018.

    e) Increase in mean number of daily serves of fruits and vegetables consumed by adults by at least 0.2 for fruits and 0.5 for vegetables from baseline for each state by 2016; 0.6 for fruits and 1.5 for vegetables from baseline by 2018.

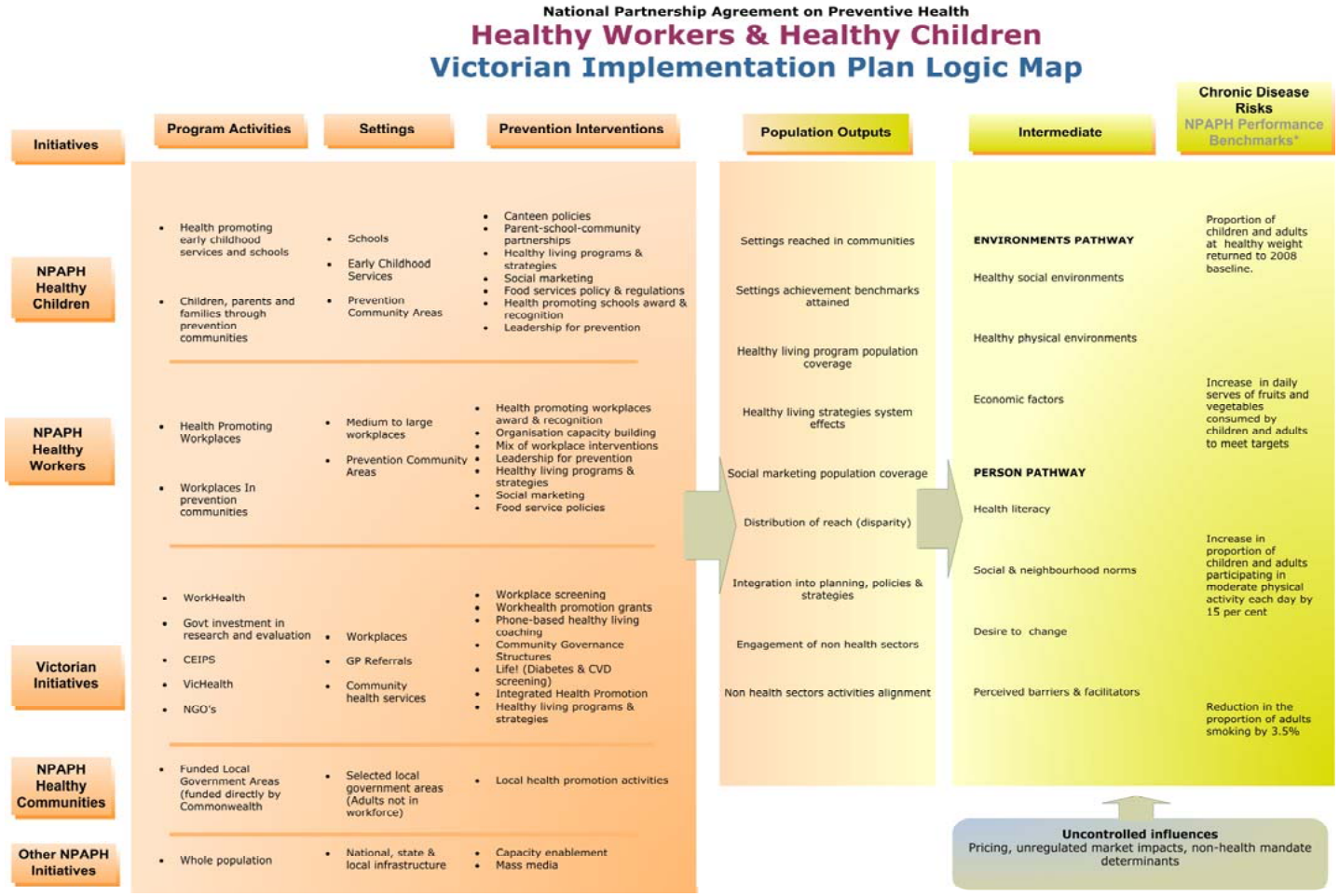
f) Increase in proportion of adults participating in at least 30 minutes of moderate physical activity on five or more days of the week of 5 per cent from baseline for each state by 2016; 15 per cent from baseline by 2018.

g) Reduction in state baseline for proportion of adults smoking daily commensurate with a two percentage point reduction in smoking from 2007 national baseline by 2011; 3.5 percentage point reduction from 2007 national baseline by 2013.

50. The requirements of performance reports will be mutually agreed following confirmation of the specifications for measuring performance benchmarks by the Standing Council on Health.

51. The performance reports are due within two months of the end of the relevant period.

ATTACHMENT A: LOGIC MAP



ATTACHMENT B:

National Partnership Agreement on Preventive Health

HEALTHY WORKERS

Scoping Statement and Guiding Policy Principles

PART 1: INTRODUCTION AND OVERVIEW

1.1 Purpose

This document, developed in consultation with states and territories, is designed to provide guidance in developing jurisdictional implementation plans and encourage a consistent approach to the implementation of the Healthy Workers initiative under the National Partnership Agreement on Preventive Health (NPAPH).

1.2 Objectives

The objective of the NPAPH is to reduce the risk of chronic disease by reducing the prevalence of overweight and obesity, improving nutrition and increasing levels of physical activity in adults, children and young people through the implementation of programs in various settings. The NPAPH provides funding for:

- settings based interventions in pre-schools, schools, workplaces and communities to support behavioural changes in the social contexts of everyday lives and focusing on improving poor nutrition, and increasing physical inactivity. For adults also focusing on smoking cessation and reducing harmful and hazardous alcohol consumption;
- social marketing for adults aimed at reducing obesity and tobacco use; and
- the enabling infrastructure to monitor and evaluate progress made by these interventions, including the National Preventive Health Agency and research fund.

1.3 Outputs

To support these objectives the Healthy Workers initiative will fund:

(i) States and territories to facilitate delivery of healthy living programs in workplaces:

a) focusing on healthy living and covering issues such as physical activity, healthy eating, the harmful/hazardous consumption of alcohol and smoking cessation;

b) meeting nationally agreed guidelines for addressing these issues, including support for risk assessment and the provision of education and information;

c) which could include the provision of incentives either directly or indirectly to employers;

d) including small and medium enterprises, which may require the support of roving teams of program providers; and

e) with support, where possible, from peak employer groups such as chambers of commerce and industry.

(ii) Commonwealth to develop a national healthy workplace charter with peak employer groups, to conduct voluntary competitive benchmarking, supporting the development of nationally agreed standards of workplace based prevention programs and national awards for healthy workplace achievements. Commonwealth in consultation with the states and territories, may consider taking responsibility for national employers.

1.4 Evidence Base

The workplace is a setting where most adults spend around half of their waking hours, and there is potential through the workplace to reach a substantial proportion of the population who may not otherwise respond to health messages, may not access the primary health care system, or may not have time to make sustained changes to their behaviour, such as participating in more regular exercise.

Nearly 11 million Australian adults are in paid employment, with around 70 per cent in full time employment.[1] Approximately five million (2004-05) Australian employees are overweight or obese (of whom 1.3 million are obese). Obesity was associated with an excess 4.25 million days lost from the workplace in 2001.[2] Obesity rates are highest among mature age workers aged 45-64, who comprise almost a third of the labour force. As obese people age, sick leave increases at twice the rate of those who are not obese.[3] Research indicates that sedentary lifestyles can also lead to more work-related illness and prolonged recovery periods as well as increased morbidity and mortality.[4]

Key factors emerging from the international and national literature that can determine the success and sustainability of workplace health promotion programs include:

- *Management involvement and support* from senior management through to middle and line mangers across an organisation ensures equal access, opportunity and support to all workers, regardless of position or job type.
- *Integrated workplace health promotion* with existing business planning and values.
- *Well established project planning and implementation* and a participatory approach helps to create employer and worker ownership and longer term success.
- *Effective and consistent communication* of the aims and purpose of the program from employers to workers builds positive engagement.
- *Multi-component programs* can ensure a variety of behavioural risk factors, issues and strategies are addressed to increase participant engagement with different preferences and health needs and ensure lasting change.
- *Monitoring and evaluation* of all program components should be established during program planning and inception.

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[1] Workforce statistics form the ABS, cited in: *Overweight and Obesity: Implications for Workplace Health and Safety And Workers' Compensation*, Australian Safety and Compensation Council, August 2008, p 8-9.

[2] Overweight and Obesity: Implications for Workplace Health and Safety And Workers' Compensation, Australian Safety and Compensation Council, August 2008, p 8-9.

[3] An American study reported that the profile of obese workers with respect to cardiovascular risk factors as well as work limitations resembled that of workers as much as 20 years older. Also see Overweight and Obesity: *Implications for Workplace Health and Safety And Workers' Compensation*, Australian Safety and Compensation Council, August 2008.

[4] McEachan, Lawton et al. 2008

PART 2: HEALTHY WORKERS

Terminology, Scoping Statement and Guiding Policy Principles

2.1 Terminology

For the purposes of the Healthy Workers initiative, the following terms are defined:

Access and equity is about ensuring that individuals and populations are not further disadvantaged in a health and social sense through the programs and activities delivered as part of the NPAPH. It requires consideration of a range of factors that can impact on access to, reach of and appropriateness of programs for certain populations, removing or reducing barriers to health and access to health-based activities. Programs must support equity of outcomes for all by increasing opportunities and removing or reducing barriers for participation. There are a number of interacting factors at both the organisational and individual level that must be considered in addressing access and equity, for example:

- the type of organisation, industry or enterprise and the structural characteristics of the workforce (does the business operate 24 hours per day or involve shift work; are those working in the industry full-time, part time, seasonal or casual; is the workforce or worker geographically isolated or mobile);
- the size of the organisation or enterprise, relative capacity and decision making autonomy to take up and implement programs and make organisational change;
- consideration of the characteristics of workers at both a group and individual level including gender, cultural and linguistic background, Aboriginal and Torres Strait Islanders, people with a disability, physical location and socio-economic status. For example, the workforce of mining operations can be physically isolated, largely male and may be drawn from culturally and linguistically diverse backgrounds. These factors should be considered in program design, delivery and evaluation;
- equity of outcome that considers all the elements above in relation to the outcomes for individuals and organisations (e.g., were there organisations and individuals who experienced better results than others in the same cohort); and
- elements outlined in the Australian Government's *Social Inclusion Toolkit.*[5]

Healthy living programs are those programs that cover physical activity, healthy eating, the harmful/hazardous consumption of alcohol and smoking. The use of the term 'program(s)' is inclusive of activities targeting individual workers, groups of workers and activities that are of an organisational wide, enabling or capacity building nature. It also includes workplace policy enhancement, system change and minor supporting infrastructure improvements directly related to the implementation in the specific setting that are made to facilitate and support the health of workers and associated behavioural changes. The following language will be used to describe the hierarchy of elements of the NPAPH:

1. NPAPH initiatives, such as Healthy Workers;
2. jurisdictional programs (i.e., state and territory programs or activities implemented according to an agreed plan); and
3. activities within jurisdictional programs, local government programs or pilot programs.

Primary and secondary prevention definitions are drawn from *The Language of Prevention,* National Public Health Partnership 2006[6] and in the context of Healthy Workers mean:

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[5] www.socialinclusion.gov.au/Documents/SIToolKit.pdf

[6] National Public Health Partnership (2006); *The Language of Prevention, Melbourne*

- *Primary prevention* - limiting the incidence of disease and disability in the population by measures that eliminate or reduce causes or determinants of departure from good health, control exposure to risk and promote factors that are protective of good health; and
- *Secondary prevention* - reduction of progression of disease through early detection, usually by screening at an asymptomatic stage, and early intervention.

Quality assurance frameworks, accreditation and standards are currently being developed by the Australian Government under the NPAPH. Programs and program providers (whether this is the employer or a third party on behalf of the employer) will be encouraged to have regard to relevant accreditation processes in order to receive funding under the initiative from jurisdictions. Note that once these processes are fully established consideration will be given to making them a requirement.

Workers, for the purpose of this initiative, are defined as individuals of working age currently in paid employment in Australia. The primary target age range for this initiative is 35 to 55 years. Other age ranges outside of this group in the workplace context can also be considered. It is acknowledged that there are differing arrangements in jurisdictions relating to age for entry into the workforce and that there is no compulsory retirement age.

2.2 Scope

Consistent with the objectives and expected outcomes of the NPAPH, the policy scope for the Healthy Workers initiative is summarised below:

2.2.1 The focus of the initiative is the prevention of lifestyle related chronic disease through addressing the modifiable lifestyle risk factors of smoking, poor nutrition, physical inactivity and hazardous and harmful alcohol consumption through sustained behaviour and organisational changes in working Australians and their workplaces.

2.2.2 The wider community, children and those who are unemployed or in an unpaid position are not a specific target population under this initiative. However, if a program through a participating worker or workplace, can also reach families, or other members of the community then this is encouraged.

2.2.3 The primary target age range for this initiative is people in paid employment aged 35 to 55 years old. Other age ranges outside of this group can also be considered. A lower and upper age limit is not specified under the initiative.

2.2.4 Programs should focus on preventive health activities. Programs with a tertiary management focus (i.e. managing existing chronic conditions) are not within the preventive scope of the initiative. However, individuals already participating in tertiary treatment programs are not to be excluded. Note that only preventive programs will attract funding.

2.2.5 Mental health is not included as a performance benchmark under the NPAPH. While programs may have a mental health element, this should not be the sole focus of the program.

2.2.6 Health promotion programs can be implemented in and through workplaces with workers as the primary target audience. There must be a direct connection with the workplace. For example, policies on food and vending machines in the workplace or a lunchtime walking group organised by workers and undertaken during working hours. A community program that is attended by a worker on the weekend, and does not have the support or endorsement of an employer (e.g., a subsidy) and is otherwise unconnected with employment, would be out of scope.

2.2.7 Needs assessments can include consideration of the policy environment, workplace culture and infrastructure as they relate to the delivery of a program. An audit of policies and infrastructure that support healthy lifestyle choices and work-life balance to identify areas for development and determine appropriate activities could be implemented as part of a

program. For example, in considering the implementation of an active transport to work program, an audit may identify whether supporting infrastructure such as bike racks in the workplace are available.

2.2.8 Investment in substantial built environment or hard infrastructure improvements is beyond the scope of the NPAPH. Substantial infrastructure improvements (i.e., change facilities and shower blocks) will need to be funded by the employer. Minor infrastructure (i.e., bike racks) may be permitted following consultation with the Commonwealth.

2.2.9 Whilst volunteers are not a specific target population under the initiative, if volunteers are in the workplace they should not be excluded from participating in programs.

2.2.10 Funding may be used, among other things, to provide direct incentives to employers to provide programs (e.g. through the provision of subsidies to purchase programs; develop jurisdiction wide programs that can be picked up by employers; or to assist existing providers) or adapt existing programs to suit a wider range of workplaces or to target specific groups.

2.2.11 Programs should cover a range of businesses regardless of size. Large business should not be the sole focus of programs and consideration should be given to the needs of small to medium enterprises.

2.3 Policy Principles

General

2.3.1 Programs under the initiative should be focused on primary and secondary prevention.

2.3.2 Funding for programs should be invested in:

- significant enhancements or expansions to existing program(s) that have already demonstrated they are efficacious;
- new programs that have demonstrated efficacy elsewhere that are directly translatable to the initiative setting;
- programs that can demonstrate significant innovation and/or promise from initial results, but lack formal evidence to demonstrate effectiveness; and
- programs that have a high likelihood of being sustainable beyond the funding received under this initiative, should the program be effective and there is a demonstrated continuing need.

2.3.3 Programs should reflect the requirements of the Australian Government's *Social Inclusion Toolkit*.

2.3.4 Access and equity in terms of both access to programs and equity of outcomes as a result of participation in programs must be a key consideration.

2.3.5 Participation in NPAPH programs is voluntary. However, the voluntary participation requirement does not override specifications of existing or new workplace legislative requirements or policies (e.g., food supply, no smoking, alcohol management policies, banning of alcohol).

2.3.6 Programs and associated evaluations should not further stigmatise obesity and other applicable health conditions or behaviours.

2.3.7 Measures must be in place to protect the privacy of individuals as appropriate. Programs must comply with applicable legislation in relation to consent to collect personal and health information and the use, access, storage and disclosure of this information.

2.3.8 Program providers may be expected to comply with specified requirements, including quality assurance frameworks, standards or other guidance in existence or currently being developed under the NPAPH.

2.3.9 Programs should be developed and implemented in consideration of relevant local enablers and barriers (i.e. appropriate stakeholder consultation and support, infrastructure issues, and different industry and workforce requirements).

2.3.10 Funding under the initiative may be used to extend existing programs or create new programs. However, the duplication of funding already allocated at a state and territory level, or by an organisation, should not be permitted.

2.3.11 Programs will not be funded if they support, promote or utilise sponsorship of food or beverage products considered to be high in sugar, salt and saturated fat, or of tobacco and/or alcohol or promote sedentary behaviour.

2.3.12 Consistency and complementarity with programs already in place should be considered. An assessment of possible efficiencies and effectiveness should be undertaken that recognises activities in other settings (i.e. schools, early childhood settings or other organisations in the community).

2.3.13 Programs should have monitoring systems in place to ensure they are capable of reporting in an accurate and timely way on the achievement of program outputs in accordance with performance monitoring and evaluation requirements under the NPAPH.

2.3.14 Programs should have mechanisms in place for continuous quality improvement. Monitoring and evaluation arrangements should, where possible, be developed to help facilitate evaluation at a national level.

And in addition for the Healthy Workers initiative

2.3.15 Programs that have a clinical risk assessment component should have identified clear and appropriate referral pathways in place that include complementary support activities that aim to address and lead to a reduction in identified lifestyle risk factors.

2.3.16 Programs should recognise the diversity of workplaces in Australia and the diversity of Australian workers.

2.3.17 Employers should consider the effect of programs across their entire workforce where an employer operates in more than one jurisdiction to ensure that all employees have the opportunity to access programs.

2.3.18 Inter-jurisdictional collaboration should be considered when the employer has a workforce operating in a number of jurisdictions or is a national employer.

2.3.19 Activities and programs implemented by each jurisdiction will need to be accessible and appropriate for small to medium enterprises, as well as large businesses.