National Partnership Agreement

on Preventive Health

National Implementation Plan 2009-2015

National Partnership Agreement on Preventive Health Implementation Working Group, June 2009

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1. INTRODUCTION

1.1 Preventing Chronic Disease

Preventable conditions now account for around one third of the total burden of disease in Australia. Of the modifiable risk factors causing the greatest disease burden, tobacco smoking, alcohol misuse, poor diet, physical inactivity and unhealthy weight are the major contributors to chronic disease, health system pressures and reduced productivity and participation.[1]

While prevention strategies for each risk factor are currently at different stages of maturity, reinvigorated efforts to address all as part of a comprehensive reform package are needed in order that an optimal return on investment may be achieved.

Tobacco currently remains the leading modifiable cause of disease in Australia, with the long term effects of smoking resulting in an estimated 15,500 deaths each year.[2] While Australia has achieved marked success in reducing the smoking rate, further reductions are clearly achievable in light of international benchmarks, such as California.[3] The sustained 1.4% drop in prevalence observed following the first phase of the National Tobacco Campaign in 1997 demonstrates that a further six percentage point decrease could be achievable with adequate investment over the next decade, supported by appropriate measures in regulation and taxation.[4]

The burden of disease attributable to alcohol is less than for tobacco and obesity. However, alcohol misuse also impacts significantly across a range of health and non-health areas such as workplace productivity, road accidents, emergency department and ambulance services, law enforcement, property damage, and insurance administration. The annual cost to the Australian community from alcohol misuse and related harm is estimated to be more than $15 billion.[5]

High body mass now accounts for some 7.5% of the total burden of disease in Australia and is likely to displace tobacco as the leading preventable risk factor for chronic disease.[6] Obesity is driving the projected two-to-three fold increase in type 2 diabetes over the next two decades, and may reverse the gains of recent decades in fighting cardiovascular disease.[7]

Forecasting from 2005 data, Access Economics estimated obesity prevalence could rise from 3.2 million in 2005 to 4.6 million in 2025[8] holding the prevalence of obesity steady at its current rate. Should the trend rate of growth in prevalence of the two decades to 2000 continue, as many as 7.2 million Australians could be obese by 2025.

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[1] Begg S, Vos T, Barker B, Stevenson C, Stanley L & Lopez AD (2007). *The burden of disease and injury in Australian 2003*. PHE 82. Canberra, Australian Institute of Health and Welfare.
[2] The Cancer Council (2007). National Cancer Prevention Policy 2007-09. New South Wales, The Cancer Council.
[3] Californian adult smoking rates have reached 13.3% in 2008. Source: California Department of Public Health (2009), New data charts released! California's Award-winning Tobacco Control Program Marks Its 20th Anniversary (April 7, 2009), available from http://www.cdph.ca.gov/programs/tobacco/Pages/CTCPMediaCampaign.aspx
[4] Hurley S, Scollo M, Younie S, English DR and Swanson M. The potential for tobacco control to reduce PBS costs for smoking-related cardiovascular disease. Medical Journal of Australia. 2004;181:252-5. Available from: http://www.mja.com.au/public/issues/181_05_060904/hur10462_fm.html
[5] Collins DJ & Lapsley HM (2008). *The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05*. National Drug Strategy Monograph Series No 64, Canberra, Commonwealth of Australia.
[6] Begg S, Vos T, Barker B, Stevenson C, Stanley L & Lopez AD (2007). *The burden of disease and injury in Australian 2003*. PHE 82. Canberra, Australian Institute of Health and Welfare.
[7] Brown L, Harris A, Picton M, Thurecht L & Yap M (2006). *Estimating the health and economic impacts of the prevention of type 2 diabetes in Australia – linking micro and macro-economic models*. Conference paper: the 28th Australian Conference of Health Economists, Perth.
[8] Access Economics (2008) *The Growing Costs of Obesity: three years on*. A report for Diabetes Australia, Access Economics, Canberra.

The potential costs to individuals, the health system and the economy will be significant:

- unhealthy weight, poor diet and physical inactivity will drive both the greatest relative projected increases in expenditure on preventable chronic disease (diabetes and musculoskeletal conditions) and the greatest absolute increase (cardiovascular disease);[9]
- without intervention, international studies suggest one-fifth of national health-care expenditures could be devoted to treating the consequences of obesity by 2020;[10]
- productivity losses associated with obesity are already in the order of $2 billion annually;[11] and
- obesity was associated with four million days lost from the workplace in 2001, and absenteeism for people with diabetes was almost double that for people without diabetes. [12]

There is evidence that up to two thirds of Australians consume less than the recommended serves of fruit and vegetables and more than 50 percent report lower than recommended levels of physical activity.[13]

Furthermore, indicators of disordered eating are becoming apparent, with studies suggesting that the percentage of young people with eating disorder behaviours has more than doubled between 1995 and 2005, from 4.7 percent to 11 percent.[14]

The Council of Australian Governments (COAG) has become increasingly involved in preventive health in recent times with the intention of tackling the growing burden of chronic disease caused by modifiable lifestyle risk factors.

1.2 Australian Better Health Initiative (ABHI)

The Australian Better Health Initiative (ABHI) was announced in February 2006 by COAG as a joint Australian, State and Territory Government initiative.

A total of $500 million over four years was assigned to this national program which aims to reduce the occurrence of risk factors contributing to chronic disease, and limit the new and current cases of disease in Australia.

The five priority areas for action are:

1. Promoting healthy lifestyles;
2. Supporting early detection of risk factors and chronic disease;
3. Supporting lifestyle and risk modification;
4. Encouraging active patient self management of chronic conditions; and
5. Improving the communication and coordination between care services.

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[9] Vos T, Goss J, Begg S & Mann N (2007). *Projection of health care expenditure by disease: a case study from Australia*. Centre for Burden of Disease and Cost-Effectiveness, School of Population Health, University of Queensland and Australian Institute of Health and Welfare.
[10] Sturm R, Ringel JS & Andreyeva T (2004). *Increasing obesity rates and disability trends.* Health Affairs, 32(2): 199-206.
[11] Access Economics estimated $1.7 billion in 2005
[12] Analysis of: Australian Bureau of Statistics (2002) *National Health Survey: Summary of Results 2001*. Accessed on-line at: **http://www.abs.gov.au/**
[13] O'Brien K (2005) Living dangerously: Australians with multiple risk factors for cardiovascular disease. Bulletin No 24, Australian Institute of Health and Welfare Cat No. AUS57. Canberra, AIHW.
[14] O'Dea, J. (2008) Gender, ethnicity, culture and social class influences on childhood obesity among Australian schoolchildren: implications for treatment, prevention and community education *Health & Social Care in the Community* 16 (3) , 282–290 doi:10.1111/j.1365-2524.2008.00768.x

1.3 Type 2 Diabetes Initiative

COAG announced in April 2007 that it would add diabetes to the Human Capital stream of the National Reform Agenda. The Commonwealth will provide $103.4 million over four years towards a national package to prevent type 2 diabetes. States and territories will provide a further $101 million for other activities to address type 2 diabetes. The initiative will conclude in June 2011.

Under this initiative, a new Medicare item has been introduced for GPs to develop a 'Diabetes Risk Plan' for those aged 40-49 years who are found to be at high risk. COAG also agreed to develop a risk assessment tool for type 2 diabetes and standards and accreditation arrangements for lifestyle modification programs. This has been cost shared among the jurisdictions with an expected total cost of approximately $2 million over 2007-08 and 2008-09.

2. NATIONAL REFORM PROJECT

2.1 COAG Commitment to Prevention

COAG at its 24th meeting on 29 November 2008, agreed to a package of reforms aimed at improving the quality and effectiveness of government services across Australia. Preventive health was identified as an area requiring reform, and the National Partnership Agreement on Preventive Health (the prevention NP) was funded to facilitate the reform process.

2.2 Reform of Federal Financial Relations

COAG has reaffirmed its commitment to cooperative working arrangements through an historic new Intergovernmental Agreement (IGA) that provides an overarching framework for the Commonwealth's financial relations with the States and Territories (the States).

The IGA provides a clearer specification of roles and responsibilities of each level of government and an improved focus on accountability for better outcomes and better service delivery. This is accompanied by a major rationalisation of the number of payments to the States for Specific Purpose Payments (SPPs), reducing the number of such payments from over 90 to five, including the National Healthcare SPP, which takes effect on 1 July 2009.

The National Healthcare Agreement, which governs the Healthcare SPP, includes a focus on prevention with mutually agreed outcomes, progress measures and outputs to ensure Australians are equipped and supported to make healthy choices and manage key risk factors. States will report annually on performance indicators including incidence/prevalence rates of important preventable diseases and risk factors, as well as health service usage.

COAG agreed to a new form of payment - National Partnership (NP) payments - to fund specific projects and to facilitate and/or reward States that deliver on nationally significant reforms. The financial arrangements may include incentive payments to reward performance. The first wave of health NPs will begin in 2009, including:

- Hospitals and Health Workforce Reform;
- Preventive Health;
- Taking Pressure off Public Hospitals; and

- Indigenous Health.[15]

The prevention NP builds on COAG's existing Australian Better Health Initiative and the National Reform Agenda's Type 2 Diabetes Initiative, and supplements the National Healthcare Agreement by funding programs that will improve health outcomes and reduce pressure on the health system in the long run.[16]

The prevention NP will:

1. extend the risk assessment and risk modification services commenced under the two existing initiatives into the workplace;
2. underpin risk assessment and risk modification with a nation-wide roll-out of healthy living programs accredited by the major non-government organisations and facilitated by local government;
3. bring a focussed and appropriately resourced effort to bear on arresting the growth in childhood obesity in family, pre-school, school and community settings; and
4. bring adequate funding to sustained social marketing on both healthy weight and anti-smoking to effect behavioural change in both these risk areas.

3. NATIONAL PARTNERSHIP AGREEMENT ON PREVENTIVE HEALTH

3.1 Prevention NP Objectives[17]

The Commonwealth, States and Territories have agreed to:

- support all Australians in reducing their risk of chronic disease by embedding healthy behaviours in the settings of their pre-schools, schools, workplaces and communities, by instituting programs across smoking, nutrition, alcohol, and physical activity (SNAP) risk factors which mobilise the resources of the private, public and non-government sectors (States, Territories and Commonwealth);
- work with the food supply and the food service sectors towards offering healthy choices and minimising choices high in fat, sugar or salt, and with the sport, recreation and commercial fitness sectors in efforts towards increasing physical activity in the community (Commonwealth);
- support behavioural change with public education by placing on a sustained and adequately resourced footing the national MeasureUP or other agreed social marketing campaigns that will be initiated until 2010 under the Australian Better Health Initiative, and administering this from the dedicated Australian National Preventive Health Agency, in order to alert, inform and educate Australians in the need for healthy lifestyles and in the resources and choices available to them for these purposes (Commonwealth);
- similarly supporting behavioural change with a national anti-smoking campaign achieving the evidence threshold of market saturation to effect further lowering of the national daily smoking rate, and also to be managed by the proposed Australian National Preventive Health Agency (Commonwealth); and

[15] COAG Communique 29 November 2008 available from http://www.coag.gov.au/coag_meeting_outcomes/2008-11-29/
[16] COAG Communique 29 November 2008 available from http://www.coag.gov.au/coag_meeting_outcomes/2008-11-29/
[17] See Appendix B: Council of Australian Governments, National Partnership Agreement on Preventive Health, Canberra: Commonwealth of Australia 2008

- invest in the evidence base necessary for effective prevention by instituting national programs in chronic disease risk factor surveillance, translational research, evaluation, a national collaboration in eating disorders, and a workforce audit, and establishing the Australian National Preventive Health Agency to inform best practice in policy design for preventive health as well as administering national social marketing (Commonwealth).

The prevention NP aims to address the rising prevalence of lifestyle related chronic diseases, by:

- 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
- 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.

3.2 Expected Outcomes [18]

The Agreement, consistent with the National Healthcare Agreement performance targets, will contribute to the following medium to long term outcomes:

a) increase the proportion of children and adults at healthy body weight by 3 percentage points within ten years;

b) increase the proportion of children and adults meeting national guidelines for healthy eating and physical activity by 15 per cent within six years;

c) reduce the proportion of Australian adults smoking daily to 10 per cent within ten years;

d) reduce the harmful and hazardous consumption of alcohol; and

e) help assure Australian children of a healthy start to life, including through promoting positive parenting and supportive communities, and an emphasis on the new-born.

[18] See Appendix B: Council of Australian Governments, National Partnership Agreement on Preventive Health, Canberra: Commonwealth of Australia 2008

3.3 Funding Arrangements and Structure

Table 3.1 Prevention NP funding arrangements

Funding totals as transfer payments to states and territories or Commonwealth own purpose expenses (COPE)								
Prevention	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**TOTAL**
	$m	**$m**	**$m**	**$m**	**$m**			
Healthy children - transfer				**32.456**	**64.912**	**97.368**	**130.790**	**325.5**
Healthy workers - transfer				**33.566**	**62.557**	**88.15**	**105.15**	**289.4**
Healthy workers - COPE				**1.25**	**1.25**	**1.25**	**1.25**	**5.0**
Healthy communities - COPE		**4.4**	**10.9**	**22.523**	**34.20**			**72.0**
Industry partnership - COPE		**0.25**	**0.25**	**0.25**	**0.25**			**1.0**
Social marketing - transfer			**6.0**	**6.0**	**6.0**			**18.0**
Social marketing - COPE		**1.95**	**33.79**	**32.73**	**33.5**			**102.0**
Tobacco		*0.6*	*20.6*	*19.465*	*20.5*			*61.0*
MeasureUp extension		*1.4*	*13.3*	*13.265*	*13.1*			*41.0*
Enabling infrastructure - transfer (surveillance)		**2.5**	**2.5**	**2.5**	**2.5**			**10.0**
Enabling infrastructure - COPE		**8.5**	**13.6**	**14.0**	**13.1**			**49.2**
Preventive Health Agency		*2.0*	*5.1*	*5.2*	*5.3*			*17.6*
Preventive Health Research Fund		*2.0*	*4.0*	*4.0*	*3.0*			*13.1*
Surveillance (Health Risk Survey)		*3.8*	*3.8*	*3.8*	*3.8*			*15.0*
Workforce audit		*0.3*	*0.3*					*0.5*
Eating Disorders Collaboration		*0.5*	*0.5*	*1.0*	*1.0*			*3.0*
Total		**17.6**	**67.0**	**145.3**	**218.3**	**186.8**	**237.2**	**872.1**
COPE		15.10	58.54	70.8	82.3	1.3	1.3	**229.2**
Funding Transfer		2.5	8.5	74.5	136.0	185.5	235.9	**642.9**

The prevention NP 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 poor nutrition, physical inactivity, smoking and excessive alcohol consumption (including binge drinking);
- Social marketing aimed at obesity and tobacco; and
- The enabling infrastructure to monitor and evaluate progress made by these interventions, and to establish the Australian National Preventive Health Agency.

The maximum funding provided for each state or territory is detailed at Appendix A.

3.4 Performance Benchmarks and Indicators[19]

The Commonwealth, the States and Territories agree to meet the following performance benchmarks:

(a) increase in proportion of children at unhealthy weight held at less than five per cent from baseline for each state by 2013; proportion of children at healthy weight returned to baseline level by 2015;

(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 2013; 0.6 for fruits and 1.5 for vegetables by 2015;

(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 2013; by 15 per cent by 2015;

(d) increase in proportion of adults at unhealthy weight held at less than five per cent from baseline for each state by 2013; proportion of adults at healthy weight returned to baseline level by 2015;

(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 2013; 0.6 for fruits and 1.5 for vegetables from baseline by 2015;

(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% from baseline for each state by 2013; 15 per cent from baseline by 2015;

(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; and

(h) performance against benchmarks will be assessed at two time points: June 2013 and December 2014.

Payments to States and Territories for the Healthy Children and Healthy Workers programs will be structured as 50 per cent facilitation and 50 per cent reward. Payments to the States and Territories for the social marketing and enabling infrastructure programs will be provided as facilitation payments, and will not be subject to a reward structure. Table 3.2 outlines the facilitation and reward structure of the initiatives covered in this Agreement for the six years 2009-10 to 2014-15.

Table 3.2 Facilitation and Reward structure for the Agreement

Program	Initiative	Facilitation ($m)	Reward ($m)
Healthy Children	State and territory programs	162.76	162.76
Healthy Workers	State and territory workplace programs	144.71	144.71
Social marketing	Local level initiatives for *MeasureUP*	18.00	
Enabling infrastructure	State and territory Computer Aided Telephone Interviews	10.00	

[19] See Appendix B: Council of Australian Governments, National Partnership Agreement on Preventive Health, Canberra: Commonwealth of Australia 2008

Performance against benchmarks for Healthy Children and Healthy Workers will be assessed as at June 2013 and December 2014. Of the funds available for reward payments (50 per cent of Healthy Children and Healthy Workers), 20 per cent will be paid against June 2013 achievement of benchmarks and 30 per cent against December 2014 achievement of benchmarks.

States and Territories will receive partial payment for partial attainment of performance targets, with partial payments proportionate to achievement. For example, a jurisdiction will receive 50 per cent of the reward payment for a move half way to the target.

3.5 Period of Agreement

The prevention NP commences 1 July 2009, and continues to 30 June 2015 or the date of the final reward payment to states and territories for performance against benchmarks. The Agreement will be reviewed in 2014-15 for the purposes of considering rolling existing funding into the Healthcare SPP.[20]

3.6 Implementation Arrangement as Required in the Agreement

The Parties have agreed to this Implementation Plan to achieve the objectives of this Agreement. The Plan will be reviewed by the Parties on an annual basis.

(a) The Commonwealth will maintain the Plans and provide updated Plans to the States and Territories following reviews.

(b) The Plans will include the timelines for achieving the performance benchmarks, including phased achievement of performance benchmarks where appropriate.

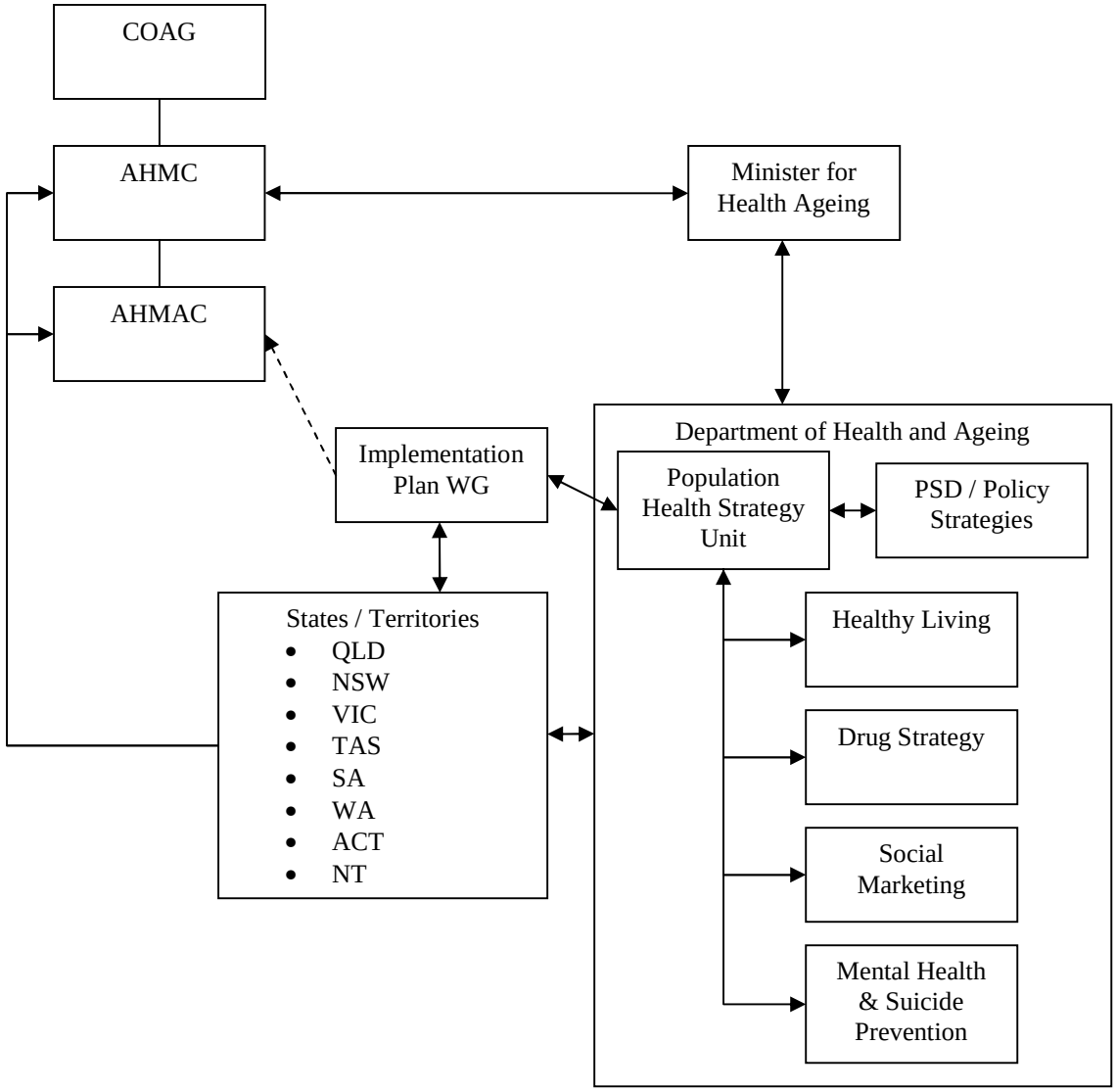
(c) Amendments to the Plan can be requested by a State or Territory at any time, to accommodate emerging issues. These amendments will be agreed with the Commonwealth and the other Parties.

The prevention NP Agreement is at Appendix B.

[20] See Appendix B: Council of Australian Governments, National Partnership Agreement on Preventive Health, Canberra: Commonwealth of Australia 2008

4. NATIONAL PARTNERSHIP GOVERNANCE

Figure 4.1 Governance Chart



4.1 National Partnership Agreement on Preventive Health Implementation Working Group

Planning and coordination of implementation arrangements for the prevention NP will be managed by the prevention NP Implementation Working Group. The Working Group is chaired by the Commonwealth and comprises deputy CEOs from all jurisdictions with responsibility for preventive health. The Working Group will oversee the development of implementation plans for all elements of the prevention NP and provide a recommendation to AHMAC.

Roles and responsibilities are clearly identified within the individual initiative implementation plans in Section 7.

4.2 Australian Health Ministers' Advisory Council (AHMAC)

AHMAC will receive advice from the prevention NP Implementation Working Group on implementation arrangements and make a recommendation to AHMC.

4.3 Australian Health Ministers' Conference (AHMC)

AHMC is responsible for agreeing implementation arrangements for the prevention NP. To support this role, AHMC will receive advice from AHMAC on implementation arrangements before making a decision.

The Commonwealth Minister for Health and Ageing has been authorised to agree to the implementation arrangements for the prevention NP, prior to facilitation payments being made to jurisdictions. Reward payments will be made by the Commonwealth following independent assessment by the COAG Reform Council to ensure that performance benchmarks have been achieved.

5. REPORTING

As specified in the prevention NP, the States and Territories will each provide a detailed report on an annual basis to the Commonwealth against milestones and timelines.[21]

The reports will be provided within two months of the end of the relevant period.

The States and Territories will provide reports outlining performance against benchmarks as at 30 June 2013 and 31 December 2014. These reports will be provided within two months of the end of the relevant period. Performance against December 2014 benchmarks will be extrapolated to June 2015 using available data.

Reporting requirements under the prevention NP should be read in conjunction with the provisions in Schedule C to the Intergovernmental Agreement on Federal Financial Relations.

6. EVALUATION

Evaluation of the prevention NP will occur at two levels. An overarching evaluation will occur through assessing how well a range of performance benchmarks are met and a more detailed evaluation will occur for each component of the Partnership.

6.1 Overarching Evaluation

Overarching evaluation will occur at two time points, June 2013 and January 2014, covering the proportion of:

- adults and children at health body weight;
- adults and children meeting the national guidelines for physical activity;
- adults and children consuming adequate amounts fruits and vegetables; and
- Australians smoking daily.

[21] See Appendix B: Council of Australian Governments, National Partnership Agreement on Preventive Health, Canberra: Commonwealth of Australia 2008

6.2 Program Level Evaluation

An evaluation plan will be developed for each program. Further information is provided within the implementation plans for each initiative in Section 7.

7. INITIATIVE IMPLEMENTATION PLANS

Individual implementation plans have been prepared for each of the following initiatives:

7.1. Healthy Communities

7.2. Healthy Children

7.3. Healthy Workers

7.4. Industry Partnership

7.5. National Health Risk Survey

7.6. Social marketing – *MeasureUp*

7.7. Social marketing - Tobacco

7.8. Enhanced State/Territory Surveillance

7.9. Workforce Audit and Strategy

7.10. Australian National Preventive Health Agency and Research Fund

7.11. Eating Disorders Collaboration

7.1 IMPLEMENTATION PLAN – HEALTHY COMMUNITIES

Version History

Version	Date	Nature of change(s)
0.1	May 2009	First draft of plan for National Partnership Agreement on Preventive Health Implementation Working Group meeting of 14 May 2009
0.2	May 2009	Second draft for distribution to Implementation Working Group on 20 May 2009
0.3	June 2009	Draft circulated to AHMAC out-of-session

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7.1.1 PROJECT DEFINITION

This document summarises planning for the Healthy Communities element of the National Partnership Agreement on Preventive Health (prevention NP).

7.1.1.1 Policy objective/outcome

a) Approved policy objective

Through the prevention NP, the Council of Australian Governments (COAG) is providing $72 million over four years to support the national roll-out of successful and effective community-based physical activity and healthy eating programs:

- including the major initiatives of the national health non-government organisations, including walking, supervised exercise and healthy eating programs;
- focusing on disadvantaged populations and those not in the workforce;
- through local government organisations, with states/territories participating in the identification of priority, high needs areas;
- utilising resources currently available through the commercial fitness and weight loss sectors to facilitate the expansion of programs; and
- with support from national level 'soft infrastructure' such as accreditation of programs and service providers, web-based directories, and recruitment strategies through primary health care and other pathways.

b) Policy context or environment

The prevention NP 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 poor nutrition, physical inactivity, smoking and excessive alcohol consumption (including binge drinking);
- social marketing aimed at reducing obesity and tobacco use; and
- the enabling infrastructure to monitor and evaluate progress made by these interventions, including the Agency and research fund.

The Healthy Communities initiative aims to increase participation in community based physical activity and healthy lifestyle programs with priority given to socio-economically disadvantaged areas.

In 2005, 3.2 million Australians were obese.[22] Access Economics forecasts this could rise to 4.6 million in 2025.[23] High body mass now accounts for some 7.5% of the total burden of disease in Australia and is likely to displace tobacco as the leading preventable risk factor for chronic disease.[24] There is evidence that up to two-thirds of Australians consume less than the recommended serves of vegetable and fruits, and more than 50% report lower than recommended levels of physical activity.[25]

In 2007, 10.3% of Australians aged 14 and over reported consuming alcohols at levels placing them at long term risk of harm, whilst 20.4% reporting consuming alcohol at levels placing them at short term risk of

[22] Access Economics (2006) *The Economics of Obesity*. A report for Diabetes Australia, Access Economics, Canberra.
[23] Access Economics (2008) *The Growing Costs of Obesity: three years on*. A report for Diabetes Australia, Access Economics, Canberra.
[24] Begg S, Vos T, Barker B, Stevenson C, Stanley L & Lopez AD (2007). *The burden of disease and injury in Australian 2003*. PHE 82. Canberra, Australian Institute of Health and Welfare.
[25] O'Brien K (2005). *Living dangerously: Australians with multiple risk factors for cardiovascular disease*. Bulletin No 24, Australian Institute of Health and Welfare Cat No AUS 57. Canberra, Australian Institute of Health and Welfare.

harm.[26] The survey also showed 16.6% of the population over 14 smoked daily.

Around one fifth (21%) of all adults in low income households were obese in 2004-05 compared to 15% in high income households. The age standardised rate of obesity for adults living in the most disadvantaged 20% of geographic areas was 22.4%. This is close to twice that of adults living in the most advantaged areas (12.9%).[27]

The objectives of the Healthy Communities initiative are consistent with the preventive health agendas of the Commonwealth, states and territories. They are also consistent with the lifestyle-related elements of the National Healthcare Agreement.

c) Approvals to date

COAG authorised the Healthy Communities initiative when it agreed the prevention NP on 29 November 2008.

d) Policy solution, delivery model, or strategy

The Commonwealth will provide grants funding to Local Government Areas (LGAs) to support the roll-out of community-based programs / activities to promote healthy living including physical activity, healthy eating and healthy weight programs.

LGAs participating in the initiative will be encouraged to undertake activities that encompass strategic planning for healthy lifestyles, and creating environments conducive to making healthy lifestyle choices.

Program guidelines, selection criteria and application documentation will be developed in consultation with states and territories and the project Implementation Reference Group (IRG).

The initiative will target disadvantaged populations and those predominately not in the workforce. Children and those in the workforce will not be specifically targeted by this initiative.

Grants are expected to be awarded in three phases (1st 'pilot' phase – January 2010, 2nd phase January 2011 & 3rd phase July 2011). This will ensure all areas will have sufficient time to implement the initiative (with a minimum funding period of 18 months).

Eligible LGAs will be identified in consultation with state and territory governments, the Australian Local Government Association and state based local government associations. A number of targeting criteria will be developed to support the identification of priority, high needs areas.

The 12 'pilot' grants offered over the first two years of the program (2009-10 – 2011-12) will serve as demonstration or "learning-by-doing" models for the remainder of the grants allocated during phases 2 and 3. The Commonwealth will work with States and Territories, the Australian Local Government Association and state based local government associations to pilot a number of implementation models during this phase. These models could include funding to a:

- single LGA;
- small group of LGAs with neighbouring clusters of disadvantage; or
- pre-established partnership between an LGA or LGA cluster and a not-for-profit organisation.

Given the limited number of pilot grants available and to ensure an even distribution across all jurisdictions, only 1 funding amount will be available to

[26] Australian Institute of Health and Welfare (2008) 2007 National Drug Strategy Household Survey First Results. Drug Statistics Series No 20. Canberra, Australian Institute of Health and Welfare

[27] Australian Social Trends 20007 – Article: Overweight and Obesity Cat. No. 4120 Aug 2007; ABS Overweight and Obesity in Adults January 2008 Cat. No. 4719

each recipient (either single LGA or LGA cluster). In this context, capacity to successfully mange a program grant will also be considered as an important selection / targeting criterion.

In July 2009 the Commonwealth will hold a planning workshop for a number of key stakeholders to discuss elements of the initiative. The workshop will focus on four aspects:

- Quality Assurance
- Program evaluation
- Pilot models; and
- Targeting

Participants at the workshop will include Project Steering Committee / Implementation Reference Group representatives and invited experts.

In addition, a pool of funding will be made available to ensure effective nationally-consistent programs are available within the recipient LGAs. Programs could include walking, supervised exercise or healthy eating education programs.

The Commonwealth anticipates that a number of new and existing program service providers will compete for this pool of funding. Funding will be awarded per program not per organisation and will be in addition to any existing funding the provider may be receiving. Recipients will be required to work alongside a majority of recipient LGAs to ensure funded programs are available within those areas. In this way, the Commonwealth is seeking to build lasting and sustainable partnerships between local government and the healthy lifestyles sector that can leverage capacity and target services.

The Commonwealth will support the implementation of the initiative through the development and funding of 'soft infrastructure' such as a Quality Assurance Framework, the accreditation / registration of programs and service providers and a web-based information portal.

7.1.1.2 Benefits statement

Table 1.1. Statement of expected benefits

Intended beneficiaries	Expected benefits
Target Group Population - Those not predominately in the workforce including, but not limited to, the unemployed and stay-at-home parents within socially and economically disadvantaged areas.	• Improved access to community based physical activity and healthy eating programs. • Increased uptake of community based physical activity and healthy eating programs. • Increased awareness of the benefits of healthy eating and regular physical activity and healthy weight.
Local Government organisations	• Increased capacity to provide community based physical activity and healthy eating programs. • Increased confidence in selecting and funding Quality Assured and / or registered community based physical activity and healthy eating programs and providers.
Those preparing for, or already looking for work	• Increased employment and training opportunities within the local area.
Carers	• Improved access to community based physical activity and healthy eating programs. • Increased uptake of community based physical activity and healthy eating programs.

Intended beneficiaries	Expected benefits
	• Increased awareness of the benefits of healthy eating, regular physical activity and healthy weight.

This initiative contributes to Outcome 1 Population Health in the Department's structure of outcomes and outputs. Further detail will be included in the 2009-10 Portfolio Budget Statements for the Health and Ageing portfolio.

7.1.1.3 Evaluation methodology

Evaluation of the Health Prevention NP will occur at two levels. An overarching evaluation will occur through assessing how well a range of performance benchmarks are met and a more detailed evaluation will occur for each component of the Partnership.

7.1.1.3.1 Overarching evaluation

Overarching evaluation will occur at two time points, June 2013 and January 2014, covering the proportion of:

- adults and children at health body weight;
- adults and children meeting the national guidelines for physical activity;
- adults and children consuming adequate amounts fruits and vegetables; and
- Australians smoking daily.

7.1.1.3.2 Program level evaluation

An evaluation plan for the Healthy Communities initiative is provided at Attachment 1.

7.1.2 GOVERNANCE

7.1.2.1 Internal governance arrangements

Responsibility for the National Partnership Agreement on Preventative Health will be shared between the Commonwealth and States and Territories. At the Commonwealth level, overarching responsibility will rest predominantly with Population Health Division. The primary officers responsible for the implementation of the Healthy Communities initiative are identified in Table 2.1.

Table 2.1. Hierarchy of internal governance arrangements

Deputy Secretary Department of Health and Ageing Name David Learmonth	Sponsor and senior responsible officer	Chair of the National Partnership Agreement on Preventive Health Implementation Working Group.
First Assistant Secretary Population Health Division Department of Health and Ageing Name Cath Halbert	Leader	Accountable for policy decisions, financial delegation, reporting to sponsor and senior responsible officer and to the Minister.
Assistant Secretary Healthy Living Branch Population Health Division Name: Cath Peachey	Manager	This position will provide overall direction to this initiative and ensure that this complements other elements of the Partnership including Healthy Workers, Healthy Children and social marketing elements.

Director Obesity and Physical Activity Section Healthy Living Branch Population Health Division Name: Sandra King	Coordinator	This position will provide direction to the initiative, high level liaison with jurisdictions and other key stakeholders, as well as being responsible for advice to the governance body responsible for the Partnership. In addition this position will foster linkages with other elements of the Partnership including Healthy Workers, Healthy Children and social marketing elements.

7.1.2.2 External governance arrangements

Committees and bodies with a role in implementation:

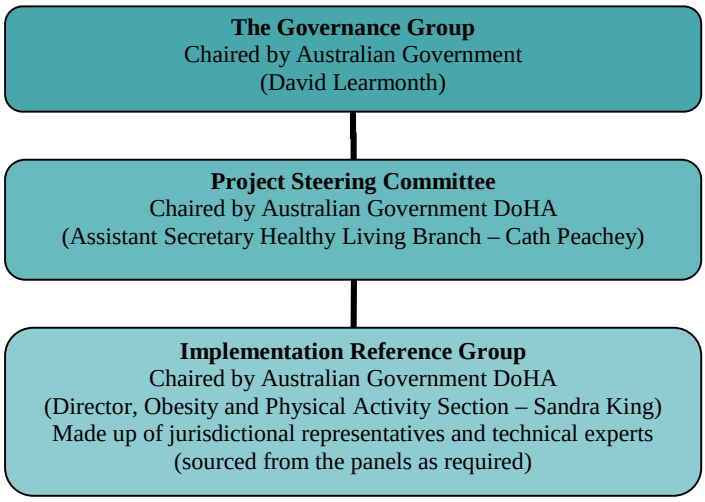
National Partnership Agreement on Preventive Health Implementation Working Group
Planning and coordination of implementation arrangements for the prevention NP will be managed by the prevention NP Implementation Working Group. The Working Group is chaired by the Commonwealth and comprises Deputy CEOs from all jurisdictions with responsibility for preventive health. The Working Group will oversee the development of implementation plans for all elements of the prevention NP and provide a recommendation to AHMAC.

Australian Health Ministers' Advisory Council (AHMAC)
AHMAC will receive advice from the prevention NP Implementation Working Group on implementation arrangements and make a recommendation to AHMC.

Australian Health Ministers' Conference (AHMC)
AHMC is responsible for agreeing implementation arrangements for the prevention NP. To support this role, AHMC will receive advice from AHMAC on implementation arrangements before making a decision.

Once the implementation plans are agreed, a Project Steering Committee to oversee the implementation of Healthy Communities will be established. External governance arrangements for the working group to oversee implementation are summarised in Figure 2.1 below.

Figure 2.1. Chart of broader governance arrangements



Project Steering Committee (PSC)
This Committee will provide overall direction for the implementation of the initiative and will ensure that it complements other elements of the Partnership Agreement. The PSC will sign off on key

program deliverables including targeting criteria, grant guidelines and specifications and the Quality Assurance Framework. Membership could include:

- Australian Government
  - Department of Health and Ageing (DoHA) - Assistant Secretary, Healthy Living Branch (CHAIR)
  - DoHA – Assistant Secretary, Population Health Strategy Unit (Overall COAG implementation)
  - Department of Infrastructure, Transport, Regional Development and Local Government (DITRDLG)
  - Department of the Prime Minister and Cabinet (PM&C)
- State and Territory health departments
- Australian Local Government Association (ALGA)
- Quality Assurance expert
- Scientific expert – Overweight and Obesity

Implementation Reference Group (IRG)
This group will help to inform the development of key program deliverables including guidelines, criteria and specifications. This is not a decision making body. Membership of the IRG will comprise:

- Australian Government
  - DoHA – Director, Obesity and Physical Activity Section (CHAIR)
  - DITRDLG – Director, Local Government Policy Section
- State and Territory health departments

In addition, the IRG may draw on expert advice to inform their recommendations from experts in Community Based Healthy Lifestyle Interventions and Quality Assurance.

7.1.3 SCOPE/DELIVERABLES

7.1.3.1 Scope/Deliverables

Table 3.1. Definition of deliverables in/out of scope

Deliverables within the scope of this measure	Deliverables/activities beyond the scope of this measure
Design and evaluate programs Development of a quality assurance framework and web based portal. Grants implemented Support provided for National programs.	Healthy lifestyle programs will not be delivered by the Australian Government. Clinical services will not be funded. Substantial (>10% x total grant) infrastructure projects will not be funded. Programs specifically targeting children and workplace programs will not be funded.

7.1.3.2 Assumptions / Dependencies

The successful implementation of this initiative will be dependent on the on-going development and delivery of national and state / territory based healthy lifestyle programs. Whilst a number of these programs will receive new or additional funding through the National Program Grants component of this initiative, existing state / territory, NGO or philanthropic funding sources will need to be maintained.

In addition, a key assumption underpinning the success of the program will be the willingness and capacity of LGAs to provide in-kind support for the program. This could include accommodation and IT support for a Healthy Lifestyles Promotion officer, free or subsidised venue hire for classes, promotion activities or community awareness raising events.

The initiative also assumes that existing Quality Assurance programs run by industry, NGOs and the philanthropic sector will continue to operate and eventually run in collaboration with Quality Assurance Framework developed to support the initiative.

7.1.4 IMPLEMENTATION SCHEDULE

This measure is made up of a number of components, including: the development of program guidelines, selection criteria and evaluation; the development of a Quality Assurance Framework, accreditation / registration of programs and service providers and a web-based information portal; the roll-out of grants to LGAs for community-based physical activity and healthy eating programs; and grants to non-government organisations to deliver and promote programs within recipient LGAs.

Table 4.1 Healthy communities – schedule of implementation milestones

	Milestones			
Date	**Output 1: Program Design and Evaluation**	**Output 2: Quality Assurance Framework and Portal**	**Output 3: Grant Implementation**	**Output 4: National Program Support**
Quarter 1 2009-10 {Jul - Sept}	• Establish the Project Steering Committee and the Implementation Reference Group • Hold a workshop with PSC and IRG to discuss key elements of the initiative • LGA Grant targeting framework established • Evaluation methodology and on-going processes agreed • Stakeholder consultations	• Advertise procurement of services to develop a national Quality Assurance framework	• Program guidelines, selection criteria and application documentation finalised • Round 1 LGA Grants advertised	• National Program Grants Phase 1 advertised
Quarter 2 2009-10 {Oct – Dec}	• Grant administration systems established • Stakeholder consultations	• Organisation contracted to develop a national Quality Assurance framework	• Round 1 LGA Grants assessed and awarded	• National Program Grants Phase 1 assessed and awarded
Quarter 3 2009-10 {Jan – Mar}	• Internal process evaluation of LGA and National Programs grants application processes completed	• Quality Assurance framework development and stakeholder consultation • Advertise procurement of services for accreditation and portal	• Round 1 LGA Grants commence	• National Program Grants Phase 1 commence
Quarter 4 2009-10 {Apr - Jun}	• Amendments made to grant processes if required	• Quality Assurance framework agreed by key stakeholders • Contract(s) awarded for portal and accreditation services		
Quarter 1 2010-11 {Jul - Sept}		• Development of accreditation services and portal	• Round 2 LGA Grants advertised • Round 1 LGA Grants reporting	
Quarter 2 2010-11 {Oct – Dec}	• Internal process evaluation of LGA and National Programs grants application processes completed	• Commencement of accreditation and portal	• Round 2 LGA Grants assessed and awarded	• National Program Grants Phase 1 reporting

	Milestones			
Date	**Output 1: Program Design and Evaluation**	**Output 2: Quality Assurance Framework and Portal**	**Output 3: Grant Implementation**	**Output 4: National Program Support**
Quarter 3 2010-11 {Jan – Mar}	• Amendments made to grant processes if required	• Accreditation and portal continues	• Round 2 LGA Grants commence • Round 3 LGA Grants advertised	• National Program Grants Phase 1 internal evaluation • National Program Grants Phase 2 advertised
Quarter 4 2010-11 {Apr - Jun}			• Round 2 LGA Grants commence • Round 3 LGA Grants assessed and awarded • Round 1 LGA Grants reporting	• National Program Grants Phase 2 assessed and awarded
Quarter 1 2011-12 {Jul - Sept}		• Progress reporting on accreditation and portal	• Round 3 LGA Grants commence	• National Program Grants Phase 2 commence
Quarter 2 2011-12 {Oct – Dec}			• Round 2 LGA Grants reporting	
Quarter 3 2011-12 {Jan – Mar}			• Round 3 LGA Grants reporting	
Quarter 4 2011-12 {Apr - Jun}			• Round 1 and 3 LGA Grants reporting	• National Program Grants Phase 2 reporting
Quarter 1 2012-13 {Jul - Sept}	• Evaluation component commences	• Progress reporting on accreditation and portal	• Round 2 LGA Grants reporting	
Quarter 2 2012-13 {Oct – Dec}				
Quarter 3 2012-13 {Jan – Mar}				• National Program Grants Phase 2 reporting
Quarter 4 2012-13 {Apr – Jun}	• Evaluation component finalised	• Final report on accreditation and portal	• Round 1, 2 and 3 LGA Grants reporting	• National Program Grants Phase 2 Evaluation

7.1.5 WORK BREAKDOWN STRUCTURE

The work under this measure is conducted primarily by the officers of the Obesity and Physical Activity Section, Healthy Living Branch, Population Health Division. The Section maintains an operational work plan (not included as part of this Implementation Plan) that sets out lower level tasks and activities and their allocations in the workplace.

7.1.6 RESOURCES

7.1.6.1 Budget

This measure was agreed to by COAG in November 2008 and will be identified in the 2009-10 Budget. An indicative budget breakdown for this initiative is shown in Table 6.1.

Table 6.1 Healthy Communities Budget

Initiative	2009-10 $m	2010-11 $m	2011-12 $m	2012-13 $m	Total $m
Program design and evaluation	0.280	0.119	0.121	0.184	0.704
Quality Assurance framework and portal	1.500	1.500	1.500	1.500	6.000
Grant implementation	1.620	7.841	24.952	25.426	59.839
National program support	1.000	1.500	1.500	1.500	5.500
TOTAL	**4.400**	**10.960***	**28.073***	**28.610***	**72.043**

* Note: $0.060m will need to be reprofiled from 2012-13 to 2010-11.
$5.539m will need to be reprofiled from 2012-13 to 2011-12.

Healthy Living Branch maintains a budgeting tool allocating administered and departmental funds for this measure to resources required. This information is not included here.

7.1.6.2 Non-financial resources

The Department of Health and Ageing may be required to utilise the expertise of external consultants to assist in the development of IT systems, Quality Assurance standards and accreditation systems. Funding to procure these services is available within the budget outlined above.

7.1.7 RISK MANAGEMENT

The Obesity and Physical Activity Section maintains a risk register which records identified risks for this initiative. The register, both risks and proposed mitigation activities, is reviewed and updated regularly. This register has informed Table 7.1 below.

Table 7.1. Risk identification and control

Risk	Risk rating	Origin/cause/source of risk and trigger point for deploying strategies	Risk mitigation/control strategies
No tenders are received to run the independent accreditation and registration processes.	Medium (Consequence Moderate, Likelihood Possible)	Workforce and capacity shortages within independent NGOs. Trigger Point – on-going market appraisal prior to March 2010	Control strategies o ongoing market appraisal o targeted consultation

Risk	Risk rating	Origin/cause/source of risk and trigger point for deploying strategies	Risk mitigation/control strategies
Accreditation processes cost more than the budgeted amount	Medium (Consequence Moderate, Likelihood Possible)	This is a new area of activity within community based healthy living programs. Trigger Point – on-going market appraisal prior to March 2010	Control strategies o slow rollout of the program as LGAs come on line o Utilisation of existing accreditation bodies and services o Early consultation with key stakeholders and potential suppliers
All stakeholders do not agree to the Quality Assurance Framework	Low (Consequence Moderate, Likelihood Low)	This is a very complex field with a number of pre-existing systems and accreditation methodologies and it may be difficult to find common ground Trigger Point – Preliminary Stakeholder workshop to be held in July 2009	o Preliminary Stakeholder workshop to be held in July 2009 o Quality Assurance national consensus workshop to agree national standards o Ongoing stakeholder consultations
The Department is unable to identify LGAs who meet the grant selection and targeting criteria who have capacity to act as 'pilots' or 'demonstration models' in year 1	Low (Consequence Moderate, Likelihood Low)	In targeting disadvantaged areas it may be difficult find LGAs with a proven capacity to successfully implement initiatives of this nature Trigger Point – consultations with states and territories in the first quarter of 2009-10	o Ongoing consultations with jurisdictions o Individual targeting meetings with each state and territory o Liaison with the Department of Transport, Regional Development and Local Government o Consultation with ALGA and state based local government associations
LGA grant recipients in year 4 (initial funding model) will not have enough time to benefit from the initiative	Low (Consequence Low, Likelihood Low)	Grant recipients in year 4 would only receive 1 year of funding Trigger Point – Preliminary consultations with jurisdictions and ALGA confirmed there was limited value in having only 1 years funding.	o Funding model reviewed bring forward fourth year funding recipients into year 3 o Funding to be reprofiled
Too many national programs may compete for the small pool of funding available for national program grants	Medium (Consequence Low, Likelihood Medium)	There are insufficient funds to support all national programs Trigger Point – Development of funding criteria	o Application criteria developed to identify those programs that have the capacity to be rolled out in funded LGAs at a low cost

7.1.8 STAKEHOLDER MANAGEMENT

There will be significant stakeholder engagement in the development of program guidelines, selection criteria and the development of a Quality Assurance framework:

- An Implementation Reference Group will be established to help inform the development of key program deliverables including guidelines, criteria, specifications and frameworks. This will be supported by two informal panels of experts and stakeholders with an interest or expertise in community based lifestyle interventions and in quality assurance. The panels will also serve as information sharing forums.
- Consultation with key stakeholders will be a requirement of the services to develop a Quality Assurance framework.
- Jurisdictions will have the opportunity to help identify eligible LGAs that could meet the funding criteria.

Table 8.1. Stakeholder management strategy

Stakeholder	Their views	Department's strengths in managing these views	Department's vulnerabilities
A range of stakeholders in the fitness, nutrition, NGO and local government sectors are expected to have views and be engaged in development and implementation of this project	Specific views not yet known but will be canvassed during consultations	The Department will consult broadly with stakeholders and providing opportunities for input. Key stakeholders and experts will have a role in the Implementation Reference Group.	Nil

7.1.9 QUALITY ASSURANCE

A range of quality assurance activities will be utilised including:

- Regular (quarterly) progress reporting to the prevention NP Implementation Working Group, including updates on progress towards milestones and financial expenditure monitoring.
- Regular reporting to the Minister for Health and Ageing.
- Annual reporting to COAG as stipulated in the prevention NP Agreement.

Attachment 1 - Healthy Communities Evaluation Plan

(RELATES TO 7.1.1.3)

The evaluation of the Healthy Communities Initiative is a three-pronged approach:

1. Internal process evaluation – an ongoing evaluation of internal processes in delivering the program will take place over the four years.

2. Evaluation of pilots:

    a) The first round of LGA grants will be a 'pilot' phase, allowing for staged evaluation of the program, prior to 'scaling –up'. Baseline data will be collected via the application process, in which LGAs will need to provide data in their application to demonstrate need.

    b) The first six months of the accreditation system and portal will be a 'pilot' phase, which will be reviewed at the end of the 2nd quarter in 2010-11. Necessary modifications will be made following the review.

3. Formal external evaluation of the initiative – an external evaluation of the program will take place. The evaluation model and performance indicators will be determined in 2009-10, with the final evaluation reporting to occur in the 3rd and 4th quarter of 2012-13.

7.2 IMPLEMENTATION PLAN – HEALTHY CHILDREN

Version History

Version	Date	Nature of change(s)
0.1	May 2009	First draft of plan for National Partnership Agreement on Preventive Health Implementation Working Group meeting of 14 May 2009
0.2	May 2009	Second draft for distribution to Implementation Working Group on 20 May 2009
0.3	June 2009	Draft circulated to AHMAC out-of-session

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7.2.1 PROJECT DEFINITION

7.2.1.1 Policy objective/outcome

The purpose of this document is to provide an interim implementation plan to support and guide the state and territory governments in developing their own individual implementation plans for the Healthy Children initiative (the initiative). The initiative is one element of the National Partnership Agreement on Preventive Health (prevention NP).

a) Approved policy objective

Through the prevention NP, COAG is providing $325.5 million over six years for the initiative. These funds will be provided to states and territories to deliver a range of programs that:

- build on existing efforts currently in place, while adapting them to suits demographic and other factors in apply at various sites;
- cover healthy weight, physical activity, healthy eating, healthy weight and primary and secondary prevention;
- in settings such as child care centres, preschools, schools , multi-disciplinary service sites, and children and family centres, and
- include family based interventions, setting based initiatives, environmental strategies in and around schools, and breastfeeding support interventions.

b) Policy context or environment

The prevention NP 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 poor nutrition, physical inactivity, smoking and excessive alcohol consumption (including binge drinking);
- social marketing aimed at reducing obesity and tobacco use; and
- the enabling infrastructure to monitor and evaluate progress made by these interventions, including the Agency and research fund.

Funding for the settings based interventions, including Healthy Children is provided in recognition of the important role they can play in supporting action on the lifestyle related risk factors for chronic conditions.

Tentative Analysis of the 1995 National Nutrition Survey and t*he 2007 Australian National Children's Nutrition and Physical Activity Survey* indicate an increase in the proportion of children aged 7-15 years who were overweight or obese from 20.7 percent in 1995 to 25.5 percent in 2007.

Results from the *2007 Australian National Children's Nutrition and Physical Activity Survey* indicate*:*

- the proportion of children meeting the guidelines for fruit intake (1-3 serves per day depending on age group and gender) declines with age (61% for 4-8 year olds, 51% for 9-13 year olds and 1% for 14-16 year olds); and
- the proportion of children meeting the guidelines for vegetable intake (2-4 serves per day depending on age group and gender) decreases with age (22% for 4-8 year olds, 14% for 9-13 year olds and 5% for 14-16 year olds).

A range of programs aimed at increased levels of physical activity and healthy eating are being delivered by all levels of government.

c) Approvals to date

The Council of Australian Governments authorised the initiative when it agreed the prevention NP in November 2008.

d) Policy solution, delivery model, or strategy

This is an interim plan for the Healthy Children initiative to assist the states and territories to develop implementation plans for programs for children aged from birth to 16.

Commonwealth

The Commonwealth will collaborate with the state and territory governments to guide development of jurisdictional implementation plans for programs to promote greater levels of physical activity and better nutrition for children aged birth to 16.

It is proposed that the collaboration would consider the use of evidence based models, reports including those from the Preventative Health Taskforce and the National Health and Hospitals Reform Commission and consultations with key stakeholders to assess opportunities and barriers to implementation.

The Commonwealth is to facilitate a forum with the states and territories to promote the sharing of evidence based strategies in relation to improving healthy eating and physical activity levels among children. Factors that will need to be considered include:

(i) needs of the population and effective targeting (both in terms of value for money and positive health gains), with consideration of high risk groups, gaps and existing programs;

(ii) the type of delivery method, eg: settings such as child care centres, pre-schools, schools, multi-disciplinary service sites, and children and family centres; as well as the merits of expanding existing programs; and

(iii) capacity of programs to contribute to national improvements in the health of children aged birth to 16 in relation to the performance objectives identified in the prevention NP.

States and Territories

States and territories will draft implementation plans to facilitate the delivery of programs for children aged 0 – 16 years that take account of the latest evidence and that:

a) build on existing efforts currently in place, while adapting them to suit demographic and other factors in apply at various sites;

b) cover physical activity, healthy eating and primary and secondary prevention;`

c) consider settings such as child care centres, preschools, schools , multi-disciplinary service sites, and children and family centres;

d) include family based interventions, setting based initiatives, environmental strategies in and around schools, and breastfeeding support interventions; and

e) position jurisdictions to meet the relevant performance objectives identified in the prevention NP.

States and territories are required to submit their implementation plans that have been approved by their Health Minister, for the Commonwealth Health Minister's consideration by 30 September 2010, with a view to Commonwealth approval by 31December 2010. The agreed state and territory implementation plans will then supersede this initial plan

7.2.1.2 Benefits statement

Table 1.1. Statement of expected benefits

Intended beneficiaries	Expected benefits
Children aged from birth to 16 years. The primary target group is children aged from preschool age to 16 years. The secondary group is children aged from birth to 3 years	Expected benefits are for the Healthy Communities initiative as a whole. **Short Term benefits** • More children in age groups from preschool to the end of high school involved in physical activity. For children already in some physical activity, maintenance or increase in those physical activity levels. • Raised awareness and increased supports to embed healthy eating patterns for children and families particularly in relation to good nutrition and higher levels of physical activity. • Conveyance of the long term effects of healthy lifestyle choices to children and their families. • Increased number of children in age range 0-16 years at a healthy weight due to improved nutrition and increased physical activity levels . **Long term benefits** • Increase in proportion of children at unhealthy weight held at less than five per cent from baseline for each state by 2013; proportion of children at healthy weight returned to baseline level by 2015. • 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 2013; 0.6 for fruits and 1.5 for vegetables by 2015. • 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 2013; by 15 per cent by 2015. Where the baseline is the latest available data as at June 2009.

7.2.1.3 Evaluation methodology

Evaluation of the Health Prevention NP will occur at two levels. An overarching evaluation will occur through assessing how well a range of performance benchmarks are met and a more detailed evaluation will occur for each component of the Partnership.

7.2.1.3.1 Overarching evaluation

Overarching evaluation will occur at two time points, June 2013 and December 2014, covering the proportion of:

- children at health body weight;
- children meeting the national guidelines for physical activity, and children who have increased their activity from previous benchmarking point; and
- children consuming adequate amounts fruits and vegetables.

7.2.1.3.2 Program level evaluation

Detailed evaluation plans will be included in agreed jurisdictional implementation plans.

7.2.2 GOVERNANCE

The states have responsibility for the management of funds under the initiative, though implementation arrangements will be agreed by the Commonwealth Minister for Health and Ageing. The role of the Commonwealth in this initiative is to provide guidance and undertake a facilitation role in conjunction with the states and territories to assist them in the development of their implementation plans. At the Commonwealth level, overarching responsibility will rest predominantly with Population Health Division.

7.2.2.1 Internal governance arrangements

Table 2.1. Hierarchy of internal governance arrangements for interim implementation plan

Deputy Secretary Department of Health and Ageing Name: David Learmonth	Sponsor and senior responsible officer	Chair of the National Partnership Implementation Working Group.
First Assistant Secretary Population Health Division Name: Cath Halbert	Leader	Accountable role responsible for policy decisions, financial delegation, reporting to sponsor and senior responsible officer.
Assistant Secretary Healthy Living Branch Population Health Division Name: Cath Peachey	Manager	Responsible for strategic policy directions and decisions, reporting to Leader and Minister.
Director Healthy Children, Healthy Workers Population Health Division Name: Catherine Winter	Coordinator	Accountable role responsible for facilitating engagement with states and territories and stakeholders in this interim phase, reporting to Manager, Leader and Minister.

7.2.2.2 External governance arrangements

Committees and bodies with a role in implementation:

National Partnership Agreement on Preventive Health Implementation Working Group
Planning and coordination of implementation arrangements for the prevention NP will be managed by the prevention NP Implementation Working Group. The Working Group is chaired by the Commonwealth and comprises deputy CEOs from all jurisdictions with responsibility for preventive health. The Working Group will oversee the development of implementation plans for all elements of the prevention NP and provide a recommendation to AHMAC.

Australian Health Ministers' Advisory Council (AHMAC)
AHMAC will receive advice from the prevention NP Implementation Working Group on implementation arrangements and make a recommendation to AHMC.

Australian Health Ministers' Conference (AHMC)
AHMC is responsible for agreeing implementation arrangements for the prevention NP. To support this role, AHMC will receive advice from AHMAC on implementation arrangements before making a decision.

Jurisdictional implementation plans will outline governance arrangements to take place once this interim arrangement is superseded.

7.2.3 SCOPE/DELIVERABLES

7.2.3.1 Scope/Deliverables

Table 3.1.1 Healthy children - definition of deliverables in/out of scope

Deliverables within the scope of this interim implementation plan	Deliverables/activities beyond the scope of this measure
• Commonwealth to support States and Territories to develop implementation arrangements. a. Review of evidence. b. Consult with stakeholders. c. Host forums to share evidence. • States and Territories to develop implementation plans.	N/A at this stage

7.2.3.2 Assumptions / Dependencies

All jurisdictions will work collaboratively to share information and evidence to support final implementation arrangements.

Funding for initiatives does not flow until the Commonwealth Minister agrees to the implementation plans as developed by the States and Territories.

7.2.4 IMPLEMENTATION SCHEDULE

Table 4.1 Healthy children - schedule of interim implementation milestones

	Milestones	
Date	**Output 1:** **COMMONWEALTH SUPPORT TO STATES AND TERRITORIES**	**Output 2:** **STATE AND TERRITORY IMPLEMENTATION**
Quarter 1 – Jul – Sept 09	• Commonwealth to organise a teleconference/ meeting in **July 2009** with states and territories to confirm a work plan. • Commonwealth to conduct a meta analysis of evidence based healthy children interventions focused on increasing physical activity and improving nutrition with a particular focus on identifying gaps that target sub-populations within the 0 – 16 year range. • Review of reports such as those from the Preventative Health Taskforce and the National Health and Hospitals Reform Commission. • Review evidence and evaluation of existing programs, including those implemented in the states and territories. • Identify and consult with key stakeholders to assess opportunities and barriers to implementation. • Commonwealth meeting with states and territories and key stakeholders to discuss findings of meta analysis and other research in **September 2009** and to agree on key principles and objectives.	• States and territories to provide details on what activities are currently underway in their state or territory before September meeting and details of any reviews or analysis of those programs for the meta- analysis. • Meeting with Commonwealth to discuss findings **September 2009**.
Quarter 2 – Oct – Dec 09		
Quarter 3 – Jan – Mar 10	• Teleconference with states and territories to report on progress in **January 2010**. • Bilateral discussion and possible forum with states and territories if required **March 2010**.	
Quarter 4 – Apr – Jun 10	• Teleconference with states and territories to report on progress in **June 2010.**	
Quarter 5 – Jul - Sept 10	• Receipt of state and territory implementation plans for Commonwealth approval by **30 September 2010**.	• State and territory approved implementation plans submitted to Commonwealth by **30 September 2010**.
Quarter 6 – Oct – Dec 10		• Commonwealth Ministerial approval by **31 December 2010.**
Quarter 7 – Jan – Mar 11		
Quarter 8 – Apr – Jun 11		
Quarter 9 – Jul – Sep 11	• Funds provided to state and territories from **1 July 2011** following Commonwealth agreement of implementation plans.	

7.2.5 WORK BREAKDOWN STRUCTURE

The Commonwealth's contribution to this component of the prevention NP will be made primarily by staff within the Healthy Living Branch. An operational work plan is in preparation which sets out lower-level activities and task allocations. This work plan will be revised fortnightly.

7.2.6 RESOURCES

7.2.6.1 Budget

This measure was agreed to by COAG in November 2008 and will be identified in the 2009-10 Budget. An indicative budget breakdown for this initiative is shown in table 6.1.

A detailed budget is not attached to this interim plan. Allocation of funding for future years is detailed in the table below. Funding is not scheduled to flow to states and territories until 2011 following Commonwealth agreement on state and territory implementation plans. There have been no resources allocated prior to these out years for planning and development.

Table 6.1 Healthy children resources

Initiative	2011-12 $m	2012-13 $m	2013-14 $m	2014-15 $m	Total $m
Healthy Children	32.456	64.912	97.368	130.790	325.5
Total	**32.456**	**64.912**	**97.368**	**130.790**	**325.5**

7.2.6.2 Non-financial resources

The Commonwealth will contribute non-financial resources to the implementation of the Agency including ASL, legal services and contracting arrangements as required.

7.2.7 RISK MANAGEMENT

The risks arising in this development phase are outlined below. Risks that may arise when states and terrorise begin to implement programs are not covered here, but will be outlined in jurisdictional implementation plans.

Table 7.1 Overarching risk identification and control

Risk	Risk rating	Origin/cause/source of risk and trigger point for deploying strategies	Risk mitigation/control strategies
Failure to meet timelines	Medium Consequence High, Likelihood Low	Approvals from relevant Delegates delayed	Consultation with States and Territories and AHMC

7.2.8 STAKEHOLDER MANAGEMENT

Stakeholders will need to be identified in conjunction with the States and Territories.

Table 8.1 Overarching stakeholder management strategy

Stakeholder	Their views	Department's strengths in managing these views	Department's vulnerabilities
State and Territory Governments	Interested in working together to achieve outcomes from the prevention NP and to best utilise the resources made available under Healthy Children. Interested to enhance existing programs within jurisdictions to maximise benefits.	The Department is working closely with the States to ensure a positive outcome.	Nil
Key experts and stakeholders in sectors for children aged birth to 16 years of age.	Likely to have a broad range of views depending on age group and health issue.	The Department will consult relevant stakeholders to ensure a positive outcome.	Nil

7.2.9 QUALITY ASSURANCE

A range of quality assurance activities will be utilised including:

- Regular (quarterly) progress reporting to the prevention NP Implementation Working Group, including updates on progress towards milestones and financial expenditure monitoring.
- Regular reporting to the Minister for Health and Ageing.
- Annual reporting to COAG as stipulated in the prevention NP Agreement.

7.3 IMPLEMENTATION PLAN – HEALTHY WORKERS

Version History

Version	Date	Nature of change(s)
0.1	May 2009	First draft of plan for National Partnership Agreement on Preventive Health Implementation Working Group meeting of 14 May 2009
0.2	May 2009	Second draft for distribution to Implementation Working Group on 20 May 2009
0.3	June 2009	Draft circulated to AHMAC out-of-session

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7.3.1 PROJECT DEFINITION

This document outlines an interim implementation plan for the Healthy Workers initiative which is funded through the National Partnership Agreement on Preventive Health (prevention NP). The purpose is to support state and territory governments in the preparation of individual plans by December 2010.

7.3.1.1 Policy objective/outcome

a) Approved policy objective

The prevention NP provides $294.4 million over six years for the Healthy Workers initiative, which will fund:

- states and territories to deliver healthy living programs in workplaces ($289.4 million); and
- the Commonwealth to provide the soft infrastructure to support state/territory programs, including a national charter, voluntary competitive benchmarking, nationally agreed standards for workplace prevention programs, and to run national awards for excellence in workplace health programs ($5 million).

b) Policy context or environment

The prevention NP provides funding for:

- o settings based interventions in pre-schools, schools, workplaces and communities to support behavioural changes in the social contexts of everyday lives, and focusing on poor nutrition, physical inactivity, smoking and excessive alcohol consumption (including binge drinking);
- o social marketing aimed at reducing obesity and tobacco use; and
- o the enabling infrastructure to monitor and evaluate progress made by these interventions.

A number of recent reports into chronic disease risks identify 4 key areas that play a major role in the risk of developing chronic disease. These are levels of physical activity, healthy eating, consumption of alcohol at harmful or hazardous levels and the cessation of smoking.

In 2005, 3.2 million Australians were obese.[28] Access Economics forecasts this could rise to 4.6 million in 2025.[29] High body mass now accounts for some 7.5% of the total burden of disease in Australia and is likely to displace tobacco as the leading preventable risk factor for chronic disease.[30] There is evidence that up to two-thirds of Australians consume less than the recommended serves of vegetable and fruits, and more than 50% report lower than recommended levels of physical activity.[31]

In 2007, 10.3% of Australians aged 14 and over reported consuming alcohols at levels placing them at long term risk of harm, whilst 20.4% reporting consuming alcohol at levels placing them at short term risk of harm.[32] The survey also showed 16.6% of the population over 14 smoked daily.

The workplace presents the ideal opportunity to engage a large number of individuals in preventive health programs whilst providing major benefits to employers by building healthier and a more productive workforce. It should

[28] Access Economics (2006) *The Economics of Obesity*. A report for Diabetes Australia, Access Economics, Canberra.
[29] Access Economics (2008) *The Growing Costs of Obesity: three years on*. A report for Diabetes Australia, Access Economics, Canberra.
[30] Begg S, Vos T, Barker B, Stevenson C, Stanley L & Lopez AD (2007). *The burden of disease and injury in Australian 2003*. PHE 82. Canberra, Australian Institute of Health and Welfare.
[31] O'Brien K (2005). *Living dangerously: Australians with multiple risk factors for cardiovascular disease*. Bulletin No 24, Australian Institute of Health and Welfare Cat No AUS 57. Canberra, Australian Institute of Health and Welfare.
[32] Australian Institute of Health and Welfare (2008) 2007 National Drug Strategy Household Survey First Results. Drug Statistics Series No 20. Canberra, Australian Institute of Health and Welfare

also be noted that approaches will need to consider the needs of national employers in terms of consistency of programs across the country as well as those of small and medium enterprises.

c) Approvals to date

The Council of Australian Governments authorised Healthy Workers when it agreed the prevention NP on 29 November 2008.

d) Policy solution, delivery model, or strategy

1.Planning Arrangements

This is an interim plan for the Healthy Workers initiative to assist all jurisdictions to develop implementation plans for approval by the Commonwealth Health Minister prior to the commencement of funding in July 2011. The agreed jurisdictional plans will supersede this initial plan.

2. Facilitation Role

The Commonwealth in conjunction with the states and territories will agree national core objectives and scope to guide the development of jurisdictional implementation plans for their workplace health promotion programs.

We propose that this approach would consider the use of evidence based models, reports including those from the Preventative Health Taskforce and the National Health and Hospitals Reform Commission and consultations with key stakeholders to assess opportunities and barriers to implementation.

As part of this role a workshop teleconference will be facilitated in July 2009 with the States and Territories to discuss national scope and focus, possible core objectives and principles for a national charter. It will also be to coordinate a meta-analysis process that focuses on consideration of the evidence base and a review of state and territory activities.

A forum to share information and evidence will be facilitated in October 2009 and will include States and Territories, industry representatives, union representatives and peak employers and will discuss barriers and opportunities for interventions.

A follow-up teleconference meeting proposed in January 2010.

A further meeting is proposed for March 2010 to agree national core objectives and to progress drafting of implementation plans.

3. Commonwealth Only Components

The Commonwealth will produce an implementation plan for the funding allocated to it under this initiative. The development of this implementation plan will include:

a) A review of evidence around existing health promotion programs in the workplace.

b) Identification of key stakeholders and appropriate channels for engagement and consultation.

c) Consultation with stakeholders.

d) Consultation with states and territories in September 2009 to present findings and agree a workplan, timetable of meetings and deliverables.

e) Establishing key dates for the drafting of the national healthy workplace charter; voluntary competitive benchmarking and development of nationally agreed standards for workplace based prevention programs.

f) Development of criteria and scheduling.

4. States and territories

States and territories to prepare implementation plans building on agreed national core objectives to engage workplaces to facilitate healthy living programs:

- focusing on healthy living and covering topics such as physical activity, healthy eating, the harmful/hazardous consumption of alcohol and smoking cessation;
- including support for risk assessment and the provision of education and information;
- which could include the provision of incentives either directly or indirectly to employers;
- including small and medium enterprises, who may require support from roving teams of program providers; and
- with support, where possible, from peak employer groups such as chambers of commerce and industry.

7.3.1.2 Benefits statement

Table 1.1. Statement of expected benefits

Intended beneficiaries	Expected benefits
Primary group are workers between the ages of 35 – 55 who are at risk of chronic disease due to unhealthy lifestyles. Secondary beneficiaries include: • Workers under the age of 35 who embed healthy lifestyle choices. • Employers who will benefit from increased workplace productivity and less absences due to chronic illness. • Health care providers and health care insurers who will benefit from reductions in the risk profile of their clients.	Expected benefits are for the Healthy Workers initiative as a whole. Short term benefits • Increased number of workers involved in physical activity programs. • Raised awareness of the importance of good nutrition and provision of support to embed healthy eating behaviours in workers including an increased intake of fruit and vegetables. • Conveyed the long term effects of healthy lifestyle choices to workers. • Reduced rate of smoking. • Reduced rate of harmful/hazardous consumption of alcohol (including binge drinking). • Increased number of workers at a healthy weight range due to improved nutrition and increased levels of physical activity. Long term benefits • Workers encouraged to make sustainable changes to their behaviour, such as increased physical activity, healthier eating behaviours, smoking cessation and reduction of alcohol intake towards recommended levels. • Which contributes to reducing morbidity and mortality due to lifestyle related chronic disease in Australian adults. • These programs will contribute to the following prevention NP indicators: o Increase in proportion of adults at an unhealthy weight held at less than five percent from baseline for each state by 2013; proportion of adults at healthy weight returned to baseline level by 2015.

Intended beneficiaries	Expected benefits
	o Increase in the 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 2013; 0.6 for fruits and 1.5 for vegetables from baseline by 2015. o increase in proportion of adults participating in at least 30 minutes of moderate physical activity on five or more days of the week of five percent from baseline for each state by 2013; fifteen percent from baseline by 2015. o Reduction in state baseline for proportion of adults smoking daily commensurate with a two percentage point reduction in smoking from 2007 national baseline by 2013; three and a half percentage point reduction from 2007 national baseline by 2015. Performance against benchmarks will be assessed at two time points: June 2013 and December 2014. The baseline for these benchmarks will be the latest available data at June 2009.

7.3.1.3 Evaluation methodology

Evaluation of the prevention NP will occur at two levels. An overarching evaluation will occur through assessing how well a range of performance benchmarks are met and a more detailed evaluation will occur for each component of the Partnership. Agreed jurisdiction implementation plans will provide a detailed evaluation processes.

7.3.1.3.1 Overarching evaluation

Overarching evaluation will occur at two time points, June 2013 and December 2014, covering the proportion of:

- adults and children at healthy body weight;
- adults and children meeting the national guidelines for physical activity;
- adults and children consuming adequate amounts of fruits and vegetables; and
- Australians smoking daily.

7.3.1.3.2 Program level evaluation

Detailed evaluation plans will be included in agreed jurisdictional implementation plans.

7.3.2 GOVERNANCE

7.3.2.1 Internal governance arrangements

All jurisdictions have responsibility for the management of funds under the initiative, though implementation arrangements will be agreed by the Commonwealth Minister for Health and Ageing. As well as manage its own funding under the initiative, the Commonwealth will work with states and territories to provide guidance and undertake a facilitation role to assist with the development of their implementation plans. At the Commonwealth level, overarching responsibility will rest predominantly with Population Health Division.

Table 2.1. Hierarchy of internal governance arrangements

Deputy Secretary Department of Health and Ageing Name David Learmonth	Sponsor and senior responsible officer	Chair of the National Partnership Implementation Working Group.
First Assistant Secretary Population Health Division Name: Cath Halbert	Leader	Accountable role responsible for policy decisions, financial delegation, reporting to sponsor and senior responsible officer.
Assistant Secretary Healthy Living Branch Population Health Division Name: Cath Peachey	Manager	Responsible for strategic policy directions and decisions, financial delegation, reporting to Leader and Minister.
Director Healthy Children, Healthy Workers Population Health Division Name: Catherine Winter	Coordinator	Accountable role responsible for program development, implementation, evaluation and stakeholder engagement decisions, reporting to Manager, Leader and Minister.

7.3.2.2 External governance arrangements

Committees and bodies with a role in implementation:

National Partnership Agreement on Preventive Health Implementation Working Group
Planning and coordination of implementation arrangements for the prevention NP will be managed by the prevention NP Implementation Working Group. The Working Group is chaired by the Commonwealth and comprises deputy CEOs from all jurisdictions with responsibility for preventive health. The Working Group will oversee the development of implementation plans for all elements of the prevention NP and provide a recommendation to AHMAC.

Australian Health Ministers' Advisory Council (AHMAC)
AHMAC will receive advice from the prevention NP Implementation Working Group on implementation arrangements and make a recommendation to AHMC.

Australian Health Ministers' Conference (AHMC)
AHMC is responsible for agreeing implementation arrangements for the prevention NP. To support this role, AHMC will receive advice from AHMAC on implementation arrangements before making a decision.

Jurisdictional implementation plans will outline governance arrangements to take place once this interim arrangement is superseded.

7.3.3 SCOPE/DELIVERABLES

7.3.3.1 Scope/Deliverables

Table 3.1.1 Healthy workers - definition of deliverables in/out of scope

Deliverables within the scope of this measure	Deliverables/activities beyond scope of this measure
1. Commonwealth to support states and territories a. Review the evidence b. Consult with stakeholders c. National core objectives. d. Develop core objectives 2. Commonwealth to develop implementation plan a. Developmental phase b. Engage with stakeholders c. Host forums to share evidence 3. States/territories to develop implementation plans	Delivery of Commonwealth program ahead of agreed implementation plan.

7.3.3.2 Assumptions / Dependencies

All jurisdictions will work collaboratively to share information and evidence to support final implementation arrangements.

Funding for initiatives does not flow until the Commonwealth Minister agrees to the implementation plans as developed by the states and territories.

7.3.4 IMPLEMENTATION SCHEDULE

Table 4.1 Healthy Workers - schedule of implementation milestones

	Milestones		
Date	Output 1: COMMONWEALTH SUPPORT TO STATES AND TERRITORIES	Output 2: COMMONWEALTH IMPLEMENTATION	Output 3: STATE AND TERRITORY IMPLEMENTATION
Quarter 1 – Jul - Sep 09	Development of draft national core objectives including: • Review evidence based healthy living programs in the workplace • Review of reports such as those from the Preventative Health Taskforce and the Health and Hospitals Reform Commission • Consultations with key stakeholders to assess opportunities and barriers to implementation • Telecon/meeting in **July 2009** with states and territories to discuss evidence and core objectives, national charter, development steps and meta analysis process. • Commonwealth meeting with states and territories, national employer peak bodies and unions to discuss findings in **October 2009** to look at initiatives, barriers and incentives to implementing workplace programs.	Development of implementation plan including: • Scoping, literature review and analysis of existing workplace health programs in the workplace • Identification of key stakeholders and appropriate channels for engagement and consultation. • Consultation with stakeholders • Commonwealth meeting with states and territories to discuss findings in **October 2009**	• Meeting with Commonwealth DoHA to discuss findings and draft core objectives in **October 2009**
Quarter 2 – Oct – Dec 09			
Quarter 3 – Jan - Mar 10	• Teleconference in late **January 2010** with states and territories to review progress. • Draft national core objectives agreed with states and territories **March 2010**	• Draft implementation plan and draft national charter **March 2010**	• Draft implementation plans **March 2010**
Quarter 4 – Apr - Jun 10	• Teleconference in **June 2010** with states and territories to review progress.		
Quarter 5 – Jul - Sep 10	• Receipt of state and territory implementation plans for Commonwealth approval by **September 2010**	• Commonwealth implementation plan submitted for approval **September 2010**	• State and territory Health Minister approved implementation plans submitted to Commonwealth **30 September 2010**.
Quarter 6 – Oct – Dec 10		• Approval by **31 December 2010**	• Commonwealth Health Minister agreement by **31 December 2010**
Quarter 7 – Jan - Mar 11			
Quarter 8 – Apr – Jun 11			
Quarter 9 – Jul – Sep 2011		• Funds provided to the Commonwealth from **1 July 2011** following agreement of Minister.	• Funds provided to states and territories from **1 July 2011** following agreement by the Commonwealth.

7.3.5 WORK BREAKDOWN STRUCTURE

The Commonwealth's contribution to this component of the prevention NP will be made primarily by staff within the Healthy Living Branch. An operational work plan is in preparation which sets out lower-level activities and task allocations. This work plan will be revised fortnightly.

7.3.6 RESOURCES

7.3.6.1 Budget

This measure was agreed to by COAG in November 2008 and will be identified in the 2009-10 Budget.

A detailed budget is not attached to this interim plan. Allocation of funding for future years is detailed in the table below. Funding is not scheduled to flow to states and territories until 2011 following Commonwealth agreement on state and territory implementation plans. There have been no resources allocated prior to these out years for planning and development.

Table 6.1 Healthy Workers Budget

Initiative	2011-12 $m	2012-13 $m	2013-14 $m	2014-15 $m	Total $m
Healthy Workers	33.57	62.56	88.15	105.15	289.4
Healthy Workers – COPE	1.25	1.25	1.25	1.25	5.0
Total	**34.82**	**63.81**	**89.4**	**106.4**	**294.4**

7.3.6.2 Non-financial resources

The Commonwealth will contribute non-financial resources to the implementation of the Agency including ASL, legal services and contracting arrangements as required.

7.3.7 RISK MANAGEMENT

The risks arising in this development phase are outlined below. Risks that may arise when states and territories begin to implement programs are not covered here, but will be outlined in jurisdictional implementation plans.

Table 7.1 Overarching risk identification and control

Risk	Risk rating	Origin/cause/source of risk and trigger point for deploying strategies	Risk mitigation/control strategies
Failure to develop agreed national core objectives to assist states and territories in program development	Medium (Consequence High, Likelihood Low)	Dispute in evidence for best models in the workplace setting. National employers raise concerns about vastly disparate approaches to workplace health management across jurisdictions.	Consultation with state and territories to find common areas.
Failure to meet timelines	Medium (Consequence High, Likelihood Low)	Approvals from relevant delegates delayed.	Consultation with states and territories and AHMC

7.3.8 STAKEHOLDER MANAGEMENT

As part of the development of guidance for states and territories key stakeholders will be consulted to regularly test ideas and ascertain the opportunities and barriers.

Stakeholders for the development of guidance will need to be discussed and agreed with the states and territories. The development of implementation plans will include a stakeholder analysis and a stakeholder management strategy. The Commonwealth will consult with national employer groups and national union representatives as part of this process.

Table 8.1 Overarching stakeholder management strategy

Stakeholder	Their views	Department's strengths in managing these views	Department's vulnerabilities
State and Territory Governments	Interested in working together to achieve outcomes from the prevention NP and to best utilise the resources made available under Healthy Workers. Interested to enhance existing programs within jurisdictions to maximise benefits.	Department is working closely with the States to ensure positive outcome.	
National employer groups such as ACCI, AIG, MBA.	Likely concern with any costs that may be levied on employers, particularly in an economic downturn. Concern with any additional 'red tape' and effect on small business. Likely to be supportive of positive productivity gains and improvements in worker health.	DOHA will need to meet with stakeholders to ascertain views. Views are mixed as large industry groups have a wide range of members.	
National union bodies such as the ACTU	Wary of motivations for drug, alcohol and stress testing.		

7.3.9 QUALITY ASSURANCE

A range of quality assurance activities will be utilised including:

- regular (quarterly) progress reporting to the prevention NP Implementation Working Group;
- including updates on progress towards milestones and financial expenditure monitoring;
- regular reporting to the Minister for Health and Ageing; and
- annual reporting to COAG as stipulated in the prevention NP Agreement.

7.4 IMPLEMENTATION PLAN – INDUSTRY PARTNERSHIP

Version History

Version	Date	Nature of change(s)
0.1	May 2009	First draft of plan for National Partnership Agreement on Preventive Health Implementation Working Group meeting of 14 May 2009
0.2	May 2009	Second draft for distribution to Implementation Working Group on 20 May 2009
0.3	June 2009	Draft circulated to AHMAC out-of-session

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7.4.1 PROJECT DEFINITION

This document outlines planning for the Industry Partnership which is to be funded through the National Partnership Agreement on Preventive Health (prevention NP).

7.4.1.1 Policy objective/outcome

a) Approved policy objective

Through the prevention NP, COAG is providing $1 million over four years for an Industry Partnership, which will enable the Australian Government, in consultation with the States and Territories, to partner with various sectors of the food, fitness and weight loss industries where appropriate to support the implementation of programs to encourage changes in policies and practices consistent with the Government's healthy living agenda.

b) Policy context or environment

The prevention NP 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 poor nutrition, physical inactivity, smoking and excessive alcohol consumption (including binge drinking);
- social marketing aimed at reducing obesity and tobacco use; and
- the enabling infrastructure to monitor and evaluate progress made by these interventions, including the Industry Partnership.

Australian Governments play a significant role in the development of policies that promote good nutrition and physical activity practices, particularly in the context of the prevention of chronic disease, in the Australian population.

The impacts and benefits of interventions to reduce the burden of chronic disease in Australia can be extended with the support and involvement of the key relevant industries. As well as complementary social marketing messages about healthy lifestyles, governments must work with industry to ensure making healthy choices is easy, affordable and sustainable. The Industry Partnership will facilitate collaborative, voluntary engagement between government, industry and health non-governmental organisations.

Initially, the Industry Partnership will focus on the food and beverage industry. Evidence obtained from monitoring through surveys indicates that the diet of a significant proportion of the general population does not meet the Australian Dietary Guidelines and this is compounded by the complexity associated with making good dietary choices.

Outside the regulatory space, the Australian Government currently engages with the food industry through a number of different voluntary forums that aim to improve the nutritional profile of foods in line with Australian Dietary Guidelines. These include:

- the Trans Fats Collaboration, established in 2006, to monitor and, where appropriate, reduce the level of trans fatty acids in food through voluntary industry action; and
- the Food and Health Dialogue, established in early 2009, to provide a collaborative, non-regulatory platform for industry action on evidence-based food and health issues through activities such as food reformulation.

The Industry Partnership will build on this work and provide an overarching framework for engagement with industry through the development of a jurisdictionally agreed set of operating principles.

Engagement with the fitness and weight loss industries will follow the initial implementation of the Healthy Communities element of the prevention NP, particularly the establishment of the quality assurance framework, and will be informed by the experiences with the food and beverage industry, including the manufacturing, retail, service and primary producer sectors.

c) Approvals to date

The Council of Australian Governments authorised the Industry Partnership when it agreed the prevention NP on 29 November 2008.

d) Policy solution, delivery model, or strategy

The Industry Partnership will initially focus on engaging with the food and beverage industry across all relevant levels of the supply chain to facilitate:

- improved consistent consumer messaging from government and industry about healthy eating and drinking in line with the Australian Dietary Guidelines;
- an understanding of food and nutrient consumption patterns and dietary intakes to inform consumer messaging and identify future areas to target engagement with industry; and
- shared information between government, industry and the broader health sector on assisting consumers to make more healthy choices.

A consultative group consisting of the Commonwealth and State and Territory governments will be established to guide the activities of the Industry Partnership.

The key elements of the Industry Partnership include:

- the development of **principles for industry engagement** on healthy eating and drinking, to govern the type, content and focus of outputs and outcomes and ensure outcomes align with the Australian Dietary Guidelines. The Commonwealth will coordinate the development of and consultation on these principles and seek the agreement of States and Territories;
- the establishment of a comprehensive **database** containing nutrient profile data on a large range of products from the food manufacturing, retail and service sectors and associated purchasing/sales data to provide an indication of consumption patterns and food and nutrient intakes. A comparative analysis with contemporary consumption data collected through the Health Risk Survey and with objective food composition data as analysed by FSANZ will be conducted in year four to improve understanding of consumption patterns. The Commonwealth will coordinate a tender process for the development of this database and analysis and will fund the service provider;
- facilitation of **information sharing** between different sectors of the food and beverage industry, different sectors of the government, health non-governmental organisations and research bodies involved in food innovation through a Department of Health and Ageing coordinated and funded conference;
- promotion of consistent industry and government **consumer messaging** on healthy eating practices through the development of a strategy that supports public awareness of healthy eating in line with the Australian Dietary Guidelines, governed by the principles described

above. This strategy may include links to social marketing campaigns such as *MeasureUp* and will identify barriers to and opportunities for communication. The Commonwealth will coordinate the tender process for this strategy and fund the service provider; and

- development of an engagement strategy with the fitness and weight loss industries based on year two and three achievements under the Healthy Communities component of the prevention NP. The Commonwealth will coordinate a tender process for the development of this strategy and will fund the service provider.

7.4.1.2 Benefits statement

Table 1.1. Statement of expected benefits

Intended beneficiaries	Expected benefits
General population At risk population groups, such as those at risk of: • developing chronic diseases such as diabetes, heart disease and kidney disease; • becoming overweight or obese; • developing poor dietary habits; or • failing to participate in physical activity sufficient to maintain good health.	• Increased consumer awareness and understanding of the link between food choices, physical activity and health outcomes. • Changed purchasing behaviours and increased consumption of healthy foods and beverages. • Improved targeting of consumer messaging to assist in making healthy choices.
Food manufacturing sector Primary food producers Grocery retailers Caterers Quick service restaurants Commercial fitness and weight loss sectors	• Improved collaboration between industry and government to improve health outcomes related to healthy eating and drinking and physical activity. • Strengthened relationship between industry and government and among industry stakeholders. • Improved information sharing focused on reformulation technologies, data collection and database building and/or assistance in implementing new technologies. • Potentially decreased need to consider government regulation on reformulation and nutrient profiling based on evidence of voluntary action as a means to impact health outcomes. • Increased connection between long term research and reformulation opportunities.

This initiative contributes to Outcome 1 Population Health in the Department's structure of outcomes and outputs. Further detail will be included in the 2009-10 Portfolio Budget Statements for the Health and Ageing portfolio.

7.4.1.3 Evaluation methodology

7.4.1.3.1 Overarching evaluation

Evaluation of the prevention NP will occur at two levels. An overarching evaluation will occur through assessing how well a range of performance benchmarks are met and a more detailed evaluation will occur for each component of the NP.

Overarching evaluation will occur at two time points, June 2013 and January 2014, covering the proportion of:

- adults and children at healthy body weight;
- adults and children meeting the national guidelines for physical activity;
- adults and children consuming adequate amounts fruits and vegetables; and
- Australians smoking daily.

7.4.1.3.2 Program level evaluation

An evaluation plan for the Industry Partnership is provided at Attachment A.

7.4.2 GOVERNANCE

7.4.2.1 Internal governance arrangements

The Commonwealth has responsibility for establishing the Industry Partnership and will work with the States and Territories through a consultative forum. At the Commonwealth level, overarching responsibility will rest predominantly with Population Health Division.

The Industry Partnership will be coordinated by the Nutrition Section within the Healthy Living Branch of the Population Health Division. The primary officers responsible are identified in Table 2.1.

Table 2.1. Hierarchy of internal governance arrangements

Deputy Secretary Department of Health and Ageing Name: David Learmonth	Sponsor and senior Responsible Officer	Accountable role: Chair of the National Partnership Agreement on Preventive Health Implementation Working Group.
First Assistant Secretary (FAS) Population Health Division Department of Health and Ageing Name: Cath Halbert	Leader	Accountable role: Responsible for reporting to Deputy Secretary on progress of Industry Partnership and work of Department in supporting this progress.
Assistant Secretary (AS) Healthy Living Branch Population Health Division Name: Cath Peachey	Manager	Accountable role: Provide strategic direction and focus regarding how to guide and implement the work under the Industry Partnership. Responsible for reporting to First Assistant Secretary on progress of Industry Partnership and work of Department in supporting this progress.
Director Nutrition Section Healthy Living Branch Population Health Division Name: Erica Kneipp	Coordinator	Supporting role: Oversee contracts established to support the Industry Partnership.

7.4.2.2 External governance arrangements

Committees and bodies with a role in implementation:

National Partnership Agreement on Preventive Health Implementation Working Group
Planning and coordination of implementation arrangements for the prevention NP will be managed by the prevention NP Implementation Working Group. The Working Group is chaired by the Commonwealth and comprises Deputy CEOs from all jurisdictions with responsibility for preventive health. The Working Group will oversee the development of implementation plans for all elements of the prevention NP and provide a recommendation to AHMAC.

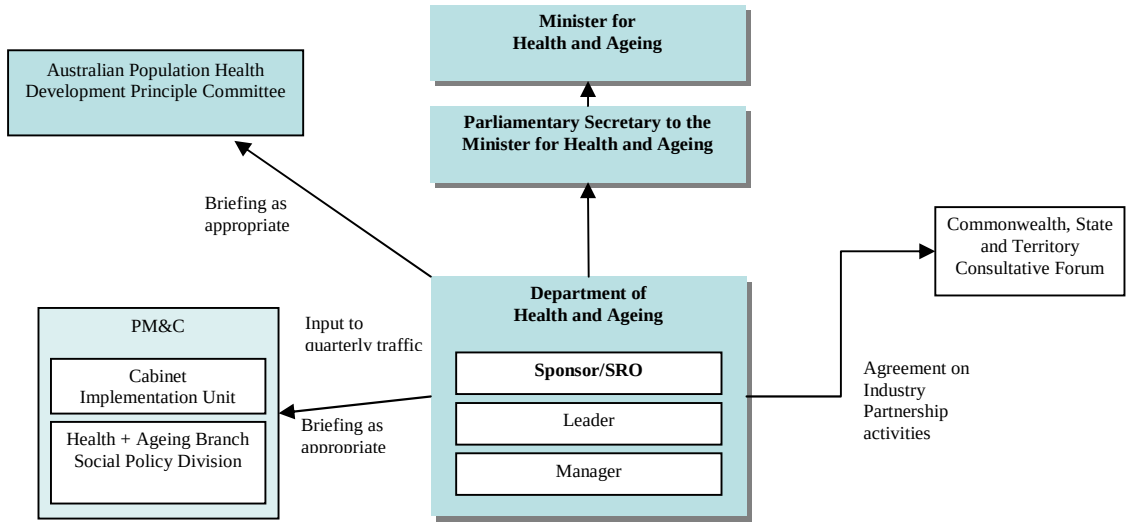
Australian Health Ministers' Advisory Council (AHMAC)
AHMAC will receive advice from the prevention NP Implementation Working Group on implementation arrangements and make a recommendation to AHMC.

Australian Health Ministers' Conference (AHMC)
AHMC is responsible for agreeing implementation arrangements for the prevention NP. To support this role, AHMC will receive advice from AHMAC on implementation arrangements before making a decision.

Once the implementation plans are agreed, governance of the Industry Partnership rests primarily with the Department of Health and Ageing (see Figure 2.1).

State and Territory Consultative Partnership Forum
State and Territory governments will be consulted through a consultative group that will be established to guide the Industry Partnership's progress.

Figure 2.1. Chart of broader governance arrangements



7.4.3 SCOPE/DELIVERABLES

7.4.3.1 Scope/Deliverables

The deliverables identified here are not co-dependent but will all contribute to a holistic approach to collaboration between Government and food and health related industries.

Table 3.1. Definition of deliverables in/out of scope

Deliverables within the scope of this measure	Deliverables/activities beyond the scope of this measure
Greater collaboration between government and food, health and fitness industries. Development of principles of industry engagement. Development of a database containing nutrient profile data on a large range of products cross referenced with purchasing/sales data and associated analysis. A conference for information sharing between different sectors of the food and beverage industry, sectors of the government and research bodies involved in food innovation. Improved consistency across government and industry on consumer messages that promote healthy eating and drinking in accordance with the Australian Dietary Guidelines. Initiated partnering with the fitness and weight loss industries to improve the levels of physical activity undertaken by Australians and to reduce levels of overweight and obesity in Australia.	Target setting for the reduction of risk–associated nutrients, and the increase of fruit, vegetables and wholegrains. Regulatory measures via legislation mandating reformulation and portion standardisation. Delivery of specific consumer awareness activities. Activities pertinent to population health that are currently being considered in other fora: • junk food advertising to children; • regulatory aspects of front-of-pack labelling; and • health claims.

7.4.3.2 Assumptions / Dependencies

Because the deliverables under this measure are not co-dependent, success of the measure does not rely upon successful, timely achievement of all deliverables. All agencies/organisations contracted to deliver the aspects of the Industry Partnership will be managed under contracts with the Department of Health and Ageing and are not expected to encounter major challenges or delays.

The success of any activities that flow from the information sharing component of the Industry Partnership will depend on the active involvement of industry and its willingness to engage and lead initiatives.

7.4.4 IMPLEMENTATION SCHEDULE

Development and implementation of the Industry Partnership will involve five key outputs. The following table indicates the timing expected for the key milestones of these components.

Table 4.1 Industry partnership - schedule of implementation milestones

	Milestones				
Date	Output 1: Development of principles of engagement with industry	Output 2: Development of a database containing nutrient profile data on a large range of products cross referenced with purchasing/sales data and associated analysis	Output 3: A conference for information sharing between different sectors of the food and beverage industry, sectors of the government and research bodies involved in food innovation	Output 4: Improved consistency across government and industry on consumer messages that promote healthy eating and drinking in accordance with the Australian Dietary Guidelines	Output 5: Initiated partnering with the fitness and weight loss industries to improve the levels of physical activity and reduce obesity
2009/2010					
Quarter 1 – {Jul – Sep}	• Establishment of consultative forum	• Project scoping: consultation with consultative forum & experts		• Procurement for engagement strategy development	
Quarter 2 – {Oct – Dec}	• Discuss and agree on principles • Define KPIs	• Tender to undertake database development		• Appointment and finalisation of contract	
Quarter 3 – {Jan – Mar}	• Implement and monitor	• Appointment and finalisation of contract		• Ongoing strategy development	
Quarter 4 – {Apr – Jun}	• Implement and monitor	• Ongoing database development		• Finalised strategy development	
2010/2011		• Update/review of data annually			
Quarter 1 – {Jul – Sep}		• Ongoing database development	• Consultative forum	• Implementation of strategy outcomes	
Quarter 2 – {Oct – Dec}		• Ongoing database development	• Logistics organisation • Call for papers		
Quarter 3 – {Jan – Mar}	• Monitor and report	• Ongoing database development – progress report	• Logistics organisation		
Quarter 4 – {Apr – Jun}		• Ongoing database development	• Conference	• Monitor and report	• Consultative forum
2011/2012		• Update/review of data annually			
Quarter 1 – {July - Sep}		• Finalisation of database – final report	• Distribution of proceedings		• Consultation with the fitness/weight loss industries • Define scope, activity
Quarter 2 – {Oct - Dec}		• Finalisation of contract			
Quarter 3 – {Jan - Mar}	• Monitor and report				
Quarter 4 – {Apr – Jun}			• Logistics organisation		
2012/2013		• Update of data annually			
Quarter 1 – {July - Sep}			• Logistics organisation		
Quarter 2 – {Oct - Dec}			• Conference		
Quarter 3 – {Jan - Mar}				• Monitor and report	
Quarter 4 – {Apr – Jun}					

7.4.5 WORK BREAKDOWN STRUCTURE

The development and implementation of the Industry Partnership will be largely undertaken by the Department of Health and Ageing and contracted service providers. Policy guidance, briefings, secretarial work, and management of the contracts will be the responsibility of staff in the Nutrition Section of the Healthy Living Branch. Procurement plans and other internal Department reports will be used to clarify the direction of the Industry Partnership's development and implementation.

7.4.6 RESOURCES

7.4.6.1 Budget

This measure was agreed to by COAG in November 2008 and will be identified in the 2009-10 Budget. The Healthy Living Branch maintains a budgeting tool allocating administered and departmental funds for this measure to resources required. This information is not included here.

The following table shows the expected funding and anticipated allocation for the Industry Partnership. The table represents administrative expenses only.

Table 6.1 Industry Partnership Budget

Initiative	2009-10 $m	2010-11 $m	2011-12 $m	2012-13 $m	Total $m
Database development and maintenance	0.15	0.15	0.1	0.1	**0.5**
Conference	0	0.1	0.1	0.1	**0.3**
Consumer messaging	0.1	0	0	0	**0.1**
Engagement with fitness and weight loss industries	0	0	0.05	0.05	**0.1**
Total	**0.25**	**0.25**	**0.25**	**0.25**	**1.0**

It is expected that all funds will be expended during the year for which they are allocated. Each aspect of the Industry Partnership has sufficient flexibility to ensure it absorbs but does not exceed the allocated funding. Funds will be expended through a number of contracts to provide the Partnership's development and implementation services. Procurement plans will be developed for each of these components, where appropriate, and submitted to the appropriate delegate for approval. Copies of these procurement plans are not included here.

7.4.6.2 Non-financial resources

Healthy Living Branch is expected to require external advice on managing technical or policy issues presented by the implementation of the Industry Partnership. Such advice will be obtained through the State and Territory consultative group, or the agencies contracted to provide the services.. If appropriate, advice will be sought through another means, particularly if the service provider has an interest in the outcome of the issue, such as in the case of the database. The cost of procuring such advice is not expected to exceed $5,000 on any one occasion and as such will be managed by the direct engagement of an adviser by the Department upon the approval of the appropriate delegate.

7.4.7 RISK MANAGEMENT

As some of the funding for the Industry Partnership will be expended through contracts for services, comprehensive risk management plans will be developed for the procurement plan for each component. Copies of these plans are not provided here.

General risks to the implementation of the Industry Partnership are described in the following table.

Table 7.1. Risk identification and control

Risk	Risk rating	Origin/cause/source of risk and trigger point for deploying strategies	Risk mitigation/control strategies
Quotes for development of a database exceed available funding	High (Consequence Severe, Likelihood Probable)	Initial investigations indicate that database development requires significant technological innovation and resources. Additionally, manufacturers and retailers may not provide data free-of-charge.	Options for database development are currently being developed. Cooperation from the broader health and industry sectors will be sought under the principles for industry engagement to ensure the methodology is cost effective.
Inconsistent consumer awareness messages from government and industry	Medium (Consequence Moderate, Likelihood Probable)	Consumer awareness activities conducted by industry focus on marketing to increase profits for industry, rather than an overall public health message.	Collaboration will enable consistent messages to be developed that meets the needs of both government and industry.
Insufficient interest in and attendance at information sharing conference	Low (Consequence Minimal, Likelihood Possible)	The conference requires good attendance in order for sufficient linkages and networks to be formed.	A number of strategies will be developed to ensure the conference is widely publicised, and sufficiently broad ranging in topics to ensure high levels of attendance.

7.4.8 STAKEHOLDER MANAGEMENT

Stakeholder management is critical to the success of the Industry Partnership. Partnerships between the food, health and fitness industries and government to address healthy lifestyles have not been developed before and if successful, will provide a forum through which a range of other initiatives can be progressed. The principles for industry engagement will guide stakeholder management strategies.

A communications strategy will be developed to ensure that consistent messages on healthy lifestyles and healthy eating and drinking are conveyed by government, industry and the health sector.

Table 8.1. Stakeholder management strategy

Stakeholder	Their views	Department's strengths in managing these views	Department's vulnerabilities
Food manufacturers Eg. Australian Food and Grocery Council Retailers (Private labels)	Currently engaged in the process and recognise consumer demand for healthier choices. Looking for confirmation from government regarding future policy direction. Concerned about: • Costs associated with reformulation and portion standardisation • Loss of market share • Brand loyalty • Access to technology • Product positioning • Commercial confidentiality	Appreciation of their views Maintaining consultation and keeping well informed Work with CSIRO and the Department of Agriculture, Fisheries and Forestry to overcome technology and innovation barriers, where appropriate	Nil at present
Primary producers	Yet to be confirmed. May involve Meat and Livestock Australia, Horticulture Australia Limited, Dairy Australia and the Egg Corporation	Nil at present	Nil at present
Caterers/QSR	Yet to be confirmed but expect concerns about reformulation costs and portion standardisation to be raised	Nil at present	Nil at present
Fitness and weight loss industries	Yet to be confirmed	Nil at present	Nil at present

7.4.9 QUALITY ASSURANCE

A range of quality assurance activities will be utilised including:

- regular reporting to the Minister for Health and Ageing;
- regular (quarterly) progress reporting to the prevention NP Implementation Working Group, including updates on progress towards milestones and financial expenditure monitoring;
- annual reporting to COAG as stipulated in the prevention NP Agreement; and
- ongoing communications between all members of the Consultative Forum and identified key stakeholders to seek advice on implementation issues.

Attachment A - Industry Partnership Collaboration Evaluation Plan

(RELATES TO 7.3.1.3)

The success of the Industry Partnership will be evaluated through monitoring the following measures:

- evidence of changes in consumer behaviour patterns in line with the Australian Dietary Guidelines;
- retail sales data (by food category and product type);
- number of industry, community and broader health sector participants at information-sharing conference; and
- analysed differences between consumption data estimated by purchasing and nutrient profile data and data collected in Health Risk Survey.

Evidence of progress towards the following measures will also be monitored through:

- consumer awareness messages that promote healthy eating and drinking patterns and physical activity are consistent across industry and government; and
- progress and final reports from successful tenders on the development of the database and the consumer messaging strategy.

7.5 IMPLEMENTATION PLAN – NATIONAL HEALTH RISK SURVEY

Version History

Version	Date	Nature of change(s)
0.1	May 2009	First draft of plan for National Partnership Agreement on Preventive Health Implementation Working Group meeting of 14 May 2009
0.2	May 2009	Second draft for distribution to Implementation Working Group on 20 May 2009
0.3	June 2009	Draft circulated to AHMAC out-of-session

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7.5.1 PROJECT DEFINITION

This document outlines planning for the National Health Risk Survey which is to be expanded with funding through the National Partnership Agreement on Preventive Health (prevention NP).

7.5.1.1 Policy objective/outcome

a) Approved policy objective

The prevention NP provides funding of $15 million to expand the National Health Risk Survey (HRS), which will collect essential data on prevalence of chronic disease risk factors in the Australian population through a series of surveys covering all Australian States and Territories.

b) Policy context or environment

The prevention NP 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 poor nutrition, physical inactivity, smoking and excessive alcohol consumption (including binge drinking);
- social marketing aimed at reducing obesity and tobacco use; and
- the enabling infrastructure to monitor and evaluate progress made by these interventions, including the HRS.

Funding for enabling infrastructure programs covering research, surveillance, and policy development is being provided to address the gap in the national infrastructure supporting action on the lifestyle related risk factors for chronic conditions.

The Australian Government plays a significant role in the development of policies that promote good nutrition and physical activity practices, particularly in the context of the prevention of chronic disease, in the Australian population.

In order to develop, implement and evaluate interventions for reducing the burden of chronic disease in Australia, health policy makers require comprehensive, up-to-date and representative data about the prevalence of these diseases and their risk factors, including nutrition intake and physical activity participation. There are major gaps in the information available to inform and sustain chronic disease policies and to evaluate related programs. The HRS will fill these information gaps.

c) Approvals to date

The Council of Australian Governments authorised the extension of the HRS when it agreed the prevention NP on 29 November 2008.

On 23 February 2009, the Minister for Health and Ageing agreed that the vAdults' National Nutrition and Physical Activity Survey planned for 2010-11 could be presented as the first survey in the National Health Risk Survey Program, incorporating broader measures of chronic disease risk and biomedical data.

d) Policy solution, delivery model, or strategy

The Commonwealth will be responsible for developing and implementing the first HRS, expected to be conducted from July 2010 – July 2011. Elements of this work will be subcontracted to agencies with experience in working with large national health surveys, which may include other Commonwealth agencies such as the Australian Institute of Health and Welfare (AIHW).

Responsibility for managing the analysis and reporting of the survey's results and planning for future surveys is expected to transfer to the new National Preventive Health Agency. Future surveys are expected to include a children's survey in 2012-13, and a third survey in around 2016 which may target adults or may aim to represent the entire Australian population.

Under this approach, the Department will still be responsible for ensuring the HRS data meets the information needs of chronic disease prevention policies and programs.

7.5.1.2 Benefits statement

Table 1.1. Statement of expected benefits

Intended beneficiaries	Expected benefits
Australians at risk of: • developing chronic diseases such as diabetes, heart disease and kidney disease; • becoming overweight or obese; • developing poor dietary habits or suffering deficiencies in essential nutrients; or • failing to participate in physical activity sufficient to maintain good health.	The HRS will provide up to date estimates of the prevalence of chronic disease risk factors and some chronic diseases. These estimates will support an increased emphasis on preventative health at all levels of government, and enable new preventative health policies and programs to be targeted to the population groups at greatest risk of developing chronic disease. The HRS will provide important insights into the relationships between chronic disease risk factors and population sub-group characteristics, facilitating the development of effective clinical interventions for people suffering from chronic disease. The HRS will provide up to date data on current food consumption patterns in Australia, which will inform the development of dietary intake recommendations including the Australian Dietary Guidelines and the Nutrient Reference Values. This data will also inform ongoing improvements to Australia's food regulatory system. The HRS will provide some baseline data on the current gap in preventative health status between Indigenous and non-Indigenous Australians, informing the evaluation of programs and policies aimed at Closing the Gap.

7.5.1.3 Evaluation methodology

Evaluation of the Health Prevention NP will occur at two levels. An overarching evaluation will occur through assessing how well a range of performance benchmarks are met and a more detailed evaluation will occur for each component of the Partnership.

7.5.1.3.1 Overarching evaluation

Overarching evaluation will occur at two time points, June 2013 and January 2014, covering the proportion of:

- adults and children at health body weight;
- adults and children meeting the national guidelines for physical activity;
- adults and children consuming adequate amounts fruits and vegetables; and
- Australians smoking daily.

7.5.1.3.2 Program level evaluation

An evaluation plan for the National Health Risk Survey is provided at Attachment A.

7.5.2 GOVERNANCE

The Commonwealth has responsibility for establishing managing the HRS and will work with the states and territories in doing so. At the Commonwealth level, Population Health Division has the overarching responsibility.

7.5.2.1 Internal governance arrangements

The work of the Department for the HRS will be conducted by the Population Health Strategy Unit. The primary officers responsible are identified in Table 2.1.

Table 2.1. Hierarchy of internal governance arrangements

Deputy Secretary Department of Health and Ageing Name: David Learmonth	Sponsor and senior responsible officer	Responsible for supporting the processes outlined in this Plan.
First Assistant Secretary Population Health Division Department of Health and Ageing Name: Cath Halbert	Leader	Responsible for reporting to Deputy Secretary on progress of the HRS development and implementation. Responsible for chairing meetings of the Steering Committee and providing strategic direction to the implementation of the HRS. Delegate for approving the contracts for services to support the HRS.
Assistant Secretary Population Health Strategy Unit Population Health Division Name: Peter Morris	Manager	Responsible for reporting to First Assistant Secretary on progress of the HRS development and implementation. Oversight of the development and implementation of the HRS, including support for the Project Coordination Committee.
Director Population Health Information and Analysis Population Health Strategy Unit Population Health Division Name: Caroline Arthur (Acting)	Coordinator	Oversight of contracts for services to develop and implement the HRS. Management of secretariat services for the Steering Committee and the Project Coordination Committee. Provision of briefs to the Assistant Secretary and First Assistant Secretary on issues arising during the development and implementation of the first survey.

7.5.2.2 External governance arrangements

Committees and bodies with a role in implementation:

National Partnership Agreement on Preventive Health Implementation Working Group
Planning and coordination of implementation arrangements for the prevention NP will be managed by the prevention NP Implementation Working Group. The Working Group is chaired by the Commonwealth and comprises deputy CEOs from all jurisdictions with responsibility for preventive health. The Working Group will oversee the development of implementation plans for all elements of the prevention NP and provide a recommendation to AHMAC.

Australian Health Ministers' Advisory Council (AHMAC)
AHMAC will receive advice from the prevention NP Implementation Working Group on implementation arrangements and make a recommendation to AHMC.

Australian Health Ministers' Conference (AHMC)
AHMC is responsible for agreeing implementation arrangements for the prevention NP. To support this role, AHMC will receive advice from AHMAC on implementation arrangements before making a decision.

Once implementation arrangements are agreed, new governance arrangements will be established. Governance of the first HRS will rest with the Department. The Department and the National Heart Foundation (NHF) are currently discussing options for the NHF's role in the first HRS. The NHF has indicated that it may be able to provide supplementary funding for the first survey. If this occurs, the NHF is expected to be invited to contribute to the governance of the first survey through participation in a Steering Committee chaired by the Department.

If established, the Steering Committee will have responsibility for the identification and funding of key development milestones, approving expenditure, and approving recommendations on the objectives, scope and methodology for the survey. The Department will maintain responsibility for managing the survey's service contracts and approving contract deliverables, and for advising the Minister for Health on the survey's progress and any issues arising from its implementation.

The Department and the NHF are currently discussing options for including an external non-voting member to the Steering Committee to provide advice on managing competing priorities for the survey's funding and participation requirements.

Agencies contracted to provide services for the HRS will be represented on a Project Coordination Committee which will provide advice to the Department on technical and methodological issues arising from the survey's implementation and reporting. Other members of the Project Coordination Committee will be drawn from agencies with experience in working with large national health surveys, including the AIHW, the Australian Bureau of Statistics, Baker Heart IDI and the NHF.

Advice on the possible role of State and Territory Health Departments in assisting with the implementation or reporting of the HRS will be sought from the Population Health Information Development Group if required.

A governance model for the second and subsequent HRS surveys will be developed following the establishment of the Australian National Preventive Health Agency. This model will describe the roles to be played by the Agency and the Department, and opportunities for contributions from jurisdictions.

7.5.3 SCOPE/DELIVERABLES

7.5.3.1 Scope / Deliverables

The deliverables identified in this second are co-dependent. If there is a delay to the first deliverable there will be delays of the same degree to all other variables as there is no scope to compress the data collection or analysis and reporting activities.

Table 3.1. Definition of deliverables in/out of scope

Deliverables within the scope of this measure	Deliverables/activities beyond the scope of this measure
1. Develop survey instruments. a. Identify provider/s. b. Consultations on instruments. c. Pilot test instruments. d. Review instruments. 2. Develop sampling and interviewing methodology. a. Identify provider. b. Consultations on methodology. c. Report on methodology. d. Review methodology. 3. Conduct survey fieldwork. a. Identify provider. b. Prepare for fieldwork. c. Conduct fieldwork. d. Review fieldwork. 4. Analyse and report survey results. a. Consult stakeholders. b. Identify providers. c. Prepare data and reporting templates. d. Release data. e. Release final reports.	Obtaining national consensus on preferred instruments and methodology for population health risk surveys. Overseeing the collection of chronic disease risk factors and related indicators by other Australian surveys. Collecting data about consumer experiences of the health system or preventative health indicators not related to chronic disease. Undertaking studies of the Australian food supply, consumer attitudes to food, or prevalence and characteristics of eating disorders.

7.5.3.2 Assumptions / Dependencies

The project is reliant upon all agencies contracted to manage the survey's components working together to identify issues early and advise the Steering Committee on options for their management. As a survey of this scope has not yet been undertaken in Australia, there is a high level of uncertainty about whether implementation of all survey components during the fieldwork will present new problems not produced by the implementation of single components.

7.5.4 IMPLEMENTATION SCHEDULE

The following table indicates the timing expected for the key milestones of these components.

Table 4.1. Schedule of implementation milestones

	Milestones			
Date 2009-10	**Output 1: Develop survey instruments**	**Output 2: Develop sampling and interviewing methodology**	**Output 3: Conduct survey fieldwork**	**Output 4: Analyse and report survey results**
Quarter 1 – Jul – Sep 09	• Contracts signed for development of food composition, nutrition, and physical activity instruments		• Contract signed for the development and implementation of a communication strategy	
Quarter 2 – Oct – Dec 09	• Contracts signed for development of general chronic disease and biomedical instruments	• Contract signed for methodology development	• Fieldwork training plan and communication strategy approved by Steering Committee	• Stakeholder consultations on analysis and reporting requirements
Quarter 3 – Jan – Mar 10	• Stakeholder and technical consultations on instrument requirements	• Stakeholder and technical consultations on methodology requirements	• Training of fieldwork staff for pilot	• RFT released for analysis and reporting services
Quarter 4 – Apr – Jun 10	• Pilot testing of instruments	• Pilot testing of methodology	• Pilot fieldwork	• Contract signed for analysis and reporting services
Quarter 5 – Jul – Sep 10	• Final instruments approved by Steering Committee	• Final methodology approved by Steering Committee	• Final training of fieldwork staff. • Fieldwork commences	• Collation and cleaning of survey data commences with fieldwork
Quarter 6 – Oct – Dec 10			• Fieldwork continues	
Quarter 7 – Jan – Mar 11			• Fieldwork continues	
Quarter 8 – Apr – Jun 11			• Fieldwork continues	• Templates of key results reports developed
Quarter 9 – Jul – Sep 11	• Instruments development teams advise on analysis and reporting of data.	• Methodology development agents advise on analysis and reporting of data.	• Fieldwork ends. • Review undertaken of fieldwork	• Templates of key results reports approved by Steering Committee
Quarter 10 – Oct – Dec 11	• Instruments development teams advise on analysis and reporting of data.	• Methodology development agents advise on analysis and reporting of data.		• Cleaning and preliminary analysis of results
Quarter 11 – Jan – Mar 12	• Reports on the development and use of survey instruments released	• Reports on the sampling and interviewing methodology released.		• Instrument and Methodology reports released, some data reports released.
Quarter 12 – Apr – Jun 12	• Review of instrument development process	• Review of methodology development process		• Further data reports released. • Provide advice to the Minister on proposed timing and scope of future surveys, expected to include a Children's Survey in 2012-13.
Quarter 13 – Jul – Sep 12				• Food and nutrient intake reports released. • Summary of key results all released.
Quarter 14 – Oct – Dec 12				• Key findings report of all survey variables released. • Review of analysis and reporting processes

7.5.5 WORK BREAKDOWN STRUCTURE

The development and implementation of the HRS will be largely undertaken by contracted service providers. Policy guidance, briefings and management of the survey contracts will be the responsibility of staff of the Population Health Strategy Unit. Procurement plans and other internal Department reports will be used to clarify the direction of the survey's development and implementation. An operational work plan is in preparation which sets out lower-level activities and task allocations. This work plan will be revised fortnightly.

7.5.6 RESOURCES

7.5.6.1 Budget

This measure was agreed to by COAG in November 2008 and will be identified in the 2009-10 Budget.

The Population Health Strategy Unit maintains a budgeting tool allocating administered and departmental funds for this measure to resources required. This information is not included here.

Core funding for the first HRS is being provided through the National Nutrition and Physical Activity Survey Program, with possible additional funds to be provided by the National Heart Foundation. Allocation of funding from COAG to HRS activities is subject to the approval of the Minister for Health; however it is expected that funding for the 2009-10 and 2010-11 years will fund the first survey to collect comprehensive data from a representative sample of Aboriginal and Torres Strait Islander Australians. Later years of funding will be used to develop and implement a children's survey, with other surveys to follow at intervals as funding accumulates.

Funds for the first survey will be expended through approximately ten contracts to provide the survey's development and implementation services. Procurement plans will be developed for each of these components and submitted to the appropriate delegate for approval. Copies of these procurement plans are not included here.

7.5.6.2 Non-financial resources

The Commonwealth will contribute non-financial resources to the implementation of the Agency including ASL, legal services and contracting arrangements as required.

7.5.7 RISK MANAGEMENT

As most of the funding for the HRS will be expended through contracts for services, comprehensive risk management plans will be developed for the procurement plan for each component. Copies of these plans are not provided here.

General risks to the timely implementation of the HRS are described in the following table.

Table 7.1. Risk identification and control

Risk	Risk rating	Origin/cause/source of risk and trigger point for deploying strategies	Risk mitigation/control strategies
Delays to Steering Committee and/or delegate decisions on key milestones and issues.	High (Consequence moderate, Likelihood likely)	The survey requires significant support and ongoing management by DoHA staff and other Departmental resources To date no funding has been approved to meet these expenses. If sufficient staff are not available to work on the HRS there will be delays to the preparation of procurement documentation and advice to the Steering Committee and delegates.	The Department will endeavour to meet the resourcing requirements for the HRS within its existing budget without significant impacts on other priorities. Agencies involved in the delivery of survey services will be invited to provide ongoing support to the Department's staff on the identification and resolution of issues arising from the survey, however their close involvement could jeopardise the objectivity of the data collection.
Delays to the development of survey instruments and methodology.	Medium (Consequence Moderate, Likelihood possible)	The survey requires high participation rates by a representative sample of Australian adults, and adequate participation rates for some specific population sub-groups.	A number of strategies will be developed to facilitate required participation rates, however if adequate rates are not achieved during the survey pilots then new strategies may be needed, which may delay the start of the fieldwork. Any such outcome will be identified early and strategies will be developed to manage stakeholder expectations.
Quotes for services exceed available budget.	Medium (Consequence Moderate, Likelihood possible)	Many of the survey components have not previously been developed for a survey of this size; hence the Department may have underestimated the costs of these components.	The survey's scope including the range of items to be included and the number of participants required for each item is sufficiently flexible to enable adjustments if this risk arises. Ongoing management of stakeholder expectations will be required given high level of interest in the survey's scope.
Delays to the survey fieldwork.	Medium (Consequence Moderate, Likelihood possible)	Experience from other large population surveys indicates fieldwork may be delayed in some areas due to unforeseen events such as natural disasters.	The survey's fieldwork methodology will be sufficiently flexible to manage scheduling problems caused by minor events however a major event may result in delays to completion of the fieldwork. Early identification of any such delays and good communications with stakeholders will mitigate the impact of this risk.

7.5.8 STAKEHOLDER MANAGEMENT

Stakeholder interest in the development and outcomes of the HRS is very high. Some of the data to be collected by the HRS has never before been collected in a nationally representative survey and most other data has not been collected on a regular basis.

Stakeholders have already been engaged with the planning for the HRS through an opportunity to provide comment on a consultation paper around the objectives and scope proposed for the first survey. This opportunity was welcomed by a range of stakeholders including State and Territory Health Departments, non-government organisations, food industry representatives, universities and Commonwealth agencies.

As part of the development of the HRS specialist communication services will be procured by the Department and a communication plan developed for the approval of the Steering Committee. The communication plan will deal largely with the need to encourage a high level of participation among people invited to participate in the survey, but will also detail strategies for managing external stakeholder expectations of the survey's outputs including their timing, quality and scope.

More detailed methods managing specific stakeholder groups are described in the following table:

Table 8.1. Stakeholder management strategy

Stakeholder	Their views	Department's strengths in managing these views	Department's vulnerabilities
NHF	The NHF is very supportive of the HRS, and is particularly keen to see key indicators of chronic disease risk collected by the survey, and for the survey to produce representative data for the Aboriginal and Torres Strait Islander population.	The Department will be able to manage the NHF's expectations for the timing and outcomes of the HRS through the involvement of both agencies on the Steering Committee. This process will enable the NHF to participate in the resolution of issues likely to affect the HRS' outcomes.	Nil at present
AIHW	The AIHW is supportive of the HRS and is keen to be involved in the analysis and reporting of the survey's results.	The Department will be able to manage the AIHW's expectations for the data to be produced by the HRS by its involvement on the Project Coordination Committee. This will enable the AIHW to provide advice to the Department on the priorities and structure of the data to be produced by the HRS.	Procurement advice may indicate that the services the AIHW could provide for the survey should be contracted through an open tender process. Should this occur the AIHW will be advised early, and regardless of the outcome the Department will ensure the AIHW obtains access to the data for its own projects.
ABS	The ABS is supportive of the HRS but has expressed concerns about its potential overlap with the National Health Survey (NHS) and possible confusion among the Australian public about the differences between the two surveys.	The Department will be able to manage the ABS's concerns about the HRS by its involvement on the Project Coordination Committee. The ABS will be encouraged to identify any issues arising from the HRS implementation and discuss the management of these issues directly with the Department.	If the participation rate for the HRS is low, the ABS may comment publicly on any concerns it has about the survey's sampling and fieldwork methodology. This issue will be managed by seeking the ABS's approval of the sampling and fieldwork methodology prior to the fieldwork commencing.
Baker Heart IDI	Baker Heart IDI is very supportive of the HRS and is keen to provide some of the services for developing and implementing the first survey.	Baker Heart IDI's interest in providing some of the survey services could lead to an apparent conflict of interest in the advice they provide. Any such issues will be managed in accordance with procurement guidelines and the oversight of the Steering Committee.	Other issues may arise as the scope of the HRS is more clearly developed. Baker Heart IDI is well aware that the scope of the HRS will not completely mirror the previous AusDiab surveys; however some of their own stakeholders may require management.

Stakeholder	Their views	Department's strengths in managing these views	Department's vulnerabilities
Food Industry	The Australian food industry is supportive of the HRS but is keen for it to retain a strong focus on nutrition and food issues rather than broader chronic disease indicators.	Food industry representatives will continue to be engaged through opportunities for public consultation on the objectives and scope of the survey and the use of the survey results.	Some external stakeholders may express concerns about food industry involvement in the previous Children's Survey, in which case the Department will make it clear that food industry is not funding or steering any aspects of the HRS.
State and Territory Governments	State and Territory Governments are generally supportive of the HRS but anxious for it to collect representative data for their own jurisdictions.	State and Territory Government representatives will continue to be engaged through opportunities for public consultation on the objectives and scope of the survey and the use of the survey results.	Nil - the survey is expected to collect sufficient representative data to enable reporting for all jurisdictions.
Other non government organisations and research agencies including universities.	These groups are supportive of the HRS. Many provided comments on the consultation paper for the survey's objectives and scope.	These groups will be provided with opportunities to comment on the objectives and scope of the survey and the use of the survey results. Some agencies may seek to provide expert services for the first survey. Such interest will be managed through the usual procurement processes.	Many agencies in these groups are expected to seek access to the survey results when they become available. The Department will need to manage their expectations around the level of support that can be provided for using the data and the timing of the data's release.

7.5.9 QUALITY ASSURANCE

A range of quality assurance activities will be utilised including:

- regular (quarterly) progress reporting to the prevention NP Implementation Working Group, including updates on progress towards milestones and financial expenditure monitoring;
- regular reporting to the Minister for Health and Ageing;
- annual reporting to COAG as stipulated in the prevention NP Agreement;
- ongoing communications between all members of the Project Coordination Committee to identify implementation issues and act or advise upon their resolution; and
- regular meetings of the Steering Committee to resolve issues identified by the Project Coordination Committee and approve the next stages of the HRS implementation.

Attachment A - National Health Risk Survey Evaluation Plan

Evaluation of the HRS will take place following completion of the first survey. Advice on the outcome of the evaluation will be provided to the Minister for Health along with recommendations for the timing and scope of future surveys consistent with learning from the implementation of the first survey. Further evaluation may take place in later years as other HRS surveys are completed.

- The first stage of the evaluation will involve the development and ongoing maintenance of a publicly available website to provide information to the survey's participants and the broader Australian community on the survey's objectives and participation processes.
    - The website will provide a function for enabling survey participants to comment on their experiences and make recommendations for how participation can be encouraged and sustained in future surveys.
    - A hotline is also expected to be established for the duration of the survey fieldwork to provide an advisory service for survey participants and their families.
    - A review of the comments received on the website and through the hotline service will inform the evaluation of the efficiency of the HRS in collecting the required data.
- The second stage of the evaluation will take place as each survey component is completed. Agencies engaged to provide instrument and methodology development services will be required to conduct a review of the process and outcomes of these services and provide advice to the Department on recommendations for future surveys.
- The third stage of the evaluation will take place after the summary results report of key components is released. This stage will engage all agencies involved in producing, analysing and reporting on the results of the survey and is expected to comprise a two day workshop to identify common or broad issues encountered in the survey's implementation and make recommendations for managing these issues in future surveys.
- Following this process, the Department will develop an evaluation report as part of its advice to the Minister for Health on future surveys.
    - Questions to be included in the report include whether the purpose of the HRS was met by the data collected, whether the outcomes were cost-effective and timely, the performance of agencies involved in the delivery of services and the reaction of stakeholders to the key milestones in the survey's implementation, particularly the release of the results reports.

An external agency may be contracted to assist with the consultations or drafting of the evaluation report if required, particularly if the HRS was thought by the Department to have failed to meet key objectives or timing or stakeholder expectations.

7.6 IMPLEMENTATION PLAN – SOCIAL MARKETING: MEASUREUP

Version History

Version	Date	Nature of change(s)
0.1	May 2009	First draft of plan for National Partnership Agreement on Preventive Health Implementation Working Group meeting of 14 May 2009
0.2	May 2009	Second draft for distribution to Implementation Working Group on 20 May 2009
0.3	June 2009	Draft circulated to AHMAC out-of-session

7.6.1 PROJECT DEFINITION

This document summarises planning for the *MeasureUp* Social Marketing Campaign - which is one element of the National Partnership Agreement on Preventive Health (prevention NP).

7.6.1.1 Policy objective/outcome

a) Approved policy objective

Through the prevention NP, the Council of Australian Governments (COAG) will use social marketing activities focusing on overweight and obesity to lay the foundations for healthy behaviours in the daily lives of Australians and address the rising prevalence of obesity related chronic diseases.

b) Policy context or environment

The prevention NP 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 poor nutrition, physical inactivity, smoking and excessive alcohol consumption (including binge drinking);
- social marketing aimed at reducing obesity and tobacco use; and
- the enabling infrastructure to monitor and evaluate progress made by these interventions, including the Agency and research fund.

Funding for social marketing aimed at obesity was provided to address a gap in national social marketing supporting action on the lifestyle related risk factors for chronic conditions.

In 2005, 3.2 million Australians were obese.[33] Access Economics forecasts this could rise to 4.6 million in 2025.[34] High body mass now accounts for some 7.5% of the total burden of disease in Australia and is likely to displace tobacco as the leading preventable risk factor for chronic disease.

Research has shown that, irrespective of height or build, if a person's waistline is getting bigger it could mean they are at increased risk of developing a lifestyle related chronic disease such as some cancers, heart disease, and type 2 diabetes.

These results will inform the future roll-out of *MeasureUp*.

c) Approvals to date

COAG authorised the expansion of the *MeasureUp* Social Marketing Campaign when it agreed the prevention NP on 29 November 2008.

d) Policy solution, delivery model, or strategy

The Commonwealth will fund a social marketing campaign to extend and complement the Australian Better Health Initiative. The *MeasureUp* Social Marketing Campaign will have funding of $41 million over four years. The Commonwealth will also provide $18 million over four years to states and territories to complement the national social marketing campaign by providing reinforcing local activities.

[33] Access Economics (2006) *The Economics of Obesity*. A report for Diabetes Australia, Access Economics, Canberra.
[34] Access Economics (2008) *The Growing Costs of Obesity: three years on*. A report for Diabetes Australia, Access Economics, Canberra.

7.6.1.2 Benefits statement

Table 1.1. Statement of expected benefits

Intended beneficiaries	Expected benefits
The target audience is adults at key life stages and high risk groups including: people from low SES backgrounds; people living in rural and remote areas; people from non-English speaking backgrounds; and Aboriginal and Torres Strait Islander people.	The short term objectives are: • to increase awareness of the link between chronic disease and lifestyle risk factors (poor nutrition, physical inactivity, unhealthy weight); • to raise appreciation of why lifestyle change should be an urgent priority; • to generate more positive attitudes towards achieving recommended changes in healthy eating, physical activity and healthy weight; and • to generate confidence in achieving the desired changes and appreciation of the significant benefits of achieving these changes. The long term objectives of the campaign are: • to encourage Australians to make and maintain changes to their behaviour to achieve recommended levels of physical activity and healthy eating and to sustain a healthy weight; and • to thereby contribute to reducing morbidity and mortality due to lifestyle related chronic disease in Australian adults.

This initiative contributes to Outcome 1 in the Department's structure of outcomes and outputs. Further detail will be included in the 2009-10 Portfolio Budget Statements for the Health and Ageing portfolio.

7.6.1.3 Evaluation methodology

Evaluation of the prevention NP will occur at two levels. An overarching evaluation will occur through assessing how well a range of performance benchmarks are met and a more detailed evaluation will occur for each component of the Partnership.

7.6.1.3.1 Overarching evaluation

Overarching evaluation will occur at two time points, June 2013 and January 2014, covering the proportion of:

- adults and children at healthy body weight;
- adults and children meeting the national guidelines for physical activity;
- adults and children meeting the national guidelines for fruits and vegetable consumption; and
- Australians smoking daily.

7.6.1.3.2 Program level evaluation

To date the following research has been undertaken for the first phase of the *MeasureUp* campaign:

Developmental	24 January - 21 February 2007	To inform the development of the social marketing campaigns
Concept testing	May – August 2007 August 2008	To develop and refine campaign materials according to the communication objectives of the campaign
Evaluation	October 2008 December 2008 April 2009	To benchmark and track the impact of Phase 1 of the campaign

Process evaluation measures are currently being undertaken, including media reach and frequency monitoring, website analytics and self-completed assessments of campaign resources/tools. In addition, a process evaluation meeting was undertaken with the campaign reference group.

Future Research
Process indicators will be included to measure reach, implementation and quality. Tracking surveys will be employed to measure impact after each media burst, whilst concept testing will be used where necessary to make further developments to the campaign materials. Formative research will be used to provide a better understanding of how to target messages and/or campaign activities to hard to reach /at risk groups.

7.6.2 GOVERNANCE

The Commonwealth has responsibility for implementing the Social Marketing *MeasureUp* initiative and will work with the states and territories in doing so. At the Commonwealth level, responsibility for development, implementation and evaluation of the Social Marketing *MeasureUp* initiative will rest with Communications Branch, Business Group. Healthy Living Branch, Population Health Division will have responsibility for policy direction.

7.6.2.1 Internal governance arrangements

The work of the Department under this measure is conducted by Communications Branch. The primary officers responsible are identified in Table 2.1.

Table 2.1. Hierarchy of internal governance arrangements

Deputy Secretary Department of Health and Ageing Name: David Learmonth	Sponsor and senior responsible officer	Chair of the National Partnership Implementation Working Group.
First Assistant Secretary Population Health Division Name: Cath Halbert	Leader	Accountable role responsible for policy decisions, financial delegation, reporting to sponsor and senior responsible officer.
General Manager Communication and People Strategy Business Group Name: Samantha Palmer	Leader	Accountable role responsible for communication and stakeholder decisions in partnership with the policy Leader, reporting to Sponsor and Senior responsible officer.
Assistant Secretary Healthy Living Branch Population Health Division Name: Cath Peachey	Manager	Responsible for strategic policy directions and decisions, financial delegation, reporting to Leader and Minister.

Assistant Secretary Communications Branch Business Group Name: Nathan Smyth	Manager	Accountable role responsible for program development, implementation, evaluation and stakeholder engagement decisions, reporting to Campaign Reference Group, Leader and Minister.
Director Social Marketing Communications Branch Business Group Name: Susan Parker	Coordinator	Supporting role responsible for program development, implementation, evaluation and stakeholder engagement decisions, reporting to Campaign Reference Group, Managers and Minister.
Director Market Research Unit Communications Branch Business Group Name: Jenny Taylor	Coordinator	Supporting role responsible for social marketing program evaluation.

7.6.2.2 External governance arrangements

Committees and bodies with a role in implementation:

National Partnership Agreement on Preventive Health Implementation Working Group
Planning and coordination of implementation arrangements for the prevention NP will be managed by the prevention NP Implementation Working Group. The Working Group is chaired by the Commonwealth and comprises deputy CEOs from all jurisdictions with responsibility for preventive health. The Working Group will oversee the development of implementation plans for all elements of the prevention NP and provide a recommendation to AHMAC.

Australian Health Ministers' Advisory Council (AHMAC)
AHMAC will receive advice from the prevention NP Implementation Working Group on implementation arrangements and make a recommendation to AHMC.

Australian Health Ministers' Conference (AHMC)
AHMC is responsible for agreeing implementation arrangements for the prevention NP. To support this role, AHMC will receive advice from AHMAC on implementation arrangements before making a decision.

Once implementation arrangements are agreed, the following groups will govern the *MeasureUp* campaign until the campaign is handed to the Agency (see Figure 2.1).

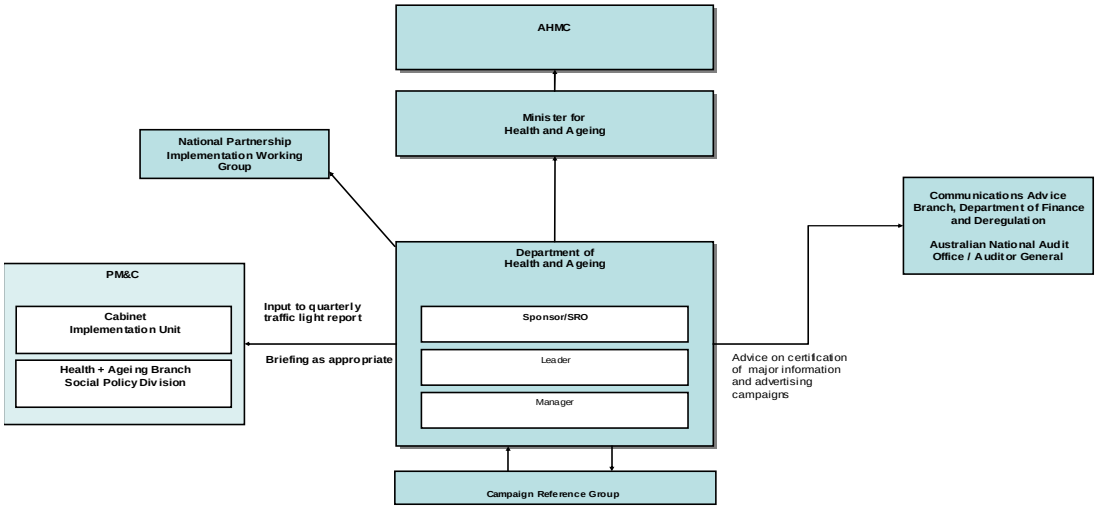
The *MeasureUp* campaign will be auspiced by a pre-existing cross jurisdictional governance group known as the Campaign Reference Group (CRG), comprised of a representative from each state and territory and currently Co-Chaired by the Australian Government and NSW. The Terms of Reference will be amended to reflect the revised governance arrangements.

The *MeasureUp* Campaign decision making and accountability rests with the Minister for Health and Ageing.

Australian Government departments and agencies undertaking information and advertising campaigns with expenditure in excess of $250,000 must be reviewed by the Auditor-General (Australian National Audit Office, ANAO), which will report on the proposed campaign's compliance with the Department of Finance and Deregulation's *Guidelines on Campaign Advertising by Australian Government Departments and Agencies*. Through this process campaigns are required to

be presented to the *Inter-Departmental Committee on Government Communications* (IDCC) at key milestones.

Figure 2.1. Interim governance arrangements



As part of transition planning, new governance arrangements for the campaign, under the management of the Agency, will be developed.

7.6.3 SCOPE/DELIVERABLES

7.6.3.1 Scope / Deliverables

The *MeasureUp* campaign will expand on program activities and resources already developed, and will be directed by evaluation recommendations. It will incorporate, where possible, links with other partnership elements including Healthy Communities, Healthy Workers and Healthy Children. The campaign will also endeavour to link with outcomes that arise from the 'Industry Partnerships' component of COAG which is designed to reshape consumer demand and industry supply towards healthy living choices by government working in partnership with relevant industry and non-government sectors.

The campaign could also seek to accommodate new nutrition messages that emerge over the next four years, particularly as a result of the revised nutritional guidelines. It will also seek to complement activity under the Closing the Gap in Indigenous Health Outcomes component of COAG.

Table 3.1. Definition of deliverables in/out of scope

Deliverables within the scope of this measure	Deliverables/activities beyond the scope of this measure
1. Two major bursts of advertising activity to roll out each financial year (Spring and Autumn). 2. Deliver a comprehensive program of support activities to extend campaign reach including: o partnerships (with other government or academic institutions, non-government organisations, industry groups), o tools and resources for consumers, health professionals, workplaces, o website augmentation, o public relations activity. 3. Deliver targeted programs to address the needs of adults at key life stages and target high risk groups including people from low SES backgrounds; people living in rural and remote areas; people from non-English speaking backgrounds; and Aboriginal and Torres Strait Islander people. 4. Research and evaluate the campaign. 5. Jurisdictions to provide final implementation plans to the Commonwealth by March 2010 for agreement prior to funds being provided to them from 1 July 2010.	1. Decisions made by the IDCC to change timing of advertising activity. 2. Activity provided by partner / supportive organisations. 3. Will not reach all language groups or meet the needs of all 'at-risk' or 'hard-to-reach' groups. 4. Measurement of behaviour change other than by survey. 5. Activity under the jurisdictional plans are the responsibility of each state and territory to implement.

7.6.3.2 Assumptions / Dependencies

The above deliverables are dependent upon adherence to the Department of Finance and Deregulation's *Guidelines on Campaign Advertising by Australian Government Departments and Agencies*.

The department will endeavour to provide national evaluation results to states and territories but implementation and evaluation of local level support activities are the responsibility of each jurisdiction.

7.6.4 IMPLEMENTATION SCHEDULE

Table 4.1 below outlines the schedule of implementation milestones for the 2009-10 financial year. Planning for the next three years will be conducted in the fifth quarter (Aug to Oct 2010).

Note that Outputs 1 to 4 will be completed with existing Australian Better Health Initiative (ABHI) funding for 2006-10 *MeasureUp* campaign 1, and output 5 will use COAG funding. Activities to be undertaken by the States are bracketed.

Table 4.1. Schedule of implementation milestones

	Milestones				
	Existing ABHI funding 2006-10				**COAG funding**
Date	**Output 1:** Two major bursts of advertising activity to roll out each financial year (Spring and Autumn).	**Output 2:** Deliver a comprehensive program of support activities to extend campaign reach.	**Output 3:** Deliver targeted programs to address the specific needs of 'at-risk' and 'hard-to-reach' groups.	**Output 4:** Research and evaluation of campaign.	**Output 5** Prevention NP funds and activities.
Quarter 1 – {Jul 09 – Sep 09}	• Plan and gain approval for Spring burst. • **Milestone: September** advertisements to go on-air.	• Development of detailed four year implementation plan for support activities. • Implementation of support activity. • PR activity to extend campaign messages post advertising. • Development of framework for local level support activities. • [Development of state and territory implementation plans for local activities]	• Indigenous strategy workshop and planning of Indigenous activity. • Planning and implementation of NESB activity. • Planning for other 'at-risk' groups including research if needed. • **Milestone: September** Indigenous and NESB advertisements on-air.	• Develop detailed research and evaluation plan. • Tracking evaluation of media burst.	• Formative research. • Concept testing of resources.
Quarter 2 – {Oct 09 – Dec 09}	• **Milestone: October** advertisements to go on-air. • Plan and gain approval for Autumn burst.	• Implementation of support activity. • PR activity to extend campaign messages post advertising. • Agree on framework for local level support activities. • [Development of state and territory implementation plans for local activities]	• **Milestone: October** Indigenous and NESB advertisements on-air. • Implementation of activity addressing Indigenous, NESB and other groups including special 'at-risk' groups.	• Tracking evaluation of media burst. • **Milestone: November / December** Results of tracking research available.	• Formative research. • Concept testing of resources.
Quarter 3 – {Jan 10 – Mar 10}	• **Milestone: February / March** Advertisements to go on-air.	• Implementation of support activity. • PR activity to extend campaign messages post advertising. • [Finalise state and territory implementation plans for local activities under the NPAPH for Commonwealth approval]	• Implementation of activity addressing Indigenous, NESB and other groups. • **Milestone: February / March** Indigenous and NESB advertisements on-air.	• Tracking evaluation of media burst. • Aggregate evaluation results to input into the direction of new creative advertisements to ensure burn out does not occur and to extend messages.	• Jurisdictions to provide final implementation plans to the Commonwealth by March 2010 for agreement prior to funds being provided to them from 1 July 2010.
Quarter 4 – {Apr 10– Jun 10}	• Plan for next burst of activity in Spring 2010.	• Implementation of support activity. • PR activity to extend campaign messages post advertising.	• Implementation of activity addressing Indigenous, NESB and other groups.	• **Milestone: May / June** Results of full evaluation and recommendation available.	• New creative advertisements planned and developed.

7.6.5 WORK BREAKDOWN STRUCTURE

The work under this measure is conducted primarily by officers of Communications Branch, in partnership with Healthy Living Branch. The Communications Branch maintains a Communications Strategy and an operational work plan (not included in this plan) that sets out lower-level activities and task allocations in the workplace. This work plan is continually reviewed.

7.6.6 RESOURCES

7.6.6.1 Budget

This measure was agreed to by COAG in November 2008 and will be identified in the 2009-10 Budget. Funding is shown in Table 6.1.

Communications Branch maintains a budgeting tool allocating administered and departmental funds for this measure. This information is not included here.

Table 6.1 Social Marketing – *MeasureUp* Budget

Initiative	**2009-10 $m**	**2010-11 $m**	**2011-12 $m**	**2012-13 $m**	**TOTAL $m**
Commonwealth Own Purpose Expense	*1.4*	*13.3*	*13.265*	*13.1*	*41.0*
Funding for state and territory complementary programs for *MeasureUp*	*0*	*6.0*	*6.0*	*6.0*	*18.0*
Total	**1.4**	**19.3**	**19.265**	**19.1**	**59**

7.6.6.2 Non-financial resources

It is expected that expert technical advice will be required for this campaign, to be provided by consultants on an as-needed basis. Service providers such as research, advertising and public relations organisations are likely to be contracted, as well as communications specialists for people of non-English speaking backgrounds and Aboriginal and Torres Strait Islander people.

7.6.7 RISK MANAGEMENT

Risk identification and control for all Communications Branch campaigns is outlined in the Communications Branch Operational Plan for each financial year. Further, risk identification and control is mitigated by adherence to the new Department of Finance and Deregulation's *Guidelines on Campaign Advertising by Australian Government Departments and Agencies* and the subsequent requirement that the Auditor General report the compliance of this campaign against these guidelines.

Table 7.1. Risk identification and control

Risk	Risk rating	Origin/cause/source of risk and trigger point for deploying strategies	Risk mitigation/control strategies
Quality: failure to provide an effective social marketing campaign.	Medium (Risk consequence is high, likelihood low).	• Ineffective, inaccurate, misinterpreted or no evidence-based developmental research or evaluation. • Failure of contract with technical expert/s. • Failure of jurisdictions to implement effective local level support.	• Strict developmental protocol and trained, experienced staff. • Management of contractual obligations within detail of contract for technical experts. • Develop an agreed framework for local level support. • Relationship management with Campaign Reference Group, the ANAO and DoFD.
Budget: changes affect delivered outcome.	Medium (Risk consequence is medium, likelihood medium).	• Funding is reduced or withdrawn.	• Relationship management with Campaign Reference Group, the ANAO and DoFD. • Progress community based social marketing activity.
Budget: is inadequate for state and territory local level activity.	Medium (Risk consequence is medium, likelihood is medium)	• Capacity to deliver local level support activity is compromised in smaller states and territories by per capita funding formula.	• Commonwealth to identify gaps and overcome with targeted delivery of statewide campaign activity where possible. • The States to identify gaps and attempt to remedy them.
Timelines of agreed national campaign advertising: are not met.	Low (Risk consequence is low, likelihood low).	• Campaign advertising bursts do not roll out according to agreed schedule. • Local level activity may not effectively extend campaign messages if not run at the same time as national advertising.	• Obtain certification from the Secretary and ANAO two to four weeks prior to launch dates. • Provide jurisdictions timely information on national campaign activity; identify timing in framework for local level support.

7.6.8 STAKEHOLDER MANAGEMENT

As mentioned above the CRG is comprised of one representative from each jurisdiction and is co–chaired by a member of the Australian Government and a member from one of the participating state or territory governments (currently NSW). The campaign's strategic direction has been and will continue to be based on formative, developmental and evaluation research, and in partnership with the CRG via regular teleconferences and face-to-face meetings.

A Commonwealth stakeholder management and engagement strategy will be developed to re–engage stakeholders through briefing on the campaign evaluation and to generate further campaign activity.

Table 8.1. Stakeholder management strategy

Stakeholder	Their views	Department's strengths in managing these views	Department's vulnerabilities
Australian Chronic Disease Prevention Alliance (ACDPA). This is a group of leading Australian non-government health organisations including: Diabetes Australia, Kidney Health Australia, National Heart Foundation of Australia, National Stroke Foundation and The Cancer Council Australia.	The ACDPA works together in primary prevention of chronic disease, initially by addressing shared risk factors of nutrition and physical activity. The Alliance may contribute to the development of evidence-based recommendations and initiatives that will contribute to chronic disease prevention, and will provide leadership and a strong, unified voice for chronic disease prevention. It works with key Government Departments and non-government organisations around Australia, as well as supporting and complimenting activities of each of the member organisation. It is not intended that ACDPA develop a public profile. The ACDPA have three key public health messages that reflect the shared risk factors of nutrition and physical activity for chronic disease. These messages are consistent for the prevention and also the management of a range of chronic lifestyle diseases, such as: kidney disease, diabetes, heart disease, vascular disease, cancer and stroke. These messages are to: § decrease energy intake, particularly from saturated fats; § Increase vegetable and fruit consumption; and § participate in at least 30 minutes of moderate-intensity physical activity on all	The stakeholder's views are consistent with the Government's on this measure, although individual members want the measure to provide more detail on their area of specific interest (e.g. kidney disease). There has been no officially shared commitments such as media releases, although members of the ACDPA put out media releases supporting the campaign at its launch.	There are no publicly held sentiments contrary to the Government's view. The waist circumference measurements used in this campaign are based on recommendations by the World Health Organization and the National Health and Medical Research Council. Other non-government campaigns have 'rounded up' these figures or used those relevant to a specific chronic disease e.g. type II diabetes.

Stakeholder	Their views	Department's strengths in managing these views	Department's vulnerabilities
	or most days of the week.		
Industry Groups	Those promoting complementary products or services are supportive (e.g. seafood, fitness industry) but some are keen to be seen as partners with the Government.	Many have supported the campaign by linking to their websites or using campaign resources. Those with products not aligned with Government messages (e.g. soft drink or confectionary) have made no comment on the campaign.	There are no publicly held sentiments contrary to the Government's view.
States and Territory Health Departments	They are very interested to see an effective campaign as it will support their ability to meet targets under the prevention NP. They will want to be able to leverage the campaign to support their activities.	Planning for the campaign will be undertaken in consultation with the States and Territories.	We anticipate productive relationships with the States and Territories.

7.6.9 QUALITY ASSURANCE

A range of quality assurance activities will be utilised including:

- regular (quarterly) progress reporting to the prevention NP Implementation Working Group, including updates on progress towards milestones and financial expenditure monitoring;
- regular reporting to the Minister for Health and Ageing;
- annual reporting to COAG as stipulated in the prevention NP Agreement;
- regular meetings of the Campaign Reference Group to plan and implement all activity;
- compliance with the Department of Finance and Deregulation's *Guidelines on Campaign Advertising by Australian Government Departments and Agencies*;
- regular research and evaluation as described in 1.3.2.; and
- development of relationships with key technical experts to ensure messages and activities are based on expert advice.

7.7 IMPLEMENTATION PLAN – SOCIAL MARKETING: TOBACCO

Version History

Version	Date	Nature of change(s)
0.1	May 2009	First draft of plan for National Partnership Agreement on Preventive Health Implementation Working Group meeting of 14 May 2009
0.2	May 2009	Second draft for distribution to Implementation Working Group on 20 May 2009
0.3	June 2009	Draft circulated to AHMAC out-of-session

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7.7.1 PROJECT DEFINITION

This document outlines planning for the Social Marketing – Tobacco initiative which is funded through the National Partnership Agreement on Preventive Health (prevention NP). Funding for this initiative will be transferred to the Australian National Preventive Health Agency (the Agency) once it is operational, and a transition strategy will be developed to facilitate this transfer.

7.7.1.1 Policy objective/outcome

a) Approved policy objective

Through the prevention NP, COAG is providing funds for national level social marketing activities focussing on smoking in order to lay the foundations for healthy behaviours in the daily lives of Australians and address the rising prevalence of smoking related chronic diseases.

b) Policy context or environment

The prevention NP 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 poor nutrition, physical inactivity, smoking and excessive alcohol consumption (including binge drinking);
- social marketing aimed at reducing obesity and tobacco use; and
- the enabling infrastructure to monitor and evaluate progress made by these interventions, including the Agency and research fund.

Funding for tobacco social marketing provided through the prevention NP builds on existing government commitments including:

- $15 million over four years provided to reinvigorate the National Tobacco Strategy to help reduce the health problems caused by tobacco smoking and to reduce smoking rates among young people.

The National Tobacco Strategy 2004-2009 (NTS) provides a framework for the tobacco social marketing campaigns. The overarching objectives of the NTS are to:

- prevent the uptake of smoking;
- encourage and assist as many smokers as possible to quit as soon as possible;
- eliminate harmful exposure to tobacco smoke among non-smokers; and
- reduce harm associated with continuing use of, and dependence on, tobacco and nicotine.

The 2007 National Drug Strategy Household Survey found that 16.6% of Australians aged 14 and over smoked daily. Through the National Healthcare Agreement and the prevention NP, Australian Governments have agreed to work collaboratively to reduce the prevalence of daily smoking from its 2007 baseline to 10 per cent by 2018. Funding for the social marketing campaign provided through the prevention NP will support this outcome.

c) Approvals to date

The Council of Australian Governments authorised the tobacco social marketing campaign when it agreed the prevention NP in November 2008.

d) Policy solution, delivery model, or strategy

The Commonwealth will conduct a series of national level social marketing campaigns aimed at increasing awareness of the risks associated with smoking. The States have committed to fund local level complementary activities to support the national messages.

7.7.1.2 Benefits statement

Table 1.1. Statement of expected benefits

Intended beneficiaries	Expected benefits
• All smokers • Adult smokers • Young Australians • Disadvantaged groups • Indigenous smokers	Short-medium term: • Increased awareness of health risks of tobacco consumption and exposure to tobacco smoke. • Increased awareness of benefits of cessation and tobacco-free lifestyles. • Increase/reinforce negative attitudes toward smoking. • Generation/maintenance of intentions among non-smokers to reject offers of a cigarette, and to remain a non-smoker. • Increased intentions among current smokers to quit. Long-term: • A reduction in the uptake and prevalence of smoking. • Contribute to a decrease in morbidity and mortality due to smoking-related diseases.

This initiative contributes to Outcome 1 in the Department's structure of outcomes and outputs. Further detail will be included in the 2009-10 Portfolio Budget Statements for the Health and Ageing portfolio.

7.7.1.3 Evaluation methodology

Evaluation of the Health Prevention NP will occur at two levels. An overarching evaluation will occur through assessing how well a range of performance benchmarks are met and a more detailed evaluation will occur for each component of the Partnership.

7.7.1.3.1 Overarching evaluation

Overarching evaluation will occur at two time points, June 2013 and January 2014, covering the proportion of:

- adults and children at health body weight;
- adults and children meeting the national guidelines for physical activity;
- adults and children consuming adequate amounts fruits and vegetables; and
- Australians smoking daily.

7.7.1.3.2 Program level evaluation

A comprehensive evaluation plan for the Tobacco Social Marketing Campaign(s) will be developed. The establishment of an external research and evaluation advisory group is anticipated, comprising experts in research and evaluation in tobacco control and/or social marketing to guide this process.

The research and evaluation plan will include the following elements.

- developmental research to explore current smoking knowledge, attitudes, behaviour and intentions and gain insights into target audiences' lifestyles, cultures, interests and needs at this point in time;
- a review of the existing evidence base will inform the priority audiences for the research which will include, but are not limited to, adults, youth and disadvantaged groups. A systematic approach will be applied which may involve qualitative and quantitative research;
- process indicators to measure reach, implementation and quality;
- formative research to develop and refine the communication components of the campaign with the relevant target groups against the communication objectives; and
- research to evaluate the effectiveness of the campaign. Benchmark research will obtain measures of pre-campaign knowledge, attitudes, intentions and behaviour. Post-campaign research will assess the effectiveness of the campaign by measuring changes in the target audiences' attitudes, knowledge, intentions and behaviour. The evaluation of the campaign will focus on key campaign elements, including advertising and public relations.

7.7.2 GOVERNANCE

Once operational, the Australian National Preventive Health Agency will have carriage of the tobacco social marketing campaigns. In the meanwhile, the Commonwealth will commence formative research with a view to providing all details to the Agency once ready. Overarching responsibility for the campaigns within the Commonwealth will rest predominantly with Business Group. Business Group will have responsibility for the Social Marketing Tobacco initiative. Drug Strategy Branch will have responsibility for policy direction.

The Commonwealth will develop a transitional strategy, to be negotiated with the Chief Executive Officer of the Agency to manage the transfer of this function to the Agency.

7.7.2.1 Internal governance arrangements

The work of the Department under this measure is conducted by Communications Branch in partnership with Drug Strategy Branch. The primary officers responsible are identified in Table 2.1.

Table 2.1. Hierarchy of internal governance arrangements

Deputy Secretary Department of Health and Ageing Name: David Learmonth	Sponsor and senior responsible officer	Chair of the National Partnership Implementation Working Group.
First Assistant Secretary Population Health Division Name: Cath Halbert	Leader	Accountable role responsible for policy decisions, financial delegation, reporting to sponsor and senior responsible officer.
Assistant Secretary Communications Branch Business Group Name: Nathan Smyth	Manager	Accountable for program development, implementation, evaluation and stakeholder engagement decisions, reporting to Campaign Reference Group, Leader and Minister.

Director Social Marketing Communications Branch Business Group Name: Sally McDonald	Coordinator	Supporting role for program development, implementation, and stakeholder engagement decisions, reporting to Campaign Reference Group, Managers and Minister.
Director Market Research Unit Communications Branch Business Group Name: Jenny Taylor	Coordinator	Supporting role research and evaluation, reporting to the Campaign Reference Group, Managers and the Minister.
Assistant Secretary Drug Strategy Branch Mental Health and Chronic Disease Division Name: Simon Cotterell	Manager	Accountable for policy decisions, financial delegation, reporting to Leader and Minister.
Director Tobacco Control Section Drug Strategy Branch Mental Health and Chronic Disease Division Name: Penny Marshall	Coordinator	Supporting role for tobacco policy direction.

7.7.2.2 External governance arrangements

National Partnership Agreement on Preventive Health Implementation Working Group

Planning and coordination of implementation arrangements for the prevention NP will be managed by the prevention NP Implementation Working Group. The Working Group is chaired by the Commonwealth and comprises deputy CEOs from all jurisdictions with responsibility for preventive health. The Working Group will oversee the development of implementation plans for all elements of the prevention NP and provide a recommendation to AHMAC.

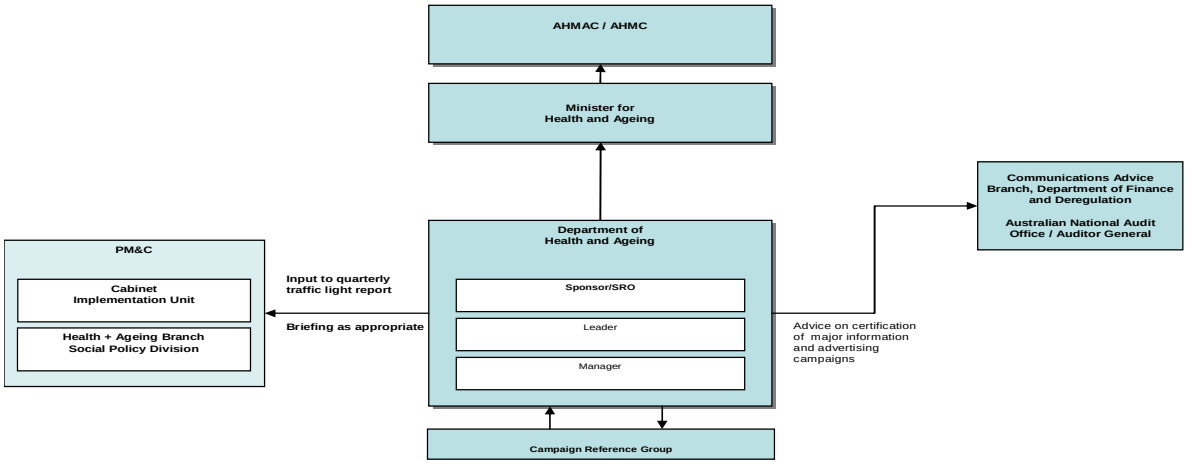
Australian Health Ministers' Advisory Council (AHMAC)

AHMAC will receive advice from the prevention NP Implementation Working Group on implementation arrangements and make a recommendation to AHMC.

Australian Health Ministers' Conference (AHMC)

AHMC is responsible for agreeing implementation arrangements for the prevention NP. To support this role, AHMC will receive advice from AHMAC on implementation arrangements before making a decision.

Figure 2.1. Chart of broader governance arrangements



A Campaign Reference Group will be formed to assist in the development of the Tobacco Social Marketing Campaign(s). The membership could draw on the existing State and Territory Quit Committee. Terms of reference will need to be established.

Campaign decision making and accountability rests with the Minister for Health and Ageing.

Australian Government departments and agencies undertaking information and advertising campaigns with expenditure in excess of $250,000 must be reviewed by the Auditor-General (Australian National Audit Office, ANAO), who will report on the proposed campaign's compliance with the Department of Finance and Deregulation's Guidelines on Campaign Advertising by Australian Government Departments and Agencies. Through this process campaigns are required to be presented to the Inter-Departmental Committee on Government Communications (IDCC) at key milestones.

As part of transition planning, new governance arrangements for the campaign, under the management of the Agency, will be developed.

7.7.3 SCOPE/DELIVERABLES

7.7.3.1 Scope/Deliverables

The Tobacco Social Marketing Campaign(s) will be developed based on developmental research and will seek to complement activity implemented under the Closing the Gap in Indigenous Health Outcomes component of COAG.

Table 3.1. Definition of deliverables in/out of scope

Deliverables within the scope of this measure	Deliverables/activities beyond the scope of this measure
1. Developmental research to inform the marketing strategy. 2. Development of a marketing strategy for the campaign. 3. Comprehensive formative research to test campaign concepts and refine campaign elements. 4. Development and implementation of campaign advertising materials. 5. A national evaluation of the program	1. Decisions made by the IDCC to change timing of advertising activity. 2. Activity provided by partner / supportive organisations. 3. Will not reach all language groups or meet the needs of all 'at-risk' or 'hard-to-reach' groups. 4. Evaluation of behaviour change other than by self-reported in surveys.

7.7.3.2 Assumptions / Dependencies

The above deliverables are dependent on the Secretary's certification of the campaign(s)' compliance with the Guidelines on Campaign Advertising by Australian Government Departments and Agencies; a favourable compliance report by the Auditor–General and on the IDCC allowing the campaign(s) advertising to be run at planned times.

Timing of public tobacco campaigns run by the Commonwealth will be influenced by any campaign activity planned by State and Territory governments.

The department will endeavour to provide national evaluation results to states and territories but implementation and evaluation of local level support activities are the responsibility of each jurisdiction.

7.7.4 IMPLEMENTATION SCHEDULE

Table 4.1 outlines the schedule of implementation milestones for the 2009-10 financial year. Planning for the following three years will commence in the fourth quarter.

Table 4.1. Schedule of implementation milestones

	Milestones				
Date	**Output 1:** Developmental research to inform the marketing strategy	**Output 2:** Development of a marketing strategy for the campaign	**Output 3:** Comprehensive formative research to test campaign concepts and refine campaign elements	**Output 4:** Development and implementation of campaign advertising materials	**Output 5:** A national evaluation of the program
Quarter 1 – {July-Sept 09}	• Establish Campaign Reference Group • Summarise evidence to date • Procurement process to appoint research agency • Consultant commissioned				
Quarter 2 – {Oct-Dec 09}	• Undertake qualitative research component				
Quarter 3 – {Jan-Mar 10}	• Undertake quantitative research component				
Quarter 4 – {Apr-Jun 10}		• Develop strategy • Procurement process to appoint agencies (creative, public relations, NESB, Indigenous)		• Discussions with proposed Agency re transitional arrangements	
			• Pending outcome of procurement process	• Pending outcome of research program	• Dependent on timing of campaign rollout

7.7.5 WORK BREAKDOWN STRUCTURE

The work under this measure is conducted primarily by officers of Communications Branch, in partnership with Drug Strategy Branch and with the States through the campaign reference group. The Communications Branch will develop a Communications Strategy and an operational work plan that sets out lower-level activities and task allocations in the workplace. This work plan will be continually reviewed.

7.7.6 RESOURCES

7.7.6.1 Budget

This measure was agreed to by COAG in November 2008 and will be identified in the 2009-10 Budget.

Communications Branch maintains a budgeting tool allocating administered and departmental funds for this measure to resources required. This information is not included here.

Table 6.1 Budget for the initiative

Initiative	**2009-10 $m**	**2010-11 $m**	**2011-12 $m**	**2012-13 $m**	**TOTAL $m**
Tobacco social marketing	0.55	20.55	19.46	20.45	61
Total	**0.55**	**20.55**	**19.46**	**20.45**	**61**

7.7.6.2 Non-financial resources

The Commonwealth will contribute non-financial resources including ASL, legal services and contracting arrangements as required. It is expected that expert technical advice will be required for the campaign(s), which will be provided by consultants on an as-needed basis. Service providers such as research, advertising, and public relations organisations are likely to be contracted, as well as communications specialists for people from non-English speaking backgrounds and Aboriginal and Torres Strait Islanders.

7.7.7 RISK MANAGEMENT

Risk identification and control for all Communications Branch campaigns is outlined in the Communications Branch Operational Plan for each financial year. Further, risk identification and control is mitigated by adherence to the new Department of Finance and Deregulation's Guidelines on Campaign Advertising by Australian Government Departments and Agencies and the subsequent requirement that the Auditor General report the compliance of this campaign against these guidelines.

Table 7.1. Risk identification and control

Risk	**Risk rating**	**Origin/cause/source of risk and trigger point for deploying strategies**	**Risk mitigation/control strategies**
Quality: failure to provide an effective social marketing campaign.	Medium (Risk consequence is high, likelihood low).	• Ineffective, inaccurate, misinterpreted or no evidence-based developmental research or evaluation. • Failure of contract with technical expert/s. • Failure of jurisdictions to implement effective local level support.	• Strict developmental protocol and trained, experienced staff. • Management of contractual obligations within detail of contract for technical experts. • Develop an agreed framework for local level support. • Relationship management with Campaign Reference Group, the ANAO and DoFD.
Budget: is inadequate	Medium (Risk consequence is medium, likelihood low).	• Funding is reduced or withdrawn.	• Relationship management with Campaign Reference Group, the ANAO and DoFD. • Progress community based social marketing activity.
Timeliness: is not met	Medium (Risk consequence is medium, likelihood low).	• Campaign advertising bursts do not roll out according to agreed schedule. • Local level activity may not extend campaign messages if not run at the same time as national advertising.	• Obtain certification from the Secretary and ANAO two to four weeks prior to launch dates. • Provide jurisdictions timely information on national campaign activity; identify timing in framework for local level support.

7.7.8 STAKEHOLDER MANAGEMENT

Table 8.1. Stakeholder management strategy

Stakeholder	Their views	Department's strengths in managing these views	Department's vulnerabilities
Action on Smoking and Health Cancer Institute NSW State/Territory Quit organisations and health departments Cancer Council Australia State/Territory Cancer Councils National Heart Foundation Australian Council on Smoking and Health Centre for Excellence in Indigenous Tobacco Control	All stakeholders would support implementation of a well-developed campaign.	The Department works to maintain a cooperative relationship with these organisations.	There is a possibility that the organisations may have different views about the target audience for a tobacco campaign and the funds available for the campaign. This can be addressed by ensuring the membership of the Campaign Reference Group comprises experts in research and evaluation in tobacco control and/or social marketing. In addition, Terms of Reference would be developed.
National Preventative Health Taskforce	Technical Report No 2 – Tobacco Control in Australia: making smoking history outlines the Taskforce's position on progress made and action proposed. The Taskforce's Strategy report is expected in June 2009.	The Taskforce's Technical Report proposes an increase in promotion of Quit and smoke-free messages, including campaigns.	There is a possibility that the Taskforce may have different views about the target audience for a tobacco campaign and the funds available for the campaign. This can be addressed by ensuring the Department is aware of the details in the Taskforce's Technical Report and Strategy and ensuring the campaign is based on sound research.
Inter-Governmental Committee on Drugs (IGCD)	The IGCD supports the Ministerial Council on Drug Strategy which endorsed the National Tobacco Strategy 2004-2009 and its objectives.	The Department is a member of the IGCD.	

7.7.9 QUALITY ASSURANCE

A range of quality assurance activities will be utilised including:

- regular (quarterly) progress reporting to the prevention NP Implementation Working Group, including updates on progress towards milestones and financial expenditure monitoring;
- regular reporting to the Minister for Health and Ageing;
- annual reporting to COAG as stipulated in the prevention NP Agreement;
- regular meetings of the Campaign Reference Group to plan and implement all activity;
- compliance with the Department of Finance and Deregulation's Guidelines on Campaign Advertising by Australian Government Departments and Agencies; and
- regular research and evaluation as described in 7.7.1.3.2.

7.8 IMPLEMENTATION PLAN – ENHANCED STATE AND TERRITORY SURVEILLANCE

Version History

Version	Date	Nature of change(s)
0.1	May 2009	First draft of plan for National Partnership Agreement on Preventive Health Implementation Working Group meeting of 14 May 2009
0.2	May 2009	Second draft for distribution to Implementation Working Group on 20 May 2009
0.3	June 2009	Draft circulated to AHMAC out-of-session

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7.8.1 PROJECT DEFINITION

This document outlines planning for the enhancement of state and territory surveillance capacity, which is funded through the National Partnership Agreement on Preventive Health (prevention NP).

7.8.1.1 Policy objective/outcome

a) Approved policy objective

Through the prevention NP, $10 million is being provided to states and territories to implement or expand existing surveillance capacity.

b) Policy context or environment

The prevention NP 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 poor nutrition, physical inactivity, smoking and excessive alcohol consumption (including binge drinking);
- social marketing aimed at reducing obesity and tobacco use; and
- the enabling infrastructure to monitor and evaluate progress made by these interventions, including enhanced surveillance for states and territories.

Funding for enabling infrastructure programs covering research, surveillance, and policy development is being provided to address the gap in the national infrastructure supporting action on the lifestyle related risk factors for chronic conditions.

Funding for states and territories for two other prevention NP programs (Healthy Children and Healthy Workers) is subject to a 50% - 50% facilitation and reward split, with reward funds contingent on their ability to meet targets specified in the Agreement around healthy weight, nutrition, physical activity and smoking. The funds provided under this initiative will support the collection of the data to monitor performance against these targets.

c) Approvals to date

The Council of Australian Governments authorised funds for enhanced surveillance when it agreed the prevention NP on 29 November 2008.

d) Policy solution, delivery model, or strategy

Under this initiative, $10 million is to be provided to states and territories to implement a complementary system of more frequent health, nutrition and physical activity monitoring surveys. These data will be provided for national aggregation and reporting, with reward payments paid to the States and Territories for achieving agreed targets.

The Commonwealth will:

- provide leadership and support through development and promotion of national data standards, performance indicators, and reporting protocols.

The states and territories:

- will collect and report on agreed performance indicators in accordance with national data standards and COAG reporting protocols and timelines;
- will implement a surveillance system using the nationally agreed methodology, survey instruments, and processing system; and
- may need to adopt a collaborative approach with other jurisdictions to meet the above requirements, for instance, where infrastructure is

inadequate to conduct surveillance in the desired manner.

7.8.1.2 Benefits statement

Table 1.1 Statement of expected benefits

Intended beneficiaries	Expected benefits
COAG, all jurisdictions	Access to data on the effectiveness of its investments (particularly relative effectiveness across jurisdictions and programs) and which may guide future policies and decisions.

7.8.1.3 Evaluation methodology

Evaluation of the prevention NP will occur at two levels. An overarching evaluation will occur through assessing how well a range of performance benchmarks are met and a more detailed evaluation will occur for each component of the Partnership.

7.8.1.3.1 Overarching evaluation

Overarching evaluation will occur at two time points, June 2013 and January 2014, covering the proportion of:

- adults and children at health body weight;
- adults and children meeting the national guidelines for physical activity;
- adults and children consuming adequate amounts fruits and vegetables; and
- Australians smoking daily.

7.8.1.3.2 Program level evaluation

The Population Health Information Development Group (PHIDG) has commenced work on this initiative. As part of that work, PHIDG will develop an evaluation plan for this element in due course.

7.8.2 GOVERNANCE

The states and territories have responsibility for the management of funds under the initiative. The role of the Commonwealth in this initiative is to provide guidance and undertake a facilitation role in conjunction with the states and territories to assist them in the development of their surveillance capacity. At the Commonwealth level, overarching responsibility will rest predominantly with Population Health Division.

7.8.2.1 Internal governance arrangements

Table 2.1 Hierarchy of internal governance arrangements

Deputy Secretary Department of Health and Ageing Name: David Learmonth	Sponsor and senior responsible officer	Chair of the National Partnership Agreement on Preventive Health Implementation Working Group**.**
First Assistant Secretary Population Health Division Name: Cath Halbert	Leader	Responsible for managing the Commonwealth role in this initiative.

Assistant Secretary Population Health Strategy Unit Population Health Division Name: Peter Morris	Manager	Responsible for overseeing the Commonwealth role in this initiative.
Director Population Health Information and Analysis Population Health Strategy Unit Population Health Division Name: Caroline Arthur (Acting)	Coordinator	Responsible for supporting the Manager.

7.8.2.2 External governance arrangements

External governance arrangements for the Prevention NP are shown in Figure 2.2.

Population Health Information Development Group (PHIDG) – Australian Population Health Principal Development Committee (APHDPC)
PHIDG comprises of the Department, State and Territory Health Department representatives, the Australian Bureau of Statistics (ABS), the Australian Institute of Health and Welfare (AIHW), and the Population Health Information Development Unit (PHIDU). PHIDG is co-chaired by the Victorian representative and the AIHW.

Following the 6 February 2009 APHDPC meeting, PHIDG was tasked to provide advice on performance reporting arrangements under the prevention NP, including:

- options for performance reporting under the prevention NP;
- associated developmental steps and implementing arrangements;
- associated costs; and
- how these options would relate to the parallel requirement for performance reporting against the same indicators under the NHA.

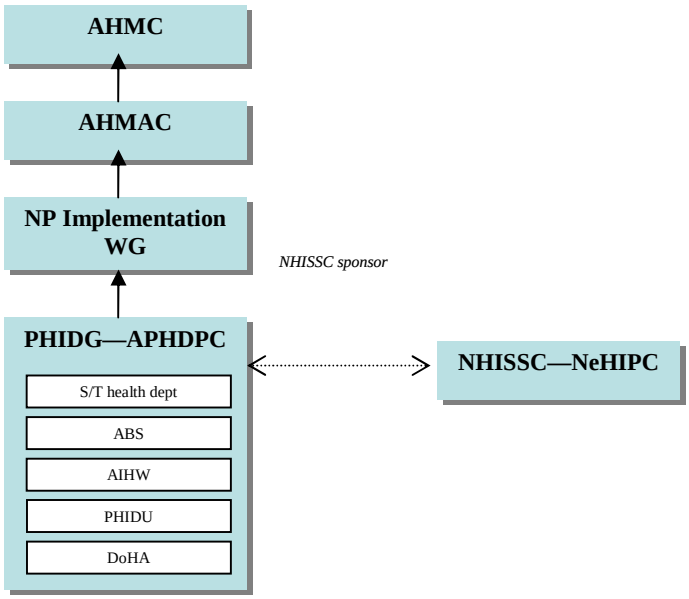
National Health Information Standards and Statistical Committee (NHISSC) – National E-Health Information Principal Committee (NeHIPC)
NHISSC under the auspices of the NeHIPC has been delegated the authority for final approval of all COAG-related performance indicators and is exercising this through its standing processes. These involve approaching NHISSC early in the conduct of any work and obtaining a NHISSC sponsor. The sponsor has been appointed and will provide advice during the data developing process and takes responsibility for shepherding the work through the final NHISSC approval process.

National Partnership Agreement on Preventive Health Implementation Working Group
Planning and coordination of implementation arrangements for the prevention NP will be managed by the prevention NP Implementation Working Group. The Working Group is chaired by the Commonwealth and comprises deputy CEOs from all jurisdictions with responsibility for preventive health. The Working Group will oversee the development of implementation plans for all elements of the prevention NP and provide a recommendation to AHMAC.

Australian Health Ministers' Advisory Council (AHMAC)
AHMAC will receive advice from the prevention NP Implementation Working Group on implementation arrangements and make a recommendation to AHMC.

Australian Health Ministers' Conference (AHMC)
AHMC is responsible for agreeing implementation arrangements for the prevention NP. To support this role, AHMC will receive advice from AHMAC on implementation arrangements before making a decision.

Figure 2.2 Chart of broader governance arrangements



7.8.3 SCOPE/DELIVERABLES

7.8.3.1 Scope/Deliverables

Table 3.1 Definition of deliverables in/out of scope

Deliverables within the scope of this measure	Deliverables/activities beyond the scope of this measure
Implementation of an enhanced surveillance system • Negotiations with jurisdictions and NHISSC on agreed national data standards. • Negotiations with jurisdictions on agreed baseline data for each indicator and survey methodology. • Small jurisdictions without existing surveillance systems (Tasmania and NT) commence negotiations with larger jurisdictions to undertake data collection on their behalf. Operational requirements • Reporting on implementation progress to the various committees (see governance structure). • Provision of data and report at two time periods to the COAG Reform Council: (i) by 30 August 2013 and (ii) by 28 February 2015. Survey in the field • Data collection at two time periods: (i) before June 2013 and (ii) before December 2014.	Not applicable.

Deliverables within the scope of this measure	Deliverables/activities beyond the scope of this measure
Transitional arrangements • Develop arrangement to transfer the initiative to the Australian National Preventive Health Agency to oversight the implementation.	

7.8.3.2 Assumptions / Dependencies

Assumptions and dependencies are as follows:

- jurisdictions are committed to enhancing their surveillance infrastructure using uniform standards and collection methods;
- states and territories are willing to work cooperatively as needed and support the national aggregation of data and facilitate extrapolation of trends;
- jurisdictions agree to baseline data;
- jurisdictions may need to adopt a collaborative approach with other jurisdictions to meet the above requirements, for instance, where infrastructure is inadequate to conduct surveillance in the desired manner; and
- jurisdictions collect the data and therefore furnish the data and reports to COAG.

7.8.4 IMPLEMENTATION SCHEDULE

Table 4.1 Schedule of implementation milestones 2009-10

	Milestones	
Date	**Output 1:** Implementation of an enhanced surveillance system	**Output 2:** Operational requirements
Quarter 1 – July-Sept 2009	• Negotiate and agree national data standards via NHISSC.	• Commence consultations with relevant jurisdictions on the specifications of the enhanced surveillance system. • In cooperation with NHISSC develop options for reporting baseline and progress measures.
Quarter 2 – Oct-Dec 2009	• Jurisdictions to prepare agreed baseline data for each indicator.	• Jurisdictions to report on progress to PHIDG (with PHIDG to inform NHISSC).
Quarter 3 – Jan – Mar 2010	• Jurisdictions to commence work to enhance their surveillance systems.	• Jurisdictions to report on progress to PHIDG (with PHIDG to inform NHISSC).
Quarter 4 - Apr-Jun 2010	• Small jurisdictions without existing surveillance systems (Tasmania and NT) commence negotiations with larger jurisdictions to undertake data collection on their behalf.	• Transitional arrangements agreed for initiative to transfer to the Agency and functions to follow according to that plan.

Table 4.2 Schedule of implementation milestones 2013 to 2015

	Milestones	
Date	**Output 1: Survey in the field**	**Output 2: Operational requirements**
By June 2013	• Jurisdictions conduct survey fieldwork for the first data collection period.	
30 August 2013		• Jurisdictions provide data and report to COAG.
By December 2014	• Jurisdictions conduct survey fieldwork for the second data collection period.	
28 February 2015		• Jurisdictions provide data and report to COAG

7.8.5 WORK BREAKDOWN STRUCTURE

The work of this component of the prevention NP will be conducted primarily by staff within the Population Health Strategy Unit. An operations work plan is in preparation which sets out lower-level activities and task allocations. This work plan will be revised on an ongoing basis.

7.8.6 RESOURCES

7.8.6.1 Budget

COAG has allocated $10 million for transfer to the States and Territories under the prevention NP to assist with bringing jurisdictional data infrastructure into a nationally consistent framework able to support the performance reporting requirements of the Agreement.

Table 6.1 Enhanced State and Territory Surveillance Budget

Initiative	**2009-10 $m**	**2010-11 $m**	**2011-12 $m**	**2012-13 $m**	**TOTAL $m**
Surveillance capacity	2.5	2.5	2.5	2.5	10
Total	2.5	2.5	2.5	2.5	10

7.8.6.2 Non-financial resources

The Commonwealth will contribute non-financial resources to the implementation of the Agency including ASL, legal services and contracting arrangements as required.

7.8.7 RISK MANAGEMENT

Table 7.1. Risk identification and control

Risk	Risk rating	Origin/cause/source of risk and trigger point for deploying strategies	Risk mitigation/control strategies
Effective governance is not established to oversee the development and implementation of the enhanced surveillance system.	Medium (Consequence moderate, Likelihood unlikely)		Progress reports to committees to ensure appropriate links to the relevant committees and stakeholders. Eg. Appointed NHISCC sponsor to link in with NeHIPC
Jurisdictions do not reach agreement on baseline data, survey standards and methods.	Medium (Consequence major, Likelihood unlikely)	Comparison across jurisdictions not possible.	Progress reports to committees. Consistent standards of surveying are promoted by NHISSC and APHDPC interactions.
Jurisdictions are unwilling to work collaboratively with others to survey in a jurisdiction with inadequate surveillance abilities.	Medium (Consequence major, Likelihood Unlikely)		Progress reports to committees.
System not able to discern or measure changes in performance indicators.	Medium (Consequence minor, Likelihood possible)		Consistent standards of surveying are promoted by NHISSC and APHDPC interactions.

7.8.8 STAKEHOLDER MANAGEMENT

Table 8.1. Stakeholder management strategy

Stakeholder	Their views	Department's strengths in managing these views	Department's vulnerabilities
AHMAC and State and Territory Governments	Concern that the enhanced surveillance system may not be able to measure changes in the performance indicators and that jurisdictions will not receive their reward payments.	The Commonwealth is working closely with the jurisdictions in recognition of the benefit that all jurisdictions will attain from an enhanced surveillance system.	
Academics and researchers	Interested to see that the information gathered is robust. Would like access to nationally consistent data to allow comparisons.	All jurisdictions working together to ensure an effective system able to produce robust data is implemented. Agreement specifies that nationally consistent data will be produced by the system.	

7.8.9 QUALITY ASSURANCE

A range of quality assurance activities will be utilised including:

- regular (quarterly) progress reporting to the prevention NP Implementation Working Group, including updates on progress towards milestones and financial expenditure monitoring;
- regular reporting to the Minister for Health and Ageing; and
- annual reporting to COAG as stipulated in the prevention NP Agreement.

7.9 IMPLEMENTATION PLAN – WORKFORCE AUDIT AND STRATEGY

Version History

Version	Date	Nature of change(s)
0.1	May 2009	First draft of plan for National Partnership Agreement on Preventive Health Implementation Working Group meeting of 14 May 2009
0.2	May 2009	Second draft for distribution to Implementation Working Group on 20 May 2009
0.3	June 2009	Draft circulated to AHMAC out-of-session

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7.9.1 PROJECT DEFINITION

This document outlines planning for the National Workforce Audit and Strategy which is funded through the National Partnership Agreement on Preventive Health (prevention NP). This initiative will be transferred to the Australian National Preventive Health Agency once it is operational.

7.9.1.1 Policy objective/outcome

a) Approved policy objective

Through the prevention NP, COAG is providing $0.5 million for an audit of the preventive health workforce to identify any gaps or issues and a strategy to be developed to address them.

b) Policy context or environment

The prevention NP provides funding for:

- o settings based interventions in pre-schools, schools, workplaces and communities to support behavioural changes in the social contexts of everyday lives, and focusing on poor nutrition, physical inactivity, smoking and excessive alcohol consumption (including binge drinking);
- o social marketing aimed at reducing obesity and tobacco use; and
- o the enabling infrastructure to monitor and evaluate progress made by these interventions, including the workforce audit and strategy.

Funding for enabling infrastructure programs covering research, surveillance, and policy development is being provided to address the gap in the national infrastructure supporting action on the lifestyle related risk factors for chronic conditions.

Very few studies have been conducted on the preventive health workforce, a clear gap in the context of the increased focus being placed on the role that preventive health can play in health system sustainability. The prevention NP provides significant funding for a range of settings based interventions, and there is a need to quantify the workforce available to deliver those programs and determine strategies to rectify any gaps or issues.

c) Approvals to date

The Council of Australian Governments authorised the workforce audit and strategy when it agreed the prevention NP on 29 November 2008.

d) Policy solution, delivery model, or strategy

This initiative will:

- define the workforce available for rolling out the activities under the prevention NP including settings based approaches;
- conduct an audit of this workforce including an assessment of preventive health employer needs;
- forecast long term preventive workforce needs related to the rollout of the prevention NP;
- develop a planning framework for the preventive health workforce involving a review of jurisdictional workforce plans; and
- develop a medium to long term national preventive health workforce strategy to provide a blueprint for addressing any identified gaps and issues.

The Commonwealth will:

- work with all states and territories through a Jurisdictional Workforce Planning Group that will oversee the project;
- appoint qualified consultants to undertake the project;

- establish a website and clearing house for the collection of data on workforce demand and supply, employer needs and training available in preventive health to address current and future needs relating to the prevention NP; and
- develop a transitional strategy to transfer the project to the Australian National Preventive Health Agency.

States and territories will:

- contribute to the national workforce audit by providing data, surveys and other information;
- contribute to workforce planning at the state/territory level which will aggregate to a national workforce planning framework with agreed national principles and objectives;
- participate in the Jurisdictional Workforce Planning Group to oversee the initiative; and
- collaborate with the Australian National Preventive Health Agency once the initiative is transferred to the Agency.

7.9.1.2 Benefits statement

Table 1.1. Statement of expected benefits

Intended beneficiaries	Expected benefits
COAG	Access to information about possible workforce shortages and the strategies to identify them, and this may guide future investments. Improved information to support workforce planning and provide a consistent focus on national and regional needs and addressing workforce demand and supply issues in the short, medium and longer term.
All governments	Improved information to support workforce planning and development in the long term, taking account of predicted long term demand.

7.9.1.3 Evaluation methodology

Evaluation of the Health Prevention NP will occur at two levels. An overarching evaluation will occur through assessing how well a range of performance benchmarks are met and a more detailed evaluation will occur for each component of the Partnership.

7.9.1.3.1 Overarching evaluation

Overarching evaluation will occur at two time points, June 2013 and January 2014, covering the proportion of:

- adults and children at health body weight;
- adults and children meeting the national guidelines for physical activity;
- adults and children consuming adequate amounts fruits and vegetables; and
- Australians smoking daily.

7.9.1.3.2 Program level evaluation

The workforce audit and strategy development will provide the information to all jurisdictions for workforce planning purposes and will ultimately contribute to program achievements under the prevention NP.

Evaluation and monitoring of the workforce audit and strategy will occur through the Jurisdictional Workforce Group assigned to oversee its implementation. This Group will be required to meet regularly over the prevention NP implementation period. The success of the approach will be measured in terms of the capacity to deliver short, medium and long term solutions to workforce development, planning and training.

The Jurisdictional Workforce Group will develop a detailed evaluation plan for the initiative.

7.9.2 GOVERNANCE

The Commonwealth has responsibility for the workforce audit and strategy and will work with the states and territories in doing so. At the Commonwealth level, Population Health Division has the overarching responsibility.

7.9.2.1 Internal governance arrangements

Table 2.1. Hierarchy of internal governance arrangements

Deputy Secretary Department of Health and Ageing Name: David Learmonth	Sponsor and senior responsible officer	Chair of the National Partnership Implementation Group
First Assistant Secretary Population Health Division Name: Cath Halbert	Leader	Management of Commonwealth Partnership responsibilities across Population Health Division
Assistant Secretary Population Health Strategy Unit Population Health Division Name: Peter Morris	Manager	Overall, take responsibility as the lead Branch for coordination of the National Partnership Agreement. Chair of the National Workforce Planning Group
Director Preventative Workforce Policy Section Population Health Strategy Unit Population Health Division Name: Karen Freedman	Coordinator	Management of the establishment phase of the National Workforce Planning Group and transfer to the Preventive Health Agency. Oversee the workforce audit, the development of the workforce planning framework, data clearing house and short to medium terms options for addressing workforce deficits.

7.9.2.2 External governance arrangements

Committees and bodies with a role in implementation:

National Partnership Agreement on Preventive Health Implementation Working Group
Planning and coordination of implementation arrangements for the prevention NP will be managed by the prevention NP Implementation Working Group. The Working Group is chaired by the Commonwealth and comprises deputy CEOs from all jurisdictions with responsibility for preventive health. The Working Group will oversee the development of implementation plans for all elements of the prevention NP and provide a recommendation to AHMAC.

Australian Health Ministers' Advisory Council (AHMAC)
AHMAC will receive advice from the prevention NP Implementation Working Group on implementation arrangements and make a recommendation to AHMC.

Australian Health Ministers' Conference (AHMC)
AHMC is responsible for agreeing implementation arrangements for the prevention NP. To support this role, AHMC will receive advice from AHMAC on implementation arrangements before making a decision.

Once implementation arrangements are agreed, new governance arrangements will be formed around the Jurisdictional Working Group.

New governance arrangements will need to be established once the Agency takes carriage of the initiative, and these will be at the discretion of the Chief Executive Officer.

7.9.3 SCOPE/DELIVERABLES

7.9.3.1 Scope/Deliverables

Table 3.1. Definition of deliverables in/out of scope

Deliverables within the scope of this measure	Deliverables/activities beyond the scope of this measure
1. Operational issues a. Establish Jurisdictional Workforce Planning Group. b. Engage consultants. c. Evaluation of the initiative. d. Transition to the Agency. 2. Data collection and audit a. Establish a website. b. Collation of data, including research and submissions. c. Forecast long term preventive workforce needs. 3. Strategy a. Planning framework. b. Strategy.	Funding to train or employ preventive health workers.

7.9.3.2 Assumptions / Dependencies

The initiative depends on all jurisdictions being committed to:

- establishing a robust evidence base for national workforce planning to support the prevention NP;
- share data on the current and future workforce patterns and needs to build a national picture; and
- a collaborative approach to workforce planning that identifies solutions to addressing workforce gaps in the short, medium and longer term.

7.9.4 IMPLEMENTATION SCHEDULE

Table 4.1 Schedule of implementation milestones 2009-10

	Milestones		
Date	**Output 1: Operational**	**Output 2: Data collection and audit**	**Output 3: Strategy**
Quarter 1 – Jul to Sept 09	Establish Jurisdictional Workforce Planning Group with members from all jurisdictions. Scope of the project determined. Engage consultants.	Website and data clearinghouse developed and functional. Website advertised along with a call for submissions from interested parties (data, surveys, needs assessments etc). Jurisdictions to provide data.	
Quarter 2 – Oct to Dec 10		Consultants to analyse all available data, including any literature. Consultants to travel to all jurisdictions for to gather information and discuss issues. Data collection continues, particularly if gaps are identified after consultations.	
Quarter 3 – Jan to March 10		Draft audit report distributed for comment. Consultation on draft report.	
Quarter 4 – Apr to Jun 10	Evaluation commences. Transitional arrangements agreed and audit and strategy to move to Agency according to that plan, along with resources.	Final audit report distributed.	
Quarter 5 – Jul – Sep 10	Jurisdictional Workforce Planning Group to revise Terms of Reference to reflect next phase of work		Consultations commence on development of the planning framework. Note Agency may have carriage of imitative.

7.9.5 WORK BREAKDOWN STRUCTURE

The work of this component of the prevention NP will be conducted primarily by staff within the Population Health Strategy Unit. An operational work plan is in preparation which sets out lower-level activities and task allocations. This work plan will be revised fortnightly.

7.9.6 RESOURCES

7.9.6.1 Budget

This measure was agreed to by COAG in November 2008 and will be identified in the 2009-10 Budget.

Population Health Strategy Unit maintains a budgeting tool allocating administered funds for this measure to resources required. This information is not included here.

Table 6.1 Workforce Audit and Strategy Budget

Initiative	**2009-10 $m**	**2010-11 $m**	**2011-12 $m**	**2012-13 $m**	**TOTAL $m**
Workforce audit and strategy	0.25	0.25	0.0	0.0	0.5
Total	**0.25**	**0.25**	**0.0**	**0.0**	0.5

7.9.6.2 Non-financial resources

The Commonwealth will contribute non-financial resources to the implementation of the Agency including ASL, legal services and contracting arrangements as required.

7.9.7 RISK MANAGEMENT

Table 7.1. Risk identification and control

Risk	**Risk rating**	**Origin/cause/source of risk and trigger point for deploying strategies**	**Risk mitigation/control strategies**
Establishment of a Jurisdictional Workforce Planning Group is delayed.	Low (Consequence minor, Likelihood unlikely)	Competing timeframes. Differing views on the composition of the group and its terms of reference.	Consult effectively and early.
Appointment of consultants is delayed.	Low (Consequence minor, Likelihood unlikely)	Shortage of qualified consultants available given timeframes.	Commence tender process early and scope the market effectively.
Inadequate or insufficient data.	High (Consequence major, Likelihood possible)	Data quantity and quality may not be consistent across jurisdictions.	Early consensus data definitions. Undertake analysis to cover gaps.

7.9.8 STAKEHOLDER MANAGEMENT

Table 8.1. Stakeholder management strategy

Stakeholder	Their views	Department's strengths in managing these views	Department's vulnerabilities
State and territory governments	Need to build on existing planning frameworks and strategies rather than overwrite. Workforce issues may be regionally or locally specific and the national framework should accommodate this.	Establishment of the Jurisdictional Workforce Planning Group will allow effective collaboration and stakeholder input to the initiative.	Nil
Public health peaks and providers	Would want to be consulted in the process. May want their particular workforce included in the audit and strategy.	Consultation to be broad but should focus on the workforce needs of the prevention NP. Relevant workforces will be identified in the scoping component of the initiative.	Nil

7.9.9 QUALITY ASSURANCE

A range of quality assurance activities will be utilised including:

- regular (quarterly) progress reporting to the prevention NP Implementation Working Group, including updates on progress towards milestones and financial expenditure monitoring;
- regular reporting to the Minister for Health and Ageing; and
- annual reporting to COAG as stipulated in the prevention NP Agreement.

7.10 IMPLEMENTATION PLAN – AUSTRALIAN NATIONAL PREVENTIVE HEALTH AGENCY

Version History

Version	Date	Nature of change(s)
0.1	May 2009	First draft of plan for National Partnership Agreement on Preventive Health Implementation Working Group meeting of 14 May 2009
0.2	May 2009	Second draft for distribution to Implementation Working Group on 20 May 2009
0.3	June 2009	Draft circulated to AHMAC out-of-session

7.10.1 PROJECT DEFINITION

This document outlines planning for establishing the Australian National Preventive Health Agency (the Agency) and the preventive health research fund, both funded through the National Partnership Agreement on Preventive Health (prevention NP). As the Commonwealth is not intending to start using the research fund until the Agency is operational, planning for these two initiatives is being conducted in unison. The Agency will have responsibility for two other prevention NP initiatives (social marketing for obesity/overweight and tobacco and an audit of the preventive health workforce and consequent strategy) and planning for these initiatives is provided separately.

7.10.1.1 Policy objective/outcome

a) Approved policy objective

Through the prevention NP, COAG is providing $17.6 million over four years for a national preventive health agency which is to:

- have responsibility for providing evidence-based policy advice to health and other ministers interested in preventive health;
- be tasked with administering social marketing programs and other national preventive health programs which it may be tasked with by Health Ministers;
- be responsible for overseeing surveillance and research activities of a national nature; and
- have responsibility for stakeholder consultation.

COAG also provided $13 million over four years for a preventive health research fund to build the evidence base for future preventive health activities and the capacity for future research, and which would focus on translational research.

b) Policy context or environment

The prevention NP provides funding for:

- o settings based interventions in pre-schools, schools, workplaces and communities to support behavioural changes in the social contexts of everyday lives, and focusing on poor nutrition, physical inactivity, smoking and excessive alcohol consumption (including binge drinking);
- o social marketing aimed at reducing obesity and tobacco use; and
- o the enabling infrastructure to monitor and evaluate progress made by these interventions, including the Agency and research fund.

Funding for enabling infrastructure programs covering research, surveillance, and policy development is being provided to address the gap in the national infrastructure supporting action on the lifestyle related risk factors for chronic conditions.

The Agency has been proposed against the backdrop of the following structures for coordinating national agendas in preventive health: the Australian Health Ministers' Conference and the Australian Health Ministers' Advisory Council; the Ministerial Council on Drug Strategy and the Intergovernmental Committee on Drugs; and the Council of Australian Governments and its Senior Officials' Meeting. None of these is supported by the dedicated machinery to take agendas forward, to translate broad policy intent into evidence-based strategies with built-in evaluation mechanisms, and to leverage a range of appropriate policy levers and sectors, both within and outside government.

In particular, the challenge posed by obesity to mobilise stakeholders and resources across jurisdictions, across portfolios within jurisdictions, and across the community and industry sectors, suggests the need for a new mechanism in Commonwealth-State coordination.

c) Approvals to date

The Council of Australian Governments authorised the Agency and research fund when it agreed the prevention NP on 29 November 2008.

d) Policy solution, delivery model, or strategy

The Agency is defined for a purpose unique to the Australian context of Commonwealth-State cooperation in the shared space of preventive health. It is intended to aid Health Ministers in their strategic leadership of the Australian preventive health agenda, and, at the election of Health Ministers, as an aid to their implementation of interventions best delivered on a national basis. The Agency is intended to complement existing jurisdictional capacity in preventive health as well as cross-jurisdictional mechanisms.

To undertake its role, the Agency will promote more effective translation of evidence to practice through its research fund, oversee surveillance and monitoring of lifestyle related causes of chronic disease and through the national audit of the preventive health workforce and subsequent strategy.

The Commonwealth will establish the Agency:

- as an independent statutory authority under its own enabling legislation and conforming with the *Financial Management and Accountability Act 1997*;
- with a Chief Executive Officer and Advisory Council appointed by the Commonwealth Minister for Health and Ageing consulting with AHMC;
- tasked under triennial strategic and annual operating plans prepared by the CEO consulting with the Advisory Council and agreed by AHMC; and
- reporting to AHMC on strategic matters and to Australian Government Ministers on financial matters.

7.10.1.2 Benefits statement

Table 1.1. Statement of expected benefits

Intended beneficiaries	Expected benefits
COAG, AHMC, all governments	• Improved surveillance of chronic conditions and their lifestyle risk factors which will support policy development. • Increased access to information on the effectiveness, particularly relative, of various interventions that will support program and policy decision making and allow more effective use of resources. • Access to evidence-based policy advice of a national nature that will enhance policy development and support effective funding allocations. • Access to information to support workforce planning and development.

Intended beneficiaries	Expected benefits
Researchers, peak and industry groups	• Improved surveillance of chronic conditions and their lifestyle risk factors that will build the evidence base available to support further research and guide peak and industry groups in their activities. • Collation of data by the Agency that will increase access to information on chronic conditions and their lifestyle related risk factors. • Collaboration with the agency may result in synergies in research that could be particularly productive. • A research fund that will provide new opportunities for these groups to access funds for their programs.
Australian children and adults	• Increased access to information about preventive health in Australia, including the current state of play. • Improved decision making by governments resulting from the Agency being an effective adviser that will lead to improved health outcomes for all Australians. • Access to social marketing campaigns on obesity and tobacco and their links to chronic diseases that will lead to improved health outcomes for all Australians.

This initiative contributes to Outcome 1 - Population Health in the Department's structure of outcomes and outputs. Further detail will be included in the 2009-10 Portfolio Budget Statements for the Health and Ageing portfolio.

7.10.1.3 Evaluation methodology

Evaluation of the prevention NP will occur at two levels. An overarching evaluation will occur through assessing how well a range of performance benchmarks are met and a more detailed evaluation will occur for each component of the Partnership.

7.10.1.3.1 Overarching evaluation

Overarching evaluation will occur at two time points, June 2013 and January 2014, covering the proportion of:

- adults and children at health body weight;
- adults and children meeting the national guidelines for physical activity;
- adults and children consuming adequate amounts fruits and vegetables; and
- Australians smoking daily.

7.10.1.3.2 Program level evaluation

The Commonwealth will undertake an internal evaluation of the Agency's establishment, seeking the views of the states and territories in doing so. Issues to be covered include achieving milestones (including introducing the legislation for the agency, establishing corporate and compliance

frameworks etc) and collaboration with the states and territories on key issues (including the appointment of the Chief Executive Officer and the Advisory Council).

7.10.2 GOVERNANCE

The Commonwealth has responsibility for establishing the agency and will work with the states and territories in doing so. At the Commonwealth level, Population Health Division has the overarching responsibility.

7.10.2.1 Internal governance arrangements

The work of the Department under this measure will be conducted by the Population Health Strategy Unit. The primary officers responsible are identified in Table 2.1.

Table 2.1. Hierarchy of internal governance arrangements

Deputy Secretary Department of Health and Ageing Name: David Learmonth	Sponsor and senior responsible officer	Chair of the National Partnership Agreement on Preventive Health Implementation Working Group.
First Assistant Secretary Population Health Division Name: Cath Halbert	Leader	Responsible for policy decisions, financial delegation, reporting to sponsor and senior responsible officer and to the Minister.
Assistant Secretary Population Health Strategy Unit Population Health Division Name: Peter Morris	Manager	Responsible for Agency implementation, including legislation and financial management issues, and responsible for reporting to Leader and Sponsor
Director Population Health Strategy Section Population Health Strategy Unit Population Health Division Name: Masha Somi	Coordinator	Responsible for implementation to support Manager.

7.10.2.2 External governance arrangements

Committees and bodies with a role in implementation:

National Partnership Agreement on Preventive Health Implementation Working Group
Planning and coordination of implementation arrangements for the prevention NP will be managed by the prevention NP Implementation Working Group. The Working Group is chaired by the Commonwealth and comprises deputy CEOs from all jurisdictions with responsibility for preventive health. The Working Group will oversee the development of implementation plans for all elements of the prevention NP and provide a recommendation to AHMAC.

Australian Health Ministers' Advisory Council (AHMAC)
AHMAC will receive advice from the prevention NP Implementation Working Group on implementation arrangements and make a recommendation to AHMC.

Australian Health Ministers' Conference (AHMC)
AHMC is responsible for agreeing implementation arrangements for the prevention NP. To support this role, AHMC will receive advice from AHMAC on implementation arrangements before making a decision.

7.10.3 SCOPE/DELIVERABLES

7.10.3.1 Scope/Deliverables

The Commonwealth will establish and have operational the Agency in 1st quarter 2010. The outputs required to achieve this are listed in Table 3.1.

Table 3.1. Definition of deliverables in/out of scope

Deliverables within the scope of this measure	Deliverables/activities beyond the scope of this measure
1. Legislation a. Negotiations with the States on governance arrangements. b. Enacting legislation introduced and passed to establish a statutory authority. **2. Operational requirements** a. Negotiate with the States on appointment of CEO and Advisory Council. b. Manage the process to appoint the CEO and Advisory Council. c. Agency communications strategy and launch. d. Support the Agency's engagement with AHMC. **3. Corporate requirements and compliance frameworks** a. Source capital infrastructure, including property leasing, equipment and local requirements. b. Establish IT capability, including mainframe and equipment, and data and records management. c. Establish financial management capability, including systems and delegations. d. Establish HR capability, including payroll and certified agreement. e. Establish compliance with OH&S, Privacy, FoI and risk management requirements. **4. Transitional arrangements** a. Work with the States to develop the Agency's first triennial Strategic Plan. b. Transitional plans developed for social marketing and the workforce audit and strategy. **5. Evaluation** a. Internal reviews undertaken at key points.	

7.10.3.2 Assumptions / Dependencies

Dependencies include:

- Engagement in the process by the States and AHMC in the establishment of the agency, including, for example, agreement to the Agency model and the triennial strategic plan.

- Passage of enacting legislation carrying the agreed model of the agency through the Houses of Parliament.

Assumptions include:

- A suitable is CEO is found through the recruitment process.
- Suitable nominations are made for appointments to the Advisory Council.

7.10.4 IMPLEMENTATION SCHEDULE

Table 4.1 below outlines the schedule of implementation milestones for the 2009-10 financial year. Planning for the next phase of the program will be conducted between March and June 2010.

Table 4.1 Milestones for the project

	Milestones				
Date	**Output 1: Legislation**	**Output 2: Operational requirements**	**Output 3: Corporate requirements and compliance frameworks**	**Output 4: Transitional arrangements**	**Output 5: Evaluation**
Quarter 1 July-Sep 2009	Legislation passed in Spring 2009 sittings. Support the agency's engagement with AHMC including acting as a sponsor of agenda items.	Commence consultations with the States on the selection criteria for the CEO. Commence recruitment process for the CEO. Commence negotiations with the States on appointments to the Advisory Council.	Scope requirements for IT, capital infrastructure, HR, financial management, records management and compliance frameworks.	Scoping of programs/ activities to be transitioned to agency and the appropriate time for the programs to be moved.	Internal review, with collaboration with the States, of the timeliness of legislation.
Quarter 2 Oct-Dec 2009	Royal Assent as soon as possible after enacting legislation is passed. Support the agency's engagement with AHMC.	Identify potential nominations for the Advisory Council and commence selection process. Communications strategy for agency promotion and launch developed. Agency website developed and commences information updates for interested parties.	Identify agencies that could supply these requirements and commence discussions regarding MoUs. Develop procedures for compliance with frameworks such as OH&S.	Transitional strategies developed for social marketing (tobacco and obesity) and the workforce audit and strategy. Commence development of triennial strategic plan (Commonwealth and the States).	Internal review, with collaboration with the States, of the timeliness of the appointment process for the CEO and Advisory Council and of the consultation process for these appointments. Internal review, with collaboration with the States, of the timeliness and consultative nature of the development of the triennial strategic plan.

	Milestones				
Date	**Output 1: Legislation**	**Output 2: Operational requirements**	**Output 3: Corporate requirements and compliance frameworks**	**Output 4: Transitional arrangements**	**Output 5: Evaluation**
Quarter 3 Jan –Mar 2010	Support the agency's engagement with AHMC.	CEO and Advisory Council members appointed (Jan 2010). Secondment of requisite staff to the agency. Commence advertising of positions at the agency. Communications strategy for the agency is approved. Agency is launched.	Corporate requirements agreed with the CEO, who would lead final negotiations and sign the MoUs. CEO to approve procedures for compliance frameworks. Financial resources transferred to the agency.	Transitional arrangements agreed with the CEO. CEO to take carriage of triennial strategic plan, with support from the Commonwealth and the States as required. Support CEO to commence annual operational planning for AHMC.	Internal review, with collaboration with the States, on the timeliness of the appointment of the CEO and Advisory Council. Internal review, with collaboration with the CEO on the quality of advice and assistance with corporate requirements and compliance frameworks.
Quarter 4 Apr-Jun 2010	Support the agency's engagement with AHMC.			Transitional arrangements agreed and programs to move to agency according to that plan, along with budgeted resources.	Internal review, with collaboration with the CEO, on the timeliness and quality of support for engagement with AHMC and in the transitional process.

7.10.5 WORK BREAKDOWN STRUCTURE

The work of this component of the prevention NP will be conducted primarily by staff within the Population Health Strategy Unit. An operational work plan is in preparation which sets out lower-level activities and task allocations. This work plan will be revised fortnightly.

7.10.6 RESOURCES

7.10.6.1 Budget

The measure was agreed to by COAG in November 2008 and was identified in the 2009-10 Budget. Overall funding is shown in Table 6.1.

The Population Health Strategy Unit maintains a budgeting tool allocating administered funds for this measure to resources required. This information is not included here.

Table 6.1 Commonwealth Own Purpose Expenses (COPE)

Initiative	2009-10 $m	2010-11 $m	2011-12 $m	2012-13 $m	TOTAL $m
Agency	2.0	5.1	5.2	5.3	17.6
Preventive Health Research Fund	2.0	4.0	4.0	3.0	13.1
Workforce Audit	0.3	0.3			0.5
Social Marketing	2.0	33.8	32.7	33.5	102.0
TOTAL	**6.2**	**43.25**	**42**	**41.9**	**133.2**

7.10.6.2 Non-financial resources

The Commonwealth will contribute non-financial resources to the implementation of the Agency including ASL, legal services and contracting arrangements as required.

7.10.7 RISK MANAGEMENT

The primary risks associated with this component of the Partnership relate to timeliness of the key milestones, including passage of the enabling legislation and operational infrastructure requirements for the agency.

Table 7.1. Risk identification and control

Risk	Risk rating	Origin/cause/source of risk and trigger point for deploying strategies	Risk mitigation/control strategies
Governance model of the agency not agreed by AHMC, or not agreed in time to allow passage of the enacting legislation in Spring 2009	High (Consequence Moderate, Likelihood Possible)	Commonwealth does not engage all jurisdictions in the consultation process effectively.	Commonwealth to communicate with the States and provide comprehensive advice as early as possible.
AHMC not able to agree on priorities for the first triennial strategic plan	Medium (Consequence Major, Likelihood Unlikely)	Commonwealth does not engage all jurisdictions in the consultation process effectively.	Commonwealth to communicate with the States as early as possible with a view to providing AHMC with recommendations in early 2010 (after review by the CEO).
Suitable CEO not found	Medium (Consequence Major, Likelihood Unlikely)	Recruitment process not advertised broadly enough.	Commonwealth to engage a well known and effective recruitment provider.

Risk	Risk rating	Origin/cause/source of risk and trigger point for deploying strategies	Risk mitigation/control strategies
Delay in getting the agency operational	Medium (Consequence Moderate, Likelihood Unlikely)	Negotiations with existing agencies that have infrastructure services available for purchase may experience delays.	Commonwealth to commence negotiations early with a view to providing options to the CEO as soon as they are appointed.
Budget is not adequate	Medium (Consequence Moderate, Likelihood Possible)	Strategic priorities identified may require resources beyond the allocated budget.	Strategic and annual operational plans to be negotiated with Budget in mind. Budget issues to be referred to AHMC or Minister for Health and Ageing.

7.10.8 STAKEHOLDER MANAGEMENT

There are a range of stakeholders with an interest in the establishment of the Agency – they, and their views, are outlined in Table 8.1.

Table 8.1. Stakeholder management strategy

Stakeholder	Their views	Department's strengths in managing these views	Department's vulnerabilities
AHMC and state governments	Concerned to ensure the agency is independent and meets the needs of AHMC. Concerned to ensure that the Agency is able to undertake social marketing activities effectively. There is a need for the Agency's range of functions to be clearly articulated, in order to avoid overlap and duplication of effort.	The Commonwealth is working closely with the States in recognition of the benefit all jurisdictions will attain from the Agency. The first triennial strategic plan will clearly scope the role and function of the agency, particularly relative to existing agencies.	
National Preventative Health Taskforce and the National and Hospitals Reform Commission	Have expressed a preference for a model of the agency that is beyond the scope of the prevention NP. The ongoing role of the Taskforce in relation to the Agency is unclear.	The Department works closely with the Taskforce and has engaged both the Taskforce and the Commission on these issues.	COAG and AHMC are unlikely to agree the model proposed by the Taskforce and the Commission.

Stakeholder	Their views	Department's strengths in managing these views	Department's vulnerabilities
Academics, researchers and peak groups	Keen to engage and work with the agency in furthering public health outcomes. Interested to see the profile of preventive health activities heightened. Concern with the cessation of Public Health Education and Research Program (PHERP).	There is good will in this sector for the Agency and the establishment of the research fund.	Given confidentiality issues, it is difficult to engage with non-government players during the establishment of the agency.
Existing Statutory Authorities (NHMRC, Vic Health, Healthway)	Keen to work with the Agency in furthering public health outcomes and not duplicate roles.	The Agency has been established with a clear mandate and has a different role than existing bodies.	

7.10.9 QUALITY ASSURANCE

A range of quality assurance activities will be utilised including:

- regular (quarterly) progress reporting to the prevention NP Implementation Working Group, including updates on progress towards milestones and financial expenditure monitoring;
- regular reporting to the Minister for Health and Ageing; and
- annual reporting to COAG as stipulated in the prevention NP Agreement.

7.11 IMPLEMENTATION PLAN – EATING DISORDERS COLLABORATION

Version History

Version	Date	Nature of change(s)
0.1	May 2009	First draft of plan for National Partnership Agreement on Preventive Health Implementation Working Group meeting of 14 May 2009
0.2	May 2009	Second draft for distribution to Implementation Working Group on 20 May 2009
0.3	June 2009	Draft circulated to AHMAC out-of-session

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7.11.1 PROJECT DEFINITION

This document outlines planning for the expansion of the Eating Disorders Collaboration (the Collaboration), which has received supplementary funding through the National Partnership Agreement on Preventive Health (prevention NP).

7.11.1.1 Policy objective/outcome

a) Approved policy objective

Through the prevention NP, COAG is providing $3 million for the expansion of the Collaboration to facilitate the implementation of a nationally consistent and comprehensive approach to promotion, prevention, early intervention and management of eating disorders.

b) Policy context or environment

The prevention NP 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 poor nutrition, physical inactivity, smoking and excessive alcohol consumption (including binge drinking);
- social marketing aimed at reducing obesity and tobacco use; and
- the enabling infrastructure to monitor and evaluate progress made by these interventions, including the Collaboration.

Funding for enabling infrastructure programs covering research, surveillance and policy development was provided to address the gap in the national infrastructure supporting healthy weight.

Eating disorders are serious mental health conditions involving intense anxiety and preoccupation with body weight and shape, eating and weight control. One in 100 adolescent girls develop Anorexia Nervosa, and five in 100 develop Bulimia Nervosa. Anorexia Nervosa has the highest mortality rate of any psychiatric illness, with approximately 15-20 per cent dying within 20 years.

There are many stakeholders within the eating disorders field, including support groups, service providers and research bodies. These groups often advocate differing approaches to eating disorders. Currently, there is also a lack of a consistent and comprehensive approach to prevention, early intervention and management of eating disorders.

c) Approvals to date

In October 2008, Minister Ellis announced $500,000 for an Eating Disorders Collaboration. In April 2009, the Butterfly Foundation was funded to establish the collaboration. The Council of Australian Governments authorised the extension of the Collaboration when it agreed the prevention NP on 29 November 2008.

d) Policy solution, delivery model, or strategy

The Commonwealth will use the COAG funds to expand and extend the Collaboration.

The funded organisation will:

- bring together key organisations and eating disorder experts involved in mental health, public health, health promotion, education and research, as well as media experts;
- review information currently available to young people and their families on the prevention and management of eating disorders;

- identify gaps in the services and information available to people with eating disorders, and to their families;
- undertake a review of the evidence for effective promotion, prevention, and early intervention and treatment of eating disorders;
- determine the best information available to help health practitioners and other professionals treat and prevent the disorders;
- develop a website to provide clear and effective messages and resources in relation to eating disorders;
- promote evidence-based messages and information about the prevention and management of eating disorders to schools, media and health service providers;
- develop an evidence-based framework for the development of promotion, prevention and early interventions for eating disorders targeting school aged children; and
- provide evidence-based information to Government on how to progress and target effective messages around both obesity and eating disorders.

7.11.1.2 Benefits statement

Table 1.1. Statement of expected benefits

Intended beneficiaries	Expected benefits
People suffering from eating disorders – Anorexia Nervosa, Bulimia Nervosa and eating disorders not otherwise specified.	The Collaboration will contribute to ensuring that people with eating disorders are able to access evidence-based, consistent information through avenues such as schools, the media and health service providers. People suffering from eating disorders will benefit from better awareness and understanding of eating disorders in the community and among health professionals. The Collaboration will facilitate a nationally consistent, evidence-based approach to early intervention and treatment of eating disorders. In the longer term, this may contribute to improved management and outcomes for people with eating disorders.
People at risk of, or in the process of developing, eating disorders.	The Collaboration will develop nationally consistent evidence-based approaches to promotion and prevention which may (in the longer term) lead to reductions in the incidence of eating disorders.
Health professionals in primary, secondary and tertiary care settings.	The Collaboration will develop an evidence-based framework for the promotion, prevention, early intervention and management of eating disorders. Health professionals will benefit from consistent, evidence based information about eating disorders. In the longer term, health professionals may diagnose, treat and manage eating disorders more effectively.

This initiative contributes to Outcome 11 — *Improve mental health care for all Australians*, in the Department's structure of outcomes and outputs. Further detail on this outcome is included in the 2009-10 Portfolio Budget Statements for the Health and Ageing portfolio.

7.11.1.3 Evaluation methodology

Evaluation of the Prevention NP will occur at two levels. An overarching evaluation will occur through assessing how well a range of performance benchmarks are met and a more detailed evaluation will occur for each component of the Partnership.

7.11.1.3.1 Overarching evaluation

Overarching evaluation will occur at two time points, June 2013 and January 2014, covering the proportion of:

- adults and children at health body weight;
- adults and children meeting the national guidelines for physical activity;
- adults and children consuming adequate amounts fruits and vegetables; and
- Australians smoking daily.

7.11.1.3.2 Program level evaluation

The evaluation of the Eating Disorders Collaboration is expected to include, but is not limited to a process, impact and outcome evaluation that analyses and reviews the effectiveness and appropriateness of the:

1. structure, function and role of the Eating Disorders Collaboration;
2. portfolio of evidence based messages and quality information on promotion, prevention and early intervention for eating disorders developed by the Collaboration; and
3. implementation of a nationally consistent, evidence-based approach to promotion, prevention, early intervention and management of eating disorders

An evaluation framework will be developed in the first year of the Collaboration.

7.11.2 GOVERNANCE

The Commonwealth has responsibility for expanding the Collaboration and will work with the states and territories in doing so. At the Commonwealth level, overarching responsibility will rest predominantly with Mental Health and Chronic Disease Division.

7.11.2.1 Internal governance arrangements

The work of the Department under this measure is conducted by the Mental Health and Suicide Prevention Programs Branch. The primary officers responsible are identified in Table 2.1.

Table 2.1. Hierarchy of internal governance arrangements

Assistant Secretary Mental Health and Suicide Prevention Programs Branch Mental Health and Workforce Division Name: Colleen Krestensen	Sponsor and senior responsible officer	Responsible officer for communicating to Deputy Secretaries and Minister's Office.
Director Child and Youth Section Mental Health and Suicide Prevention Programs Branch Name: Stanford Harrison	Leader	Financial delegate responsible for approving progress reports and payments to funded organisation. Attendance at Collaboration's steering committee meetings. Liaison with funded bodies. Draft briefing papers relating to the National Eating Disorders Collaboration. Monitor funding agreement, including milestones, deliverables and budget. Assess progress reports including milestones, deliverables and budget. Recommendation to delegate to accept progress reports and process payments. Responsible officer for communicating progress of Collaboration and emerging issues to delegate.

7.11.2.2 External governance arrangements

Committees and bodies with a role in implementation:

National Partnership Agreement on Preventive Health Implementation Working Group
Planning and coordination of implementation arrangements for the prevention NP will be managed by the prevention NP Implementation Working Group. The Working Group is chaired by the Commonwealth and comprises deputy CEOs from all jurisdictions with responsibility for preventive health. The Working Group will oversee the development of implementation plans for all elements of the prevention NP and provide a recommendation to AHMAC.

Australian Health Ministers' Advisory Council (AHMAC)
AHMAC will receive advice from the prevention NP Implementation Working Group on implementation arrangements and make a recommendation to AHMC.

Australian Health Ministers' Conference (AHMC)
AHMC is responsible for agreeing implementation arrangements for the prevention NP. To support this role, AHMC will receive advice from AHMAC on implementation arrangements before making a decision.

Once implementation plans are agreed, normal governance arrangements will resume. The Eating Disorders Collaboration is expected to be supported by a steering committee which has oversight of the Collaboration and is headed by the funded organisation with representatives from the Department and key stakeholder organisations.

The Collaboration will be expected to have strong links with the Australian Government Office for Youth which was established within the Department of Education, Employment and Workplace Relations.

7.11.3 SCOPE/DELIVERABLES

7.11.3.1 Scope / Deliverables

The Collaboration will contribute to the prevention NP which will:

- increase the proportion of adults and children with healthy body weight, reduce rates of obesity and avert new cases of diabetes in adults each year;
- increase the proportion of children and adults meeting national guidelines for physical activity and healthy eating; and
- reduce the proportion of adults smoking daily, averting premature deaths and ameliorating costs.

In contributing to the Prevention NP, the Collaboration will take a long term approach to the promotion, prevention and early intervention for eating disorders. It will:

- analyse information currently available to young people and their families on the prevention and management of eating disorders and healthy eating;
- undertake work to ensure a consistent and national approach to the promotion, prevention, early intervention and management of eating disorders; and
- develop and implement a comprehensive national strategy to communicate appropriate evidence based messages to schools, the media and health service providers.

The required outputs for the Collaboration are listed in Table 3.1.

Table 3.1. Definition of deliverables in/out of scope

Deliverables within the scope of this measure	Deliverables/activities beyond the scope of this measure
1. Develop a national evidence-based framework for eating disorders, informed by analysis of existing resources, approaches and their evidence base and identifying further work that needs to be undertaken to ensure a consistent and national approach to eating disorders. 2. Build a collaboration of experts and key stakeholders in the field of eating disorders, including delivery of national workshops to build inter-sectoral and interdisciplinary coordination and evidence sharing on eating disorders. 3. Develop and implement a comprehensive national strategy to communicate appropriate evidence based messages to schools, the media and health service providers. 4. Evaluation of the project (as outlined in 7.11.1.3).	Direct delivery or funding of services to people affected by eating disorders. Direct funding of research .

7.11.3.2 Assumptions / Dependencies

The Office for Youth, within the Department of Education, Employment and Workplace Relations will continue to take carriage of body image issues, including the development of a voluntary industry code of conduct on body image.

7.11.4 IMPLEMENTATION SCHEDULE

Table 4.1 outlines the schedule of implementation milestones from July 2009 to June 2013.

Table 4.1. Schedule of implementation milestones

	Milestones			
Date	**Output 1: Evidence-based framework**	**Output 2: Collaboration of experts**	**Output 3: Communication strategy**	**Output 4: Evaluation**
Year 1 – July 2009 to June 2010	• Environmental scan of similar activities currently being undertaken in Australia and overseas (Quarter 1 and 2) Findings to inform the development of outputs 2, 3 and 4 • Draft an evidence based framework (Quarter 3 and 4) • Consultations with jurisdictions on draft evidence-based framework (Quarter 4) ***Milestone: December 2009*** • Environmental scan completed	• Define scope for collaboration (informed by environmental scan) (Quarter 2) • Manage open process for selection of lead organisation (Quarter 3) ***Milestone: March 2010*** • Lead organisation announced • Work with lead organisation to develop process for inviting participation in Collaboration (Quarter 4) • Collaboration arrangements completed and list of agreed key stakeholders finalised (Quarter 4) • Development of governance structure for collaboration (Quarter 3 and 4 - informed by environmental scan) ***Milestone: June 2010*** • Governance structure agreed	• Work with lead organisation to analyse existing communication tools such as websites, resources and publications commenced (Quarter 3 and 4) • Analysis of evidence and development of key messages • Development of processes for jurisdictional engagement (Quarter 2 and 3) • Development of an extensive communication strategy commenced (Quarters 3 and 4) ***Milestone: June 2010*** • Development of communication strategy completed	• Development of Evaluation framework (Quarter 3 and 4) ***Milestone: March 2010*** • Development of evaluation framework completed
Year 2 – July 2010 to June 2011	• Development of strategy to respond to gaps and enhance current approaches (All year) • Appropriate professional and jurisdictional endorsements sought (Quarters 2 and 3) ***Milestone: June 2011*** • Strategy to enhance current approaches completed	• Development of national consultation process (Quarter 1) • Consultations with key stakeholders to determine priority areas for action and develop work plan (Quarter 2) • Ongoing evaluation of collaboration members' participation and satisfaction (All year) ***Milestone: December 2010*** • Priority areas for action identified and Collaboration work plan agreed	• Implementation of communication strategy commenced (Quarter 1) • Ongoing implementation of communication strategy (Quarters 2, 3 and 4)	• Evaluation commenced (Quarter 1) • Ongoing evaluation (Quarters 2, 3 and 4)

	Milestones			
Date	**Output 1: Evidence-based framework**	**Output 2: Collaboration of experts**	**Output 3: Communication strategy**	**Output 4: Evaluation**
Year 3 – July 2011 to June 2012	• Implementation of strategy to enhance current approaches (all year)	• Ongoing evaluation of collaboration members' participation and satisfaction (All year) • Findings to inform the development of output 4	• Ongoing implementation of communication strategy (All year) ***Milestone: September 2011*** • Launch of major promotion, prevention and early intervention resources	• Ongoing evaluation (All year)
Year 4 – July 2012 to June 2013	• Ongoing implementation of strategies to improve current approaches (Quarters 1 and 2) ***Milestone: May 2013*** • Implementation of improvement strategies completed	• Ongoing evaluation of collaboration members' participation and satisfaction (All year) • Development of strategy for ongoing collaboration (All year) ***Milestone: June 2013*** • Completion of Collaboration and report on findings completed	• Ongoing implementation of communication strategy (All year) ***Milestone: May 2013*** • Implementation of communication strategy completed	• Ongoing evaluation (Quarters 1 and 2) ***Milestone: June 2013*** • Evaluation completed

7.11.5 WORK BREAKDOWN STRUCTURE

Officers of the Mental Health and Suicide Prevention Programs Branch work closely with the organisation funded to manage the Collaboration. The Branch maintains an operational work plan that sets out lower-level activities and task allocations in the workplace. This work plan is reviewed on a regular basis.

7.11.6 RESOURCES

7.11.6.1 Budget

This measure is to be funded as part of the 2009-10 Budget. At the time of Budget, the resourcing allocation was as follows, as identified in the same year's Portfolio Budget Statements.

Table 6.1 Eating Disorders Collaboration Budget

Initiative	**2009-10 $m**	**2010-11 $m**	**2011-12 $m**	**2012-13 $m**	**TOTAL $m**
National Eating Disorders Collaboration	0.5	0.5	1.0	1.0	3.0
TOTAL	**0.5**	**0.5**	**1.0**	**1.0**	**3.0**

The Mental Health and Suicide Prevention Programs Branch maintains a budgeting tool allocating administered and departmental funds for this measure to resources required. This information is not included here.

7.11.6.2 Non-financial resources

The Commonwealth will contribute non-financial resources including ASL, legal services and contracting arrangements as required.

7.11.7 RISK MANAGEMENT

A risk management plan will be developed for this measure during the development of the funding process. This risk management plan will be informed by the outcomes of the 2009 collaboration.

Feedback from the Senior Executive indicates that a productive collaboration between a large number of stakeholders with varying expectations and interests requires significant Departmental investment in time and resources to ensure adequate monitoring and management of the collaboration.

As the funded organisation will be expected to collaborate with a wide range of organisations and establish a steering committee, the Department will ensure that the governance and roles and responsibilities of the lead agency and partner organisations are articulated clearly in the funding agreement and monitored closely during the funding period.

The funded organisation will also be expected to provide evidence of collaboration, communication protocols, and develop clearance processes for resources and reports as part of its deliverables.

The risk management plan is expected to include the following risks and control strategies:

Table 7.1. Risk identification and control

Risk	Risk rating	Origin/cause/source of risk and trigger point for deploying strategies	Risk mitigation/control strategies
Project deliverables are not delivered on time	Medium (Consequence Minor, Likelihood Possible)	• Competing deadlines • Working with small organisations with limited capacity	1. Departmental participation on steering committee 2. Schedule of funding agreement will detail the deliverables and milestones 3. Regular meetings with project managers 4. Funding payments to be linked to deliverables
Governance of the collaboration experiences difficulties	Medium (Consequence Moderate, Likelihood Possible)	• Key eating disorders members do not participate or withdraw • The members of the Collaboration experience difficulty in working together to produce outcomes	1. The funding agreement will specify governance of the project and roles and responsibilities of groups established within the collaboration 2. The funding agreement will detail 'dispute resolution' protocol 3. Evaluation to regularly monitor Collaboration members' satisfaction and participation

7.11.8 STAKEHOLDER MANAGEMENT

The Collaboration by definition is an inclusive group of key stakeholders and experts with an interest in eating disorders and related mental health, health promotion, media and educational issues.

The sector has already self-organised in late 2008 with the creation of the Eating Disorders Australian National Network which already engages over 50 such stakeholders.

The lead agency, once selected, will be required to take an inclusive approach and a list of key stakeholders will be provided who they must formally invite.

Conflict resolution processes will be established by the lead agency (in consultation with the Commonwealth).

7.11.9 QUALITY ASSURANCE

Periodic liaison meetings are planned between the Mental Health and Suicide Prevention Programs Branch, Healthy Living Branch, Population Health Strategy Unit and the Office for Youth in the Department of Education, Employment and Workplace Relations to coordinate the relationships between obesity, healthy eating, body image and eating disorders initiatives.

A range of quality assurance activities will be utilised including:

- regular (quarterly) progress reporting to the prevention NP Implementation Working Group, including updates on progress towards milestones and financial expenditure monitoring;
- regular reporting to the Minister for Health and Ageing; and
- annual reporting to COAG as stipulated in the prevention NP Agreement.

In addition, it is expected that a departmental officer will attend most steering committee meetings in the initial stages.

APPENDIX A: MAXIMUM STATE AND TERRITORY FUNDING TRANSFER

	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	Total
	$m	$m	$m	$m	$m	$m	$m
New South Wales							
Healthy children							
State/territory interventions			10.662	21.324	31.986	42.965	106.937
Healthy workers							
State/territory workplace programs			10.680	19.904	28.047	33.455	92.085
Social marketing							
MeasureUP Local level activities		1.959	1.959	1.959			5.876
Enabling infrastructure							
State/territory CATIs	0.816	0.816	0.816	0.816			3.265
	0.816	**2.775**	**24.116**	**44.003**	**60.032**	**76.421**	**208.163**
Victoria							
Healthy children							
State/territory interventions			7.826	15.652	23.478	31.537	78.494
Healthy workers							
State/territory workplace programs			8.255	15.385	21.680	25.860	71.180
Social marketing							
MeasureUP Local level activities		1.487	1.487	1.487			4.461
Enabling infrastructure							
State/territory CATIs	0.620	0.620	0.620	0.620			2.479
	0.620	**2.107**	**18.188**	**33.144**	**45.158**	**57.398**	**156.614**
Queensland							
Healthy children							
State/territory interventions			6.648	13.297	19.945	26.792	66.682
Healthy workers							
State/territory workplace programs			6.885	12.831	18.081	21.568	59.365
Social marketing							
MeasureUP Local level activities		1.199	1.199	1.199			3.598
Enabling infrastructure							
State/territory CATIs	0.500	0.500	0.500	0.500			1.999
	0.500	**1.699**	**15.232**	**27.827**	**38.026**	**48.360**	**131.644**
Western Australia							
Healthy children							
State/territory interventions			3.301	6.602	9.904	13.303	33.110
Healthy workers							
State/territory workplace programs			3.608	6.724	9.475	11.302	31.109
Social marketing							
MeasureUP Local level activities		0.606	0.606	0.606			1.818
Enabling infrastructure							
State/territory CATIs	0.252	0.252	0.252	0.252			1.010
	0.252	**0.858**	**7.767**	**14.185**	**19.378**	**24.605**	**67.047**
South Australia							
Healthy children							
State/territory interventions			2.316	4.633	6.949	9.334	23.232
Healthy workers							
State/territory workplace programs			2.452	4.569	6.439	7.680	21.140
Social marketing							
MeasureUP Local level activities		0.451	0.451	0.451			1.352
Enabling infrastructure							
State/territory CATIs	0.188	0.188	0.188	0.188			0.751

	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	Total
	$m	$m	$m	$m	$m	$m	$m
	0.188	0.638	5.406	9.840	13.387	17.014	46.474

	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	Total
	$m	$m	$m	$m	$m	$m	$m
Tasmania							
Healthy children							
State/territory interventions			0.786	1.573	2.359	3.169	7.887
Healthy workers							
State/territory workplace programs			0.738	1.375	1.938	2.312	6.364
Social marketing							
MeasureUP Local level activities		0.140	0.140	0.140			0.421
Enabling infrastructure							
State/territory CATIs	0.058	0.058	0.058	0.058			0.234
Total excluding STI / BBV	**0.058**	**0.199**	**1.723**	**3.147**	**4.297**	**5.481**	**14.905**
Northern Territory							
Healthy children							
State/territory interventions			0.407	0.813	1.220	1.638	4.078
Healthy workers							
State/territory workplace programs			0.347	0.646	0.911	1.086	2.990
Social marketing							
MeasureUP Local level activities		0.062	0.062	0.062			0.185
Enabling infrastructure							
State/territory CATIs	0.026	0.026	0.026	0.026			0.103
	0.026	**0.087**	**0.841**	**1.547**	**2.130**	**2.725**	**7.355**
Australian Capital Territory							
Healthy children							
State/territory interventions			0.509	1.018	1.527	2.052	5.106
Healthy workers							
State/territory workplace programs			0.602	1.122	1.581	1.885	5.190
Social marketing							
MeasureUP Local level activities		0.097	0.097	0.097			0.290
Enabling infrastructure							
State/territory CATIs	0.040	0.040	0.040	0.040			0.161
	0.040	**0.137**	**1.248**	**2.277**	**3.108**	**3.937**	**10.747**

APPENDIX B: NATIONAL PARTNERSHIP AGREEMENT ON PREVENTIVE HEALTH