ACT Government

ACT Preventive Health Plan Mid-Term Review

Final Report

December 2022

Policy Design and Evaluation Team

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ACT Government

We wish to acknowledge the Traditional Custodians of the ACT, the Ngunnawal People. We wish to acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.

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Executive Summary

The *Healthy Canberra: ACT Preventive Health Plan 2020-25* ('the Plan') aims primarily at the prevention of chronic ill-health and diseases such as cardiovascular disease, diabetes, back pain, and cancer in the ACT. Half of all Canberrans live with a long-term health condition.

The Evaluation Framework for the Plan noted the challenges with evaluating prevention efforts in the ACT, including small sample size, long time lags between interventions and the realisation of associated benefits, and factors outside the control of the ACT Government.

As a result, the Evaluation Framework proposed a staged, two-tiered evaluation structure commencing with this Mid-Term Review ('the Review'), which focuses primarily on actions and processes underpinning the whole-of-government approach to the Plan.

The second stage of the evaluation effort will involve a rolling series of evaluations exploring the impact of actions on health outcomes across the Plan's five Priority Areas, and a final evaluation at the end of the Plan's term in 2025.

During the first half of 2022 the Review team commissioned a community survey, carried out rapid literature and document reviews, and completed an internal survey and interviews of cross-government stakeholders to inform a Social Network Analysis (SNA).

Important context

The Plan was launched in November 2019, just weeks before bushfire smoke, a serious hailstorm, and COVID-19 hit Canberra. ACT Government effort was redirected to deal with these emergencies, with many staff members assisting with the public health response.

At the time, health staff including Senior Executives were also still working through some of the implications of the restructure which had only recently created the two separate organisations, the ACT Health Directorate (ACTHD) and Canberra Health Services (CHS).

These factors were outside the Plan's control but played an important role in limiting the visibility and impact which the Plan was able to generate at an organisational level.

Strong community support for prevention

The community survey conducted for this Review revealed that preventing illness ranks alongside treating illness as a top policy issue that is "very important" to Canberrans, ahead even of the cost of living, crime and safety, climate change, and unemployment.

More than 9 out of 10 Canberrans surveyed agreed with significantly increasing expenditure on prevention and supported more than doubling it to *at least* 5 per cent of the health budget.

When asked about actions that the ACT Government could take for prevention, Canberrans put working with health professionals such as GPs to deliver specific prevention projects (e.g., Heart Health Checks) at the top of the list.

Protecting our environment (e.g., air quality), planning the city with future health in mind (e.g., green spaces), and investing in infrastructure related to prevention (e.g., bike paths) were the next three actions deemed most important by community members.

Canberrans are less supportive of government action that impacts on their personal choices, such as restricting access to unhealthy food and drink – they feel that individuals are responsible for prevention as much as governments.

Governance

With the Plan's release in late 2019 and many Health staff moving to support the pandemic response, it took two years to finalise the formal governance of the Plan.

Governance arrangements which had been established for the Plan's 'precursors', the *Healthy Weight Initiative* and the *Healthy and Active Living Strategy*, included significant external input, but this was not rolled over into the Plan, and previous momentum was lost.

The governance arrangements which have now been formalised do not require routine external input or oversight, limiting the voice experts, the community, and peak bodies have in shaping the Plan.

This Review recommends that an external engagement plan be developed to support the next phase of the Plan's implementation. Reinvigorated engagement should strengthen the sense of a shared agenda and reaffirm the shared aspiration between key partners.

Such engagement would also support the readiness of the system to work more ambitiously on a systems-level collaborative response and help identify high-leverage activities that could be undertaken. Achieving a shared vision and effective *collective governance* for the Plan is a key goal for the Plan going forward.

Finally, the Review notes that the Plan's Project Team did an excellent job supporting the Plan's governance with limited resources and under difficult circumstances.

Collaboration

The Social Network Analysis (SNA) and internal survey undertaken for this Review confirmed that there is active and strong collaboration occurring in the delivery of the Plan, particularly within Directorates and at a person-to-person level.

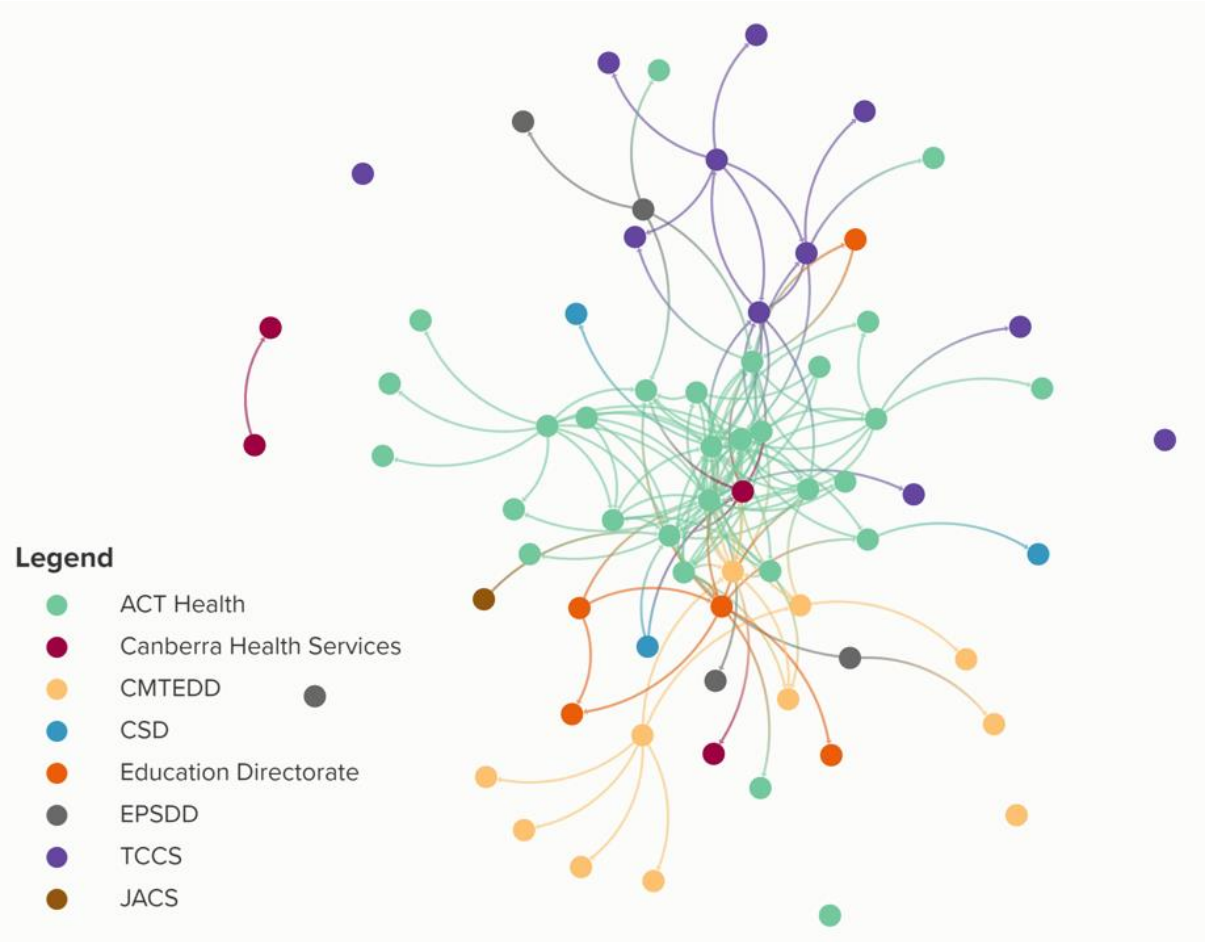
As the social network map in Figure ES1 demonstrates, there are many pathways around the network, indicating there is little risk of key person dependency; however, most paths connecting different actors on the map go via ACTHD, which is central to the Plan.

ACTHD staff also have the highest number of 'incoming' connections. This is likely reflective of people 'coming to' ACTHD staff for information, advice, or reporting. This means that there is an *organisational* dependency on ACTHD.

While ACTHD staff have more visibility of what is happening across the network, the small number of connections identified between ACTHD and CHS may point to a gap across Health and should be further investigated.

Overall, while the internal survey and SNA show collaboration is occurring, it appears to be largely within or driven by ACTHD, with relatively little occurring outside of these interactions (i.e., limited collaboration on prevention *across* non-Health directorates.

Figure ES1 – Social network map for the Plan



Stakeholder opinion

Interviews of 14 stakeholders, the majority from non-Health directorates, revealed that there was strong agreement that the Plan is evidence-based and presents a clear vision. A majority of interviewees also agreed that it is appropriately focused (see Diagram ES2).

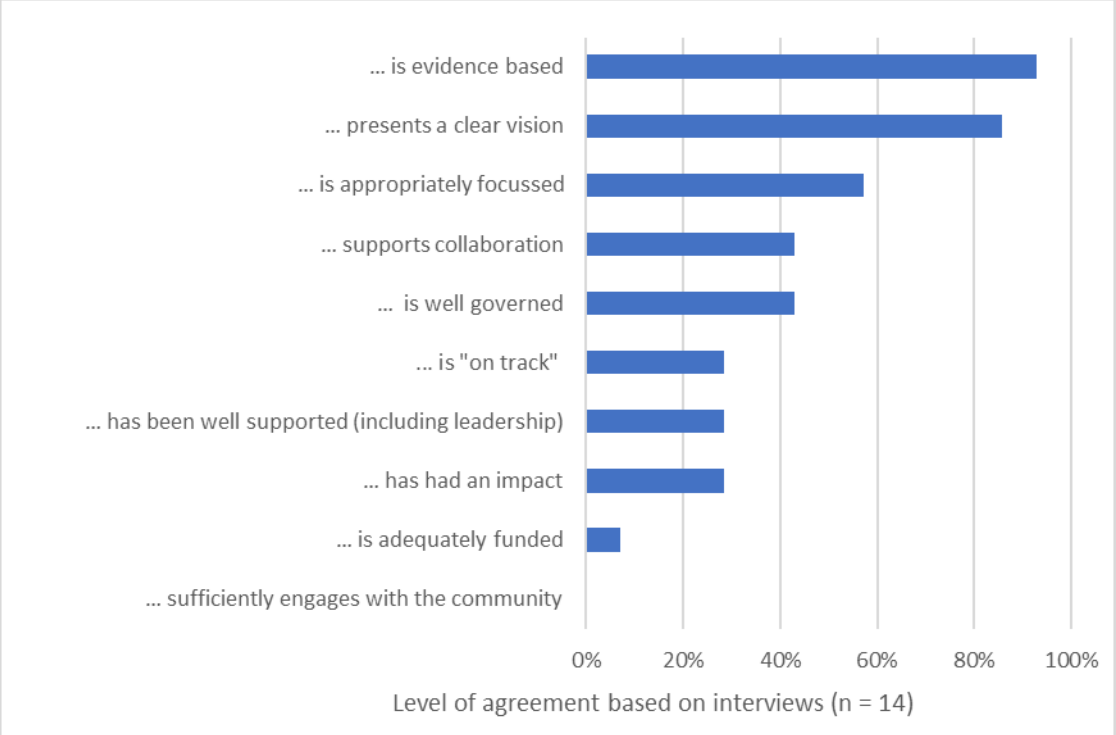
The level of agreement with other statements about the Plan was lower, particularly that the Plan is "on track", that it had been well supported, or that it has had an impact (only 4 out of 14 interviewees agreed to each of these). None of the interviewees thought it sufficiently engages with the community.

Among the stakeholders who could comment on the genesis of the Plan during 2019, there was a feeling that it was developed rapidly, resulting in existing rather than new initiatives being included in the Plan.

Several interviewees from other directorates also noted that while the overarching governance of the Plan had now been formalised, further work on governance needed to occur within their respective line areas to address the Plan.

Stakeholders generally disliked the expression "preventive health" itself, noting it is difficult to comprehend to the non-expert and hinders broader communication of the Plan.

Figure ES2 – The Preventive Health Plan …



The impact of the Plan

As already noted, the evaluation of the Plan's impacts on health outcomes is set to occur over the next three years under the associated Evaluation Framework. It has also been noted that the Plan itself did not fund any new initiatives at the time of its launch.

At this stage, the following positive impacts of the Plan can however be noted:

> It has kept prevention on the government agenda (including through this Review),
> It provides a useful point of reference for staff especially in non-Health directorates, and
> It supports collaboration through the PHP Project Team, including in evaluation.

Achievements in prevention are always a type of *collective impact* – at the local, national, and international levels, and the Plan has played a supporting role in this.

The work undertaken for the Review indicates that highly cost-effective prevention interventions are available and could yield significant additional health and wellbeing benefits to Canberrans:

> This includes media campaigns, potential actions such as a collaboration on CVD prevention in the ACT (one of the World Health Organisation's *Best Buys*), and a range of other potentially cost-effective interventions (e.g., in mental health and other areas).

Next steps and recommendations

In summary, eight key recommendations have been identified in this Review:

1. Strengthen the backbone of the Plan through increasing capability in data, research, epidemiology, evaluation, health economic work, and project cost funding to drive preventive health action in the ACT,
2. Identify opportunities to improve collaboration across government to support delivery and evaluation of the Plan, in particular between ACT Health and Canberra Health Services and potentially those individuals identified on the periphery of the SNA,
3. In line with the Evaluation Framework, conduct a series of evaluation exercises linked to the Program Logics developed by ACTHD to better understand how specific programs and projects link to outcomes,
4. Develop an external engagement plan to support the next phase of the Plan's implementation through strengthening the sense of a shared agenda and reaffirming the shared aspiration between key partners.
5. Continue using media campaigns to promote preventive health and increase awareness of the prevalence of chronic disease in the ACT,
6. Increase emphasis on early detection and secondary prevention in the Plan to achieve better recognition,
7. Consider actions for the Second Three Year Action Plan that address potential high visibility, high leverage and high impact chronic condition opportunities, and
8. Continue to address inequality as a major contributor to chronic illnesses.

A 'sense-making' workshop is also recommended to follow up on the findings of this Review.

Introduction

The ACT Government's *Healthy Canberra: Preventive Health Plan* ('the Plan') is a whole-of-government plan covering the six-year period from 2020-25, launched at the end of 2019.[1] The first of the two associated three-year Action Plans was launched at the same time.[2]

The Plan follows up on a commitment made in the 2016 Parliamentary Agreement for the 9th Legislative Assembly to reduce the incidence of heart disease, diabetes, obesity and other preventable health conditions in the ACT.

The intention at the time was to expand and refocus what was then known as the *Healthy Weight Initiative*, appoint a Preventive Health Coordinator, and to develop a comprehensive preventive health strategy, initially known as the *Healthy and Active Living* (HAL) Strategy.

A series of stakeholder reference group meetings and public workshops were held in 2017 and 2018 to inform the development of the HAL Strategy. These highlighted the need for a community-wide approach to prevention, including recognition of the range of influences and social determinants that contribute to the health and wellbeing of Canberrans.

This subsequently fed into the decision by the Chief Minister and then Minister for Health and Wellbeing to develop a set of Wellbeing Indicators, to measure and report on the wellbeing of Canberrans.

The focus on preventive health through the development of the Plan by the ACT Health Directorate (ACTHD) was intended to complement the work on the Wellbeing Indicators taken on by the Chief Minister, Treasury and Economic Development Directorate (CMTEDD).

Much of the groundwork that had been laid by the HAL Strategy is reflected in the Plan as launched in November 2019. It is important to note that when the Plan was launched, all of its associated actions were already funded – in other words, the Plan itself did not require any new expenditure.

The Plan aims to support all Canberrans to be healthy and active at every stage of life. The Plan sets a framework for coordinated, government-led action and a platform for broader community engagement across five Priority Areas (further discussed later in this Review):

a) Supporting children and families,
b) Enabling active living,
c) Increasing healthy eating,
d) Reducing risky behaviours, and
e) Promoting healthy ageing.

The community and stakeholder feedback obtained during the HAL consultations held in 2017-18 and the Wellbeing Indicators project in 2019 helped to inform the choice of these Priority Areas.

The Plan forms the cornerstone of the ACT's local-level response to national strategies, including the *National Obesity Strategy* and *National Preventive Health Strategy*.

The Health Minister's Foreword to the Plan included a strong commitment to evaluation:

> *It will be important to know that what we deliver under the Plan is making a difference. An evaluation framework will therefore be developed to measure our success and, where needed, identify opportunities to recalibrate our efforts.*[1]

The Policy Design and Evaluation (PDE) team at CMTEDD collaborated with the Preventive Health Plan (PHP) Project Team over the last two years to develop the Evaluation Framework for the Plan.

Evaluation Framework

A series of planning discussions, scoping papers, concept notes and briefings informed the development of the Evaluation Framework, which was agreed by the Health Minister Rachel Stephen-Smith on 3 November 2021 and included a commitment to this Review.

The Evaluation Framework established the principles and goals of evaluation activity. It also outlined the Plan's governance structure, data requirements, key evaluation questions, and proposed a process to develop program logics and success measures.

It is worth noting that this Review represents the first collaborative cross-government evaluation exercise for a whole-of-government plan since the launch of the ACT Wellbeing Framework in March 2020.[3]

As part of the ongoing collaboration between ACTHD and CMTEDD, the PDE team remains involved with the evaluation effort, currently chairing the Plan's cross-directorate Expert Evaluation Working Group (EEWG) which endorsed the approach to this Review.

The Plan's Evaluation Framework includes a two-tiered approach to evaluation:

- This Review represents the first tier (Level 1) evaluation which is focused on the whole-of-government approach to the Plan, and
- The second tier (Level 2) of the Evaluation Framework evaluates the implementation and impact of the actions across each of the Priority Areas in the short, medium, and long term.

Approach to the Mid-Term Review

The approach to this Review is a systems level evaluation with much of the focus on government process at a higher level, dealing with questions such as:

- 'How did we collaborate?'
- 'How was the Plan governed?'
- 'Did we resource the Plan appropriately?'
- 'Is the plan relevant to government and community priorities?'.

The Review is neither a formal process evaluation nor a formal impact evaluation. The ultimate impacts of successful prevention tend to accrue over a much longer term and are difficult to measure – tying specific impacts to initiatives is even more difficult.

It is reasonable to assume the Plan has a better chance of having an impact if government processes are appropriate, effective, and efficient. This Review examines those processes and will be followed by a rolling series of evaluations at the Priority Area level, and a final impact evaluation at the end of the Plan's term.

While the Review is also not a formal implementation evaluation, several of the questions posed (and responses received) touched upon a range implementation-related issues.

In sum, the approach taken in this Review is to probe a range of relevant issues, including with regard to process, implementation, and outcomes.

The approach was refined in consultation with the PHP Project Team and the EEWG. Most of the activity – interviews and collection of data – occurred between February and June 2022.

In addition to desktop research including rapid literature reviews and a small number of interviews with external experts, there were four major components to the Review:

- ***Document analysis*** including thematic analysis and sentiment analysis with a focus on internal and cross-government governance arrangements,
- ***A cross-government stakeholder survey*** (including Social Network Analysis) to assess collaboration across the government system in relation to PHP actions and to assess the effectiveness of interactions,
- ***A community Survey*** (review of community attitudes towards PHP actions), and
- ***Stakeholder interviews across government*** (in-depth assessment of PHP-related topics and issues).

Collectively, these components deliver insights into *process* as well as the overarching questions around appropriateness, governance, and resourcing, amongst other issues.

The initial design of the survey instruments was undertaken by the PDE team, as was the development of the interview protocol. Refinements were agreed in consultation with EEWG and the external partners who delivered the community survey (Pollinate Pty Ltd).

For the Social Network Analysis (SNA), external advice was provided by Matthew Healey of First Person Consulting (FPC). He assisted the Review team with the initial design of the SNA but also provided an independent, external peer review of the implementation of the SNA, its results, and their analysis.

The Review team consisted of Dr Jasmin Kientzel, who has technical expertise in survey design and analysis, and Raoul Craemer, who has relevant prior experience as a health economist.

Over the last two years, the Review team has carried out a number of health-related evaluations within the ACT Government setting, including the Mid-Term Review of the

Office for Mental Health and Wellbeing, the Nurses and Midwives: Towards a Safer Culture (TASC) Strategy Evaluation, and the associated Safewards Model of Care Post-Implementation Review.

Issues in prevention

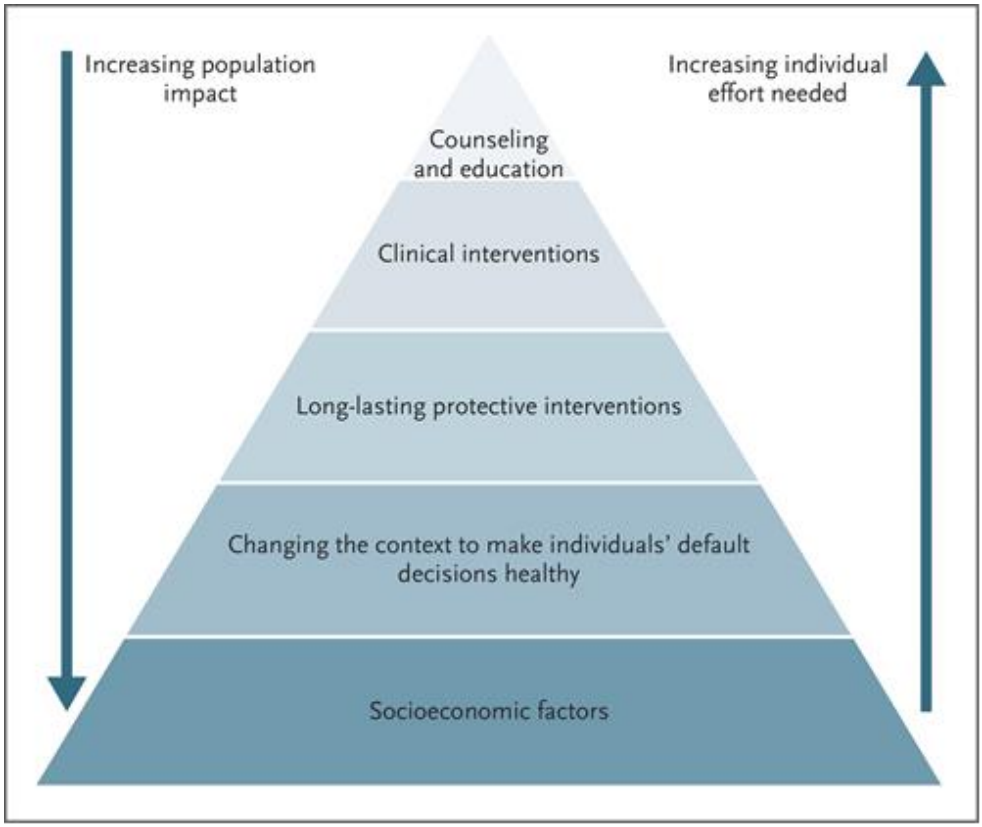
Chronic disease is responsible for 83 per cent of all premature deaths in Australia and 66 per cent of the burden of disease, making it our nation's greatest preventive health challenge.[4]

The update of the Australian Burden of Disease Study published by the Australian Institute of Health and Welfare (AIHW) in late 2021 confirmed previous findings that chronic diseases such as cancer, musculoskeletal conditions, cardiovascular diseases, and mental and substance use disorders contributed the most burden in Australia.[5]

In addition, and importantly for this Review, the AIHW also found that 38 per cent of the burden could have been avoided or reduced as it was due to so-called modifiable risk factors such as tobacco use and overweight (including obesity).[5]

The AIHW's report found that coronary heart disease, back pain, dementia, chronic obstructive pulmonary disease (COPD), and lung cancer were the top five diseases causing burden of disease in Australia.

Figure 1 – The public health pyramid



The public health pyramid

The old adage that "prevention is better than cure" is often repeated in public policy discussions. There is a vast body of literature on the prevention of disease in particular, which cannot be summarised here.

> A word search on "cost-effectiveness of prevention" for the years 2021 and 2022 alone yielded 122 academic papers on PubMed (National Library of Medicine).

Source: Frieden (2015).[6]

Prevention policy operates on multiple fronts. From primordial to quaternary prevention, it seeks the avoidance or control of chronic conditions and infectious diseases, with differing aetiologies and a broad range of risk factors:

> Primordial prevention focuses on the wider environment and conditions that affect health in general,
> Primary prevention deals with addressing known risk factors for specific diseases to stop them occurring (e.g., behaviour-related interventions),
> Secondary prevention focuses on early detection and best practice management of disease to minimise its impact once it has occurred,
> Tertiary prevention seeks to reduce harms in people who have a disease that has progressed beyond the initial stages (e.g., avoid complications or manage comorbidities), and
> Quaternary prevention focuses on reducing harms *caused* by medical interventions.[7]

The policy frame covers individual and social determinants, stretches across an array of solutions and technologies, incorporates policy levers including taxation and regulation, and interfaces with housing, education, planning, and justice-related policies, among others.

The broader context and key issues that are relevant to this Review are also summarised in the National Preventive Health Strategy which was released last year.[7] These include:

> The role of prevention in the health system, including the role it can play in reorienting it from an "illness system" to a "wellness system",
> Strong evidence of cost-effectiveness for many preventive health interventions,
> A recognition that the root causes of poor health often lie outside the health system and are beyond the control of individuals, making this a collective responsibility,
> An acknowledgment that groups within society experience a disproportionate burden of disease, and there is no 'one size fits all' approach,
> The importance of the public health workforce as highlighted by COVID-19, and its role in prevention *as well as* managing public health emergencies,
> The need for planning, partnerships and linkages (including efficient referral pathways), so that coordinated care addresses the social and economic influences on health and wellbeing, and

- Understanding that Australia is already an international leader in many areas of prevention, notably tobacco control, the response to the HIV epidemic, skin cancer prevention, road safety, cancer screening, and immunisation, but that:
  - Success comes from sustained and coordinated action,
  - To have real impact, prevention needs to be financed,
  - Healthy environments support healthy living, and
  - Data, research, and evidence are important drivers.[7]

Social and other determinants

Socioeconomic inequalities in health continue to be significant in Australia. An example of this is the number of years Australians can expect to live in good health. The AIHW recently reported disparities in Health-adjusted life expectancy (HALE) by socioeconomic group:

- In 2018, the least disadvantaged socioeconomic group expected, at birth, to live more healthy years (75.4 for males and 77.3 for females) than those in the most disadvantaged socioeconomic group (68.6 for males and 71.4 for females).
- Also noteworthy was that the proportion of life expectancy at age 65 spent in full health remained largely the same for those in the highest socioeconomic group and declined for those in the lowest socioeconomic group during the period 2011 to 2018.[5]

The social determinants of health have become a major focus in prevention policy. When the National Preventive Health Strategy was being developed, for example, an influential think tank noted in its response to a Consultation Paper that:

> *…the wording "Individuals will be enabled to make the best possible decisions about their health" implies that people are able to make health decisions in the first place… Aboriginal and Torres Strait Islander peoples are often not able to 'make decisions' that lead to good health due to social and cultural determinants such as access to housing, transport, employment, healthcare, food, and because of racism, disconnection from culture and policies grounded in colonial thinking.*[8]

This raises the question of what can be done in practice to change the wider system in support of prevention. While Australia has a progressive income tax system, major redistribution of wealth or fundamental reform of the welfare state is currently not seriously on the policy agenda (e.g., death taxes, universal basic income, reparations).

Such high-level policy levers are typically also outside the remit of the ACT Government. Similarly, ACT Government cannot intervene with targeted interventions such as a "sugar tax" (tax on sugary drinks) and has limited powers to change food labelling standards (Food Standards Code) or to regulate food formulation (salt content in processed foods, etc.).

To address the social and economic determinants of health, however, the ACT Government has other policy options including:

- Investing in public housing and improving the quality of the housing stock,

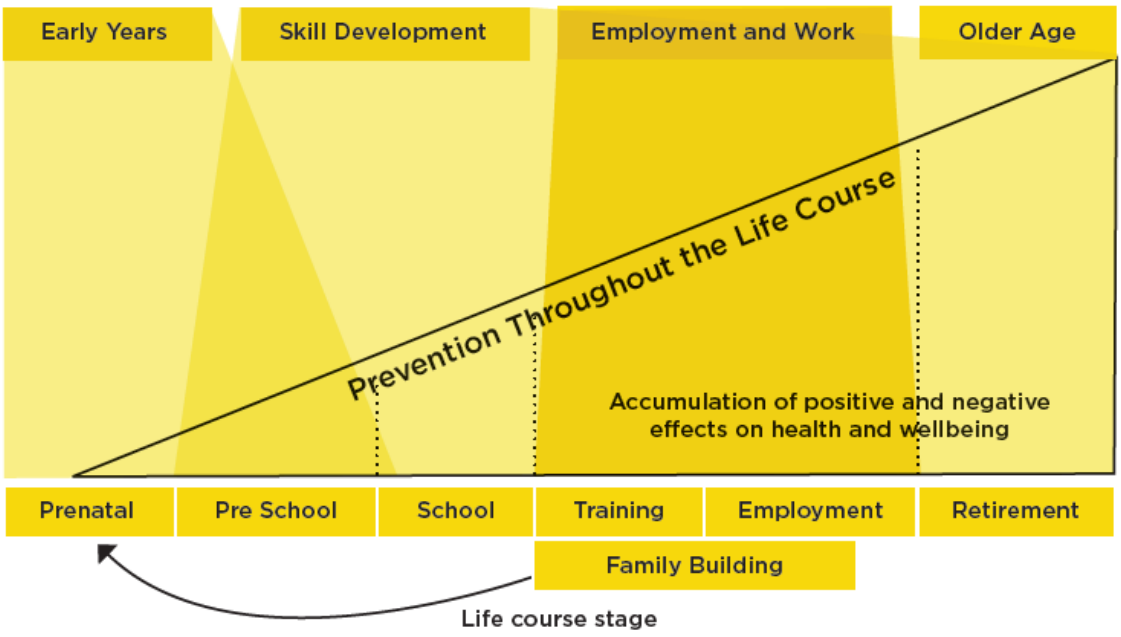
- Expanding access to free early childhood education and subsidising access to childcare,
- Targeted interventions to support vulnerable groups,
- Training in cultural awareness and recognising unconscious bias,
- Free travel to school and potentially wider subsidy of public transport,
- Choices relating to billboards and advertising,
- Subsidised apprenticeships, etc.

Much of this aligns with existing policy platforms and the Parliamentary and Governance Agreement (PAGA) for the ACT's 10th Parliament;[9] but it should be noted that most of these types of policy interventions are not covered by the Plan.

The life course approach

Another way of looking at prevention which has become very influential in health policy is the life course approach. This approach highlights the positive and negative health impacts encountered through life, and notes the changing health needs as we age.[7]

Figure 2 – The life course approach



Source: National Preventive Health Strategy, adapted from the Marmot Review.[10]

The Plan states that adopting a life course approach means intervening at critical life stages to mitigate the causes, not the consequences, of ill health. This has brought additional focus, in particular, on interventions targeting the early years of life, from preconception and pregnancy through to childhood.

This approach also aligns with ACT Wellbeing Framework.[3] In the Health domain the stated aspiration of the ACT Wellbeing Framework is:

> *Canberrans have good physical and mental health at every stage of life and can access the services they need to lead healthier lives and manage illness. Individuals take steps to proactively maintain good health with the support of health-promoting environments.*[3]

There was significant interaction between the ACT Wellbeing Framework and the development of the ACT Preventive Health Plan.

A series of stakeholder engagement exercises undertaken during the development of the ACT Wellbeing Framework influenced the selection and description of the five Priority Areas under the Plan discussed later in this Introduction.

In the public health policy context, Duckett and Wilcox have previously argued that the public health focus on the "three Ps" (protection, prevention, and promotion) is at risk of being displaced by a strong focus on personal responsibility.[11]

The approach embedded in the ACT Wellbeing Framework can play a positive role in counteracting this tendency in the ACT.

Loneliness and disconnection

The emphasis on personal responsibility (e.g., use of health apps, etc.) mirrors the atomisation of society itself, which is a long-term trend in advanced industrialised countries. Cultural atomisation and a disconnect from nature are related processes.

Starting with the rise of the nuclear family this trend has increasingly led to social isolation and is reflected in the ACT in a rising number and rising share of lone person households – an additional 13,000 or so between the 2011 and 2021 Censuses, meaning that the share of lone person households now exceeds one in four in the ACT (43,338 out of 168,400).

Although social isolation differs from loneliness, a recent *Lancet Public Health* article which analysed risk factors for excess mortality in isolated and lonely individuals using UK Biobank cohort study data found that:

> *Isolated and lonely people are at increased risk of death. Health policies addressing risk factors such as adverse socioeconomic conditions, unhealthy lifestyle, and lower mental wellbeing might reduce excess mortality among the isolated and the lonely.*[12]

The increasing 'disconnection' of communities has a clear impact on the health and wellbeing of individuals and therefore has important consequences for prevention policy.

Community engagement and social connection interventions, which sit towards the broadest point of the public health pyramid discussed earlier, therefore have potential to deliver cost-effective interventions.

Innovations like social prescribing,[13,14] arts-for-health programs[15-17] or using nature as a community health tool[18-20] have potential to operate at this level, and could span activity across Directorates. Evidence on these types of programs is emerging.

The expanded chronic care model

V.J. Barr et al (2003) introduced the so-called Expanded Chronic Care Model, which integrated aspects of prevention and health promotion into the existing chronic care model.[21]

The model is still widely accepted as the universal best practice model for integrated chronic disease prevention and management.[22]

It recognises the importance of broadly based prevention efforts and the social determinants of health, and that enhanced community participation can also inform health professionals as they work to address chronic disease issues.

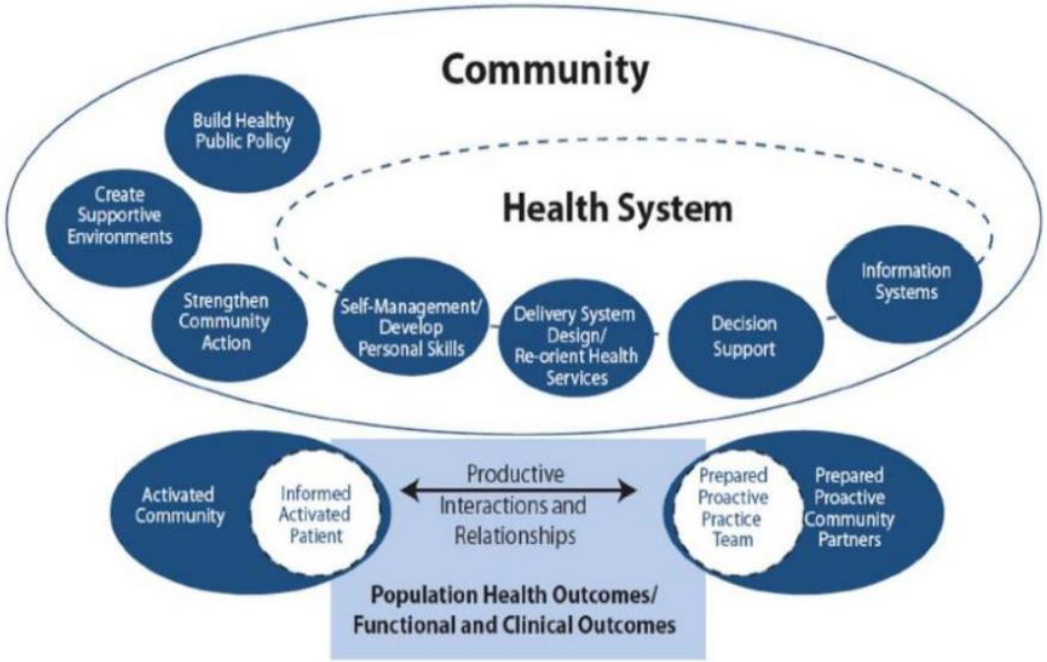
This model highlights the links between the health system and the community. It highlights opportunities to deeply embed prevention as part of routine health service delivery and implementation, including in primary health care, hospitals, and community health services.

There are particular opportunities in the hospital system, where clinicians can contribute to prevention, but where current systems (including charging systems), treatment protocols and practice may not allow, give time for, or incentivise them to engage with prevention.

By pursuing such an approach, the National Preventive Health Strategy for example notes it is likely that clinicians' professional satisfaction would increase; this has implications for workforce strategy, as this would:

> *…reduce the frustration that many doctors feel in being unable to address the underlying cause of many of the health problems they encounter among their patients.*[23]

Figure 3 – The Expanded Chronic Care Model



Source: Barr (2003).[21]

Valuing prevention

According to the US Centers for Disease Control and Prevention (usually referred to as "CDC"), prevention is the "best buy in the health sector".[24] In a similar vein, a recent paper by Blecher et al argues that:

> *COVID-19 reminds us that the greatest impact on public health is the prevention of disease through population health measures, and we should be focussing more on spending there, rather than just on more tertiary facilities.*[25]

The value of prevention is however not well or widely understood. A simple health economic analysis suggests that even in Canberra, where life expectancy and a range of health outcomes are generally good, incremental improvements are very valuable.

Consider a small change to a health state – say a one percentage point improvement in a person's health state. In the health economic literature this might be measured in quality-adjusted life years (QALYs) or disability-adjusted life years (DALYs):

- Using the 'value of a statistical life year' method, the Office of Best Practice Regulation's reference figure values a one percentage point change at $2,220 per person per year.[26]
- Applied to 450,000 residents in the ACT such a change would be valued at $1 billion per year.

Specific interventions would of course typically affect smaller subgroups of the population, and would apply to differing conditions or diseases:

- For such smaller groups, and for specific conditions, the change in health states that can be achieved is often significantly greater than the one percentage point used in the example above.
- Mild lower back pain has been associated with a two per cent 'disability weight' and moderate lower back pain with a 5-percentage point decrement; mild-to-moderate anxiety or depression are associated with decrements of 3 to 13 percentage points.[27]
    - As a more realistic example, therefore, if an intervention avoided (say) 300 cases of moderate lower back pain this would be valued at $3.3 million per year using the value of a statistical life year method, while an intervention that avoided 300 cases of moderate anxiety would be valued at $8.6 million per year.

The assumption here is that the benefits accrue soon after an intervention; however, as the costs of prevention are often incurred long before the benefits of the action accrue, the role of the discount rate must be considered.

The role of the discount rate

Where health interventions yield health benefits in the future, a discount rate is used in health economic analyses to reflect that a benefit received now is valued more than a similar benefit received in the future:

- With a seven per cent discount rate, a benefit received in ten years' time is equivalent in discounted terms to half of that benefit received now; for example, the discounted value of saving two lives in ten years' time becomes the same as one life saved now.
- With a zero per cent discount rate, a life saved now is valued the same as a life saved in ten years from now.

The choice of the discount rate used in assessing prevention projects is therefore significant, and this raises an important issue in prevention:

- Primordial (and often primary prevention) yields benefits that accrue many years after an intervention takes place; by comparison, secondary prevention has more immediate and measurable impacts, and
- The lower the discount rate that is applied, the better the more 'distal' or primordial interventions will fare in comparison to secondary prevention.

On balance, it would appear sensible that prevention policy takes a portfolio approach to investment, ensuring there is an appropriate mix of interventions that deliver prevention benefits both in the shorter term as well as the longer term.

Cost-effectiveness of prevention

A number of studies have examined the cost-effectiveness of prevention programs and interventions. The CDC's view that prevention is the "best buy" in the health sector has already been noted.

In Australia, the Assessing Cost Effectiveness (ACE) in Prevention Study (2010) was influential.[30] It covered 150 interventions and, at the time, was the largest and most rigorous evaluation of preventive strategies undertaken anywhere in the world.

Its main findings were that a *large impact* on population health could be achieved by a limited number of cost-effective interventions, namely:

- Taxation of tobacco, alcohol, and unhealthy foods,
- Mandatory limits on salt in bread, cereals, and margarine,
- Use of blood pressure- and cholesterol-lowering drugs (further detail in next section),
- Gastric banding for severe obesity, and
- An intensive SunSmart campaign.

The study found significant variations in cost-effectiveness, with many other interventions across a range of areas also found to be cost-effective. Overall, the majority of interventions in the ACE study (94 out of 150) were found to be cost-effective.

The key lesson of this and other literature on cost-effectiveness is however that it is important to assess each intervention on its merits and compare it to the alternative options available.

The Review found limited evidence that current ACT Government expenditure on prevention activity has been subjected to the type of evaluation that could establish the cost-effectiveness of specific interventions that have been supported in the ACT.

The ACT Health website provides some relevant information, such as the Report Card on the ACT Health Promotion Grants Program for the period 2013 to 2015, which provides useful data on the disbursal of around $2 million in grants per year, including commentary on impacts and early outcomes.

The website states that since 2013, 90% of grant funding has gone towards programs and projects that address overweight and obesity. An evaluation of the Grants program planned for 2023 will include an update to this Report Card.

'Best buys' and the Plan

In 2017, the World Health Organization (WHO) published an updated list of 16 'best buys' for the prevention and control of noncommunicable diseases (NCDs).[31] The evidence for most of the 'best buys' came from high-income countries.[32]

The review team scanned the 'best buys' to gain an impression of whether the activity under the Plan covered off on these interventions. Several 'best buys' require national legislation, e.g., increasing excise taxes and prices on tobacco products. For these, the potential role for the ACT Government is largely limited to advocacy in national fora.

Without being able to review in detail all of the Strategic Actions that are being supported across the ACT, at a high level the scan did indicate that most of the 'best buys' have indeed been covered off in the Plan. Some potential gaps were however identified.

First is a 'best buy' that would require significant social licence, namely, to enact and enforce restrictions on the physical availability of retailed alcohol (via reduced hours of sale).

Second, the following 'best buys' stood out as interventions for which more could be done in the ACT:

- **Reduce salt intake** through the establishment of a supportive environment in public institutions such as hospitals, schools, workplaces and nursing homes, to enable lower sodium options to be provided, and through a behaviour change communication and mass media campaign, and
- **Drug therapy and counselling to individuals who have had a heart attack or stroke and to persons with high risk** (this includes glycaemic control for diabetes mellitus and control of hypertension using a total risk approach).

Salt-related messaging and lower sodium options is partially covered by programs run in education settings in the ACT (e.g., Healthy Choices) and action such as low-sodium meals at Canberra hospitals. Achieving salt intake reductions also relies heavily on national action.

The CVD-related 'best buy' is also one of the highly cost-effective (dominant) interventions identified in the ACE study (see also the Case Study in Box 1 below).

Box 1 – Screening and treatment for cardiovascular disease (CVD)

The WHO 'best buy' on CVD presents two potential opportunities for collaborative action across the ACT health system, one in primary prevention and one in secondary prevention:

- Primary prevention: Identifying those at high risk (e.g., through Heart Health checks) and prescribing basic pharmacotherapy on a preventative basis, and
- Secondary prevention: ensuring those hospitalised with CVD receive the appropriate recommended pharmacotherapy.

The extent of the problem was outlined in a study by Banks et al (2016) which found that about one-fifth of the Australian population aged 45-74 years (about 1.4 million individuals) were estimated to have a high absolute risk of a future CVD event, and that:

> *76 per cent of those who were at high risk of a first heart attack or stroke were not receiving the recommended pharmacotherapy (combination blood pressure- and lipid-lowering therapy), and also somewhat disturbingly that around 56 per cent of those with prior CVD were not receiving the most basic preventive pharmacotherapy.*[33]

With around 29,000 people in the 45-74 age bracket in 2021, the findings suggest there are likely many individuals in the ACT who could benefit from this 'best buy' in prevention.

Health and wellbeing in the ACT

While there is still room for improvement, as outlined in the last section, comparatively the ACT already fares very well in terms of health and wellbeing. The last ACT Chief Health Officer (CHO) Report released in May 2021 stated that:

> *Overall, people in the ACT enjoy one of the highest life expectancies in the world. The average ACT resident has a longer length of life and a lower burden of the chronic illnesses associated with lifestyle and ageing. This is due to the comparatively large number of young people, higher levels of*

education, higher average income, low risk workplaces, healthy environment and availability of quality services, which support good health and wellbeing.[34]

The CHO Report 2020 also outlines a series of encouraging trends in the ACT, including a lower incidence of cancer (age-standardised), higher participation in the nation's three cancer screening programs (breast, cervical, and bowel), and high immunisation rates.

A challenge for the ACT will be to maintain this level of achievement and, where possible, improve upon it. Well-known challenges will require ongoing commitment, such as further reducing the rates of smoking or risky drinking.

A continuing and possibly growing issue of concern is that about half of all Canberrans (48.5 per cent) have one or more chronic disease, with one in five having at least two conditions (20.2 per cent).

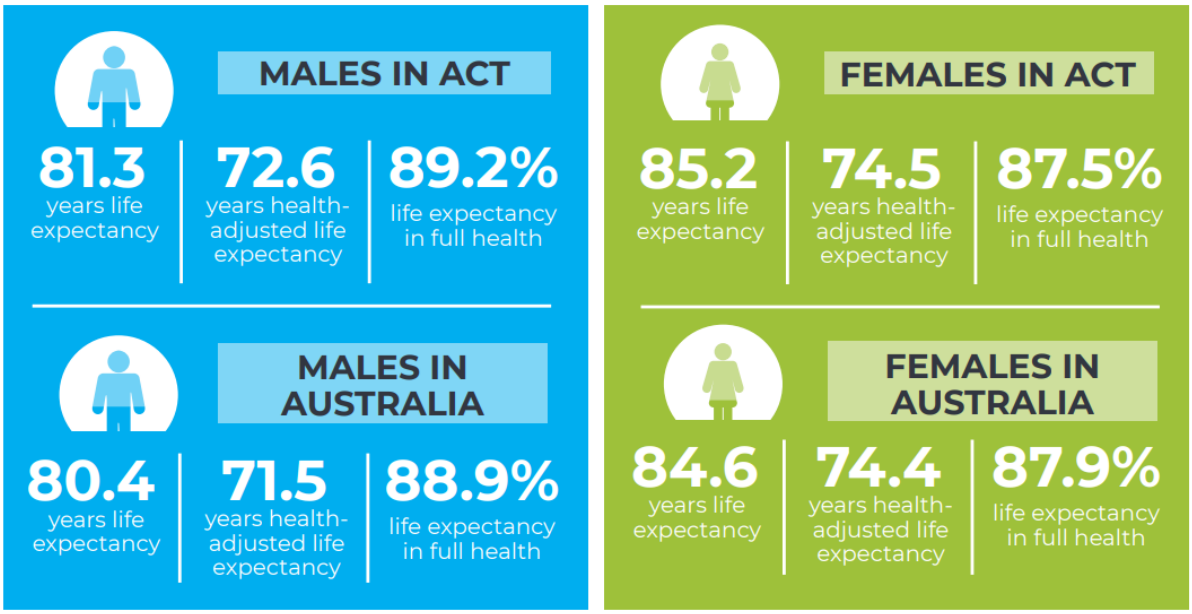
Citing AIHW data the CHO Report 2020 states that in 2015, the leading causes of disease burden in the ACT were coronary heart disease, anxiety disorders, and back pain and problems. These continue to be major issues.

- For males, the leading causes of disease burden were coronary heart disease, other injuries, and suicide and self-inflicted injuries, and
- For females, anxiety disorders, other musculoskeletal disorders, and back pain and problems were the leading causes of disease burden.

The ageing of the population and other trends discussed in this introduction (e.g., increasing social isolation), as well as the increasing complexity of disease,[35] and new health challenges such as COVID-19 and e-cigarettes will require innovation in prevention.

The Plan acknowledges that some population groups in the ACT, such as those living with disadvantage, are also at higher risk of developing chronic disease. Health inequalities must continue to be addressed.

Figure 4 – Life expectancy in the ACT



Source: ACT Chief Health Officer Report 2020, *Healthy People* section.[34]

As indicated earlier in this introductory chapter, the ACT Government has adopted the ACT Wellbeing Framework, a move which dovetails with the desire to build a health system focussed not only on treating illness but also on maintaining and improving life-long wellbeing:

> This approach implies a broadening of the concept of prevention for health. New approaches such as community, arts, and nature-based interventions offer increasingly evidence-based options.

It may be noted that the move towards lifelong health and wellbeing is also reflected at an international level in the Sustainable Development Goals (SDGs) enshrined in the 2030 Agenda for Sustainable Development:

> SDG 3 is to "ensure healthy lives and promote well-being for all at all ages".[36] The 2030 Agenda was endorsed by all United Nations Member States in 2015.[36]

The *Living Well in the ACT Region* survey led by Professor Schirmer and Dr Mylek of the University of Canberra has collected data four times since late 2019. This survey has found that Canberrans have comparatively high levels of wellbeing.

Nonetheless, wellbeing varies across groups and in response to events such as COVID-19:

> During April/May 2020, with the first lockdown, low personal wellbeing was reported by 28.4 per cent of respondents; this was a significant increase on the 20.7 per cent of Canberrans who reported low personal wellbeing just four months earlier.
> Personal wellbeing returned to 'normal' by late 2020, and only 17.6 per cent of Canberrans reported low wellbeing during the second lockdown in Oct/Nov 2021.

> Groups most likely to have low wellbeing as of Oct/Nov 2021 were those with disability (36.3%), carers (34.9%), and the unemployed (33.0%).

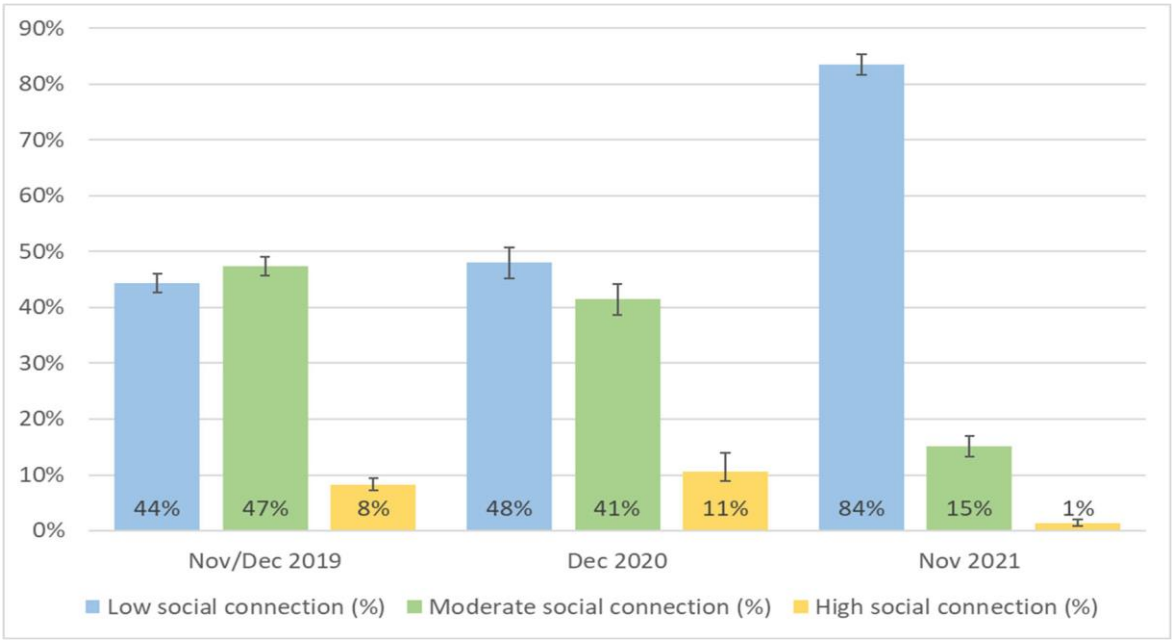
The *Living Well in the ACT Region* survey covers a wealth of information on various aspects of wellbeing, and has become an important resource for the ACT Government:

> Apart from self-reported personal wellbeing, it provides insights on caring, housework, quality of time use, participation in community groups and activities, commuting times, feeling safe at night, affordability of living costs, and a range of other factors.

An example is provided in Figure 5 below, which reveals that even in periods of no or reduced COVID-19 related restrictions, a low proportion of the Canberrans surveyed reported high social connection, with only eight per cent in 2019, eleven per cent in 2020 and one per cent in 2021. The proportion of residents reporting low social connection significantly increased from 44 per cent in 2019 to 84 per cent in 2021.[37]

Tracking these statistics over time and developing appropriate responses to the insights emerging from them is important if government policy (not just in prevention) is to be successful in maintaining and improving the wellbeing of Canberrans.

Figure 5 – Proportion of ACT adults with low, moderate and high social connection



Source: Schirmer and Mylek (2022).[37]

Further information on the *Living Well in the ACT Region* survey can be found on the University of Canberra's website, which also includes a link to complete the survey. The survey has been approved by the University of Canberra Human Research Ethics Committee and is funded by the Medical Research Future Fund.

The Plan's Priority Areas and Strategic Actions

The Plan's five broad Priority Areas for action are shown in Table 1 below. This reflects a life course approach intertwined with a reflection of the key areas in prevention that have been highlighted above. The Plan also stresses the need for comprehensive, coordinated effort across the ACT Government.

Table 1 – The five priority areas of the Plan

Priority Area	Description
Supporting children and families	Infant and child health checks, health during pregnancy, childhood vaccinations
Enabling active living	Walking paths, bike paths, water fountains, green spaces and sporting facilities
Increasing healthy eating	Programs in schools and workplaces, making it easy to choose a healthy diet
Reducing risky behaviours	Smoking, alcohol, sexually transmitted diseases
Promoting healthy ageing	Cancer screening, lifestyle changes

The Plan's five Priority Areas cover a very broad array of possible interventions. At least in theory, they capture almost *everything* that is currently thought important in prevention.

A limitation of such an all-encompassing approach is that it can make it difficult to identify and communicate *specific* areas for action and improvement, and to marshal support for proposed solutions in these specific areas.

On the other hand, an advantage of such a broad overarching framework is that it gives areas implementing relevant actions a degree of flexibility, which may also strengthen their willingness to participate in the Plan.

Given the broad coverage of the Plan, one of the questions that can be posed relates to the *balance* across the Plan – are specific Priority Areas or interventions emphasised by the Plan more than others?

On this count, currently the balance of weight under the Plan would appear to be more on primordial and primary prevention, i.e., creating the necessary *conditions* for good health and wellbeing and addressing specific risk factors, rather than (say) secondary prevention.

The associated Action Plan lists 40 Strategic Actions, which are being implemented across the ACT Government directorates. The majority of the actions are however led by ACT Health.

The Action Plan currently does not cover mental health actions, as the establishment of the Office for Mental Health and Wellbeing was underway at around the time the Plan was launched, and work plans and actions for mental health were still under review at that time.

Information provided by the Plan's Project Team highlights some of the more specific achievements and where the emphasis appears to have been placed. This is provided in the form of a summary update below.

Update from the Plan's Project Team

The Plan's Project Team at ACT Health provided data tables on a range of measures for each of the five Priority Areas, including data on life expectancy and the burden of disease already discussed above.

Trends on other markers such as participation in organised sport outside school hours, which *appears* to have fallen by 44 per cent on average in 2020 and 2021 when compared to the previous two years, may have to be treated with caution as the sample size for the ACT is typically very small (in this case, the 2021 sample for ACT children was just 126 people).

While such a result may simply be due to chance, it appears more likely that it is due to the impact of COVID-19 on community sports outside school hours, and in that case, it does not reflect a failure of existing prevention programs and initiatives (e.g., that aim to increase participation).

A larger sample regarding physical activity in the ACT (again drawn from a national survey) was for adults participating in physical activity including sport at least once per week. This proportion has remained largely unchanged at around 88 per cent of the adult population in the ACT.

Changes in indicators related to healthy eating, smoking, risky drinking were not statistically significant, and the rates of sexually transmitted diseases and blood borne viruses per 100,000 population in the ACT were largely unchanged over the period 2011 to 2021, with the exception of gonorrhoea, the rate of which appears to have at least doubled over the last decade. While absolute numbers are low, ACT Health is investigating this trend.

In addition to this summary data, the Plan's Project Team reported that progress has been made to improve the food environment both in schools and in junior sport:

- The *Fresh Tastes* program which supports primary schools to take a whole-school approach towards embedding a healthy school food and drink culture has reached 87 per cent of ACT primary schools, representing over 42,000 students; 80 per cent of these schools reported a positive shift in food and drink culture.
- *Gamechangers* was launched in 2022 and aims to reduce children's exposure to unhealthy food and drink marketing in junior sport settings by facilitating sponsorship relationships between local non-harmful industry businesses and junior sport clubs. Although in its infancy, uptake has been rapid with ten state sporting organisations and their junior clubs adopting a healthy sponsorship approach.

Additionally, several initiatives show positive impact towards creating supportive environments for physical activity:

- *Kids at Play Active Play* is a program that provides professional training and resources in physical activity for early childhood educators. Evaluation to date indicates that 98 per cent of survey respondents indicated an intention to use the knowledge and resources from the course in their educational setting.
- Similarly, evaluation of *Its Your Move*, a program designed to foster a supportive physical activity environment at school has demonstrated positive steps towards achieving systems level change.

The ACT Health Promotion Grants Program (Healthy Canberra Grants) continues to reach local community organisations to deliver programs and services to the people of Canberra in accordance with the five priority areas of the PHP. Since 2019, 33 new community programs have been funded across four Healthy Canberra Grants rounds.

During the first two years of the Preventive Health Plan several directorates have invested significant resources in progressing overarching strategies which align with the Plan's priority areas. These key strategies are expected to further drive the preventive health agenda:

- The *Best Start for Canberra's Children: The First 1000 Days Strategy* is a ten-year ambition to improve health literacy surrounding the First 1000 Days and ensure that families and communities are better supported to care for children during this critical period of child growth and development.
- Another example is the *Active Travel Plan* which has been recently revised to ensure walking, cycling and other forms of active travel are at the centre of planning to make Canberra an even more liveable and sustainable city.

The challenge of measuring progress

The evaluation of the Plan is complex in part due to the fact that the Plan has adopted existing (ongoing) initiatives that, in turn, will have grown out of – or been influenced by – previous prevention efforts.

One of the issues with prevention is that it often involves long-term aims; for example, an early childhood intervention may have impacts on educational attainment and employment prospects decades after the early childhood intervention takes place.

This creates a real challenge in linking prevention interventions to outcomes. Many government programs can claim to have contributed to progress, but exact attribution of change and proving causal links to specific interventions is typically fraught with difficulty.

In many cases, robust evidence requires long-term follow-up studies or randomised trials, and this tends to fall into the realm of academic research. Studies may involve decades of work, with careers built on teasing out the evidence on specific interventions.

This means that many of the practical efforts or schemes and initiatives that governments implement over the shorter term do not, and indeed often cannot, demonstrate impact on such long-term outcomes. This is certainly the case with the Plan.

What can (and should) be done within government is to develop a strong rationale for how specific investments *might* play a role in delivering the longer term aims. This is typically done through building so-called 'logic models', where interventions are linked through a stepped out causal chain to intended long term outcomes, for example:

- A workshop is delivered to a target audience (activity/participation)
- This provides health information to target audiences (knowledge),
- This changes the audience's attitude to a particular issue (willingness to change),
- The change in attitude motivates them to make different choices (behavioural change),
- Different choices result in short-term outcomes (initial and intermediate outcomes, e.g., 'feeling better'),
- The different choices become a longer-term habit (*persistence* of initial effect), and
- Ultimately, this in turn leads to longer-term health improvements.

As a simple example of this could be the work done in schools to bring about a commitment to stop violence against women, where evaluation requires follow up to understand whether workshop participants have changed attitudes and behaviours, and whether this change (if any) has persisted over time.

The key points along the chain of a logic model should be articulated in a way that facilitated measurement or interrogation (whether qualitative or quantitative). A good logic model is usually underpinned by a clearly articulated Theory of Change, and this should draw upon the best available evidence (and be revised if and when the evidence changes).

The Plan's Project Team identified early on in the process of developing the Evaluation Framework that logic models had not been developed for the Priority Areas and/or Strategic Actions.

ACT Health has since then progressed the development of logic models for each of the five priority areas.

More detailed analysis of progress against the markers identified through the logic models is the remit of further evaluation over the next three-year period, alongside the implementation of the second three-year Action Plan.

Canberra community survey

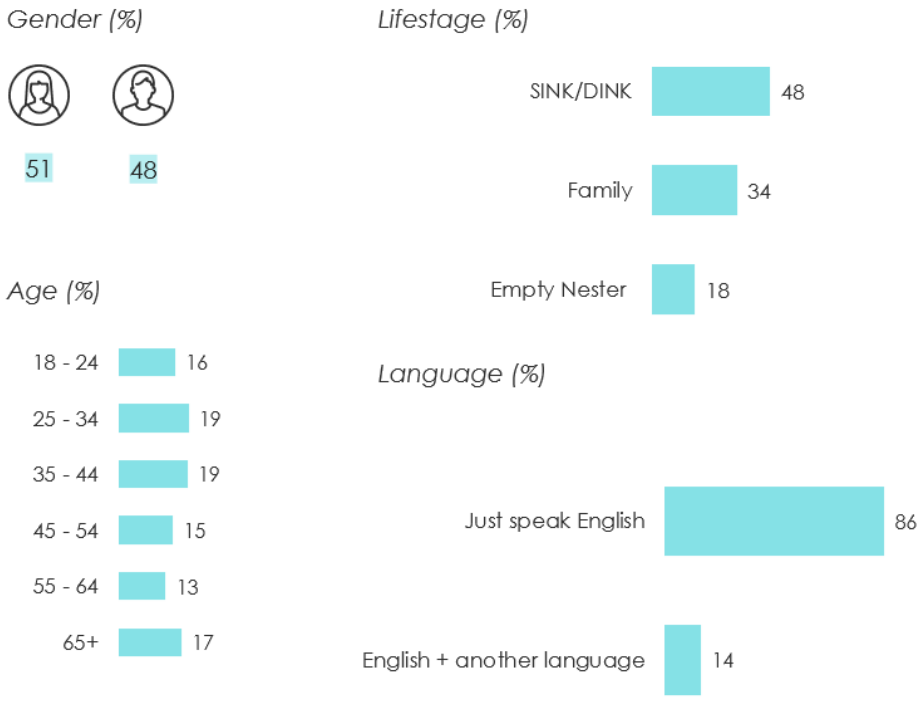
The review team contracted Pollinate Pty Ltd ('Pollinate') to conduct a representative survey of the Canberra community to understand and measure the level of community buy-in and also its recognition of the prevention work that is covered by the Plan.

An initial draft of survey questions was developed during February and March 2022 by the PDE team in collaboration with the PHP Project Team and Pollinate. The inter-directorate Expert Evaluation Working Group (EEWG) then also provided feedback to refine the survey.

The 10-minute online survey went 'live' during April 2022 with 648 responses collected over a period of two weeks. Summary information on the response group is shown in Figure 6 below.

> There was a good representation across adult age groups, and the expected balance of genders in the response group. About half of the group were Single Income No Kids (SINK) or Double Income No Kids (DINK), while around a third were from families.

Figure 6 – Basic demographic information on community survey respondents



Source: Pollinate Community Survey, April 2022.[38]

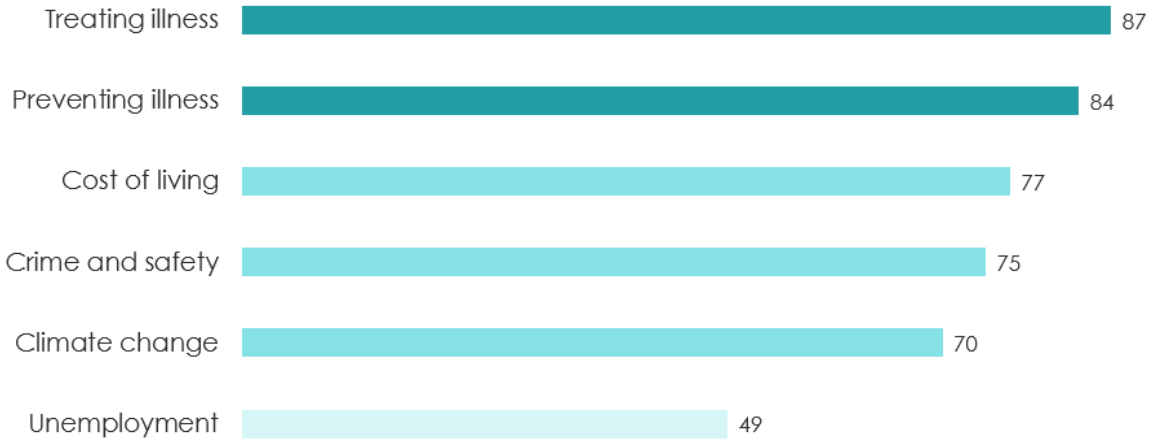
Prevention is a key issue

One of the questions posed to Canberrans in the survey related to the importance they place on a range of policy issues ('How important are the following issues to you?').

Respondents were asked to choose using a scale from 'Not at all important' or 'Of low importance' at the bottom end of the scale, through to 'Important', 'Very important', and 'Extremely important'.

Figure 7 below reveals the proportion of Canberrans who rated the listed issues as "very" or "extremely" important. On this measure, *preventing* illness took second place with 84 per cent of Canberrans, just after *treating* illness (87 per cent).

Figure 7 – Canberrans perceiving selected issues as "very" or "extremely" important (%)



Source: Pollinate Community Survey, April 2022.

This ranking of issues remains largely the same when considering only those who find an issue "extremely" important: treating and preventing illness stay in the top two spots with 50 and 44 per cent of Canberrans respectively finding these extremely important.

There was one change in the ranking with climate change overtaking crime and safety as an issue that is considered extremely important. This took climate change into third place alongside the cost of living (40 to 41 per cent found these two issues extremely important).

Preventing illness is clearly an issue that is very important to a significant number of Canberrans – perhaps not surprising given the number of Canberrans who suffer from preventable long-term health conditions, as discussed in the next section.

Long-term health conditions in the ACT

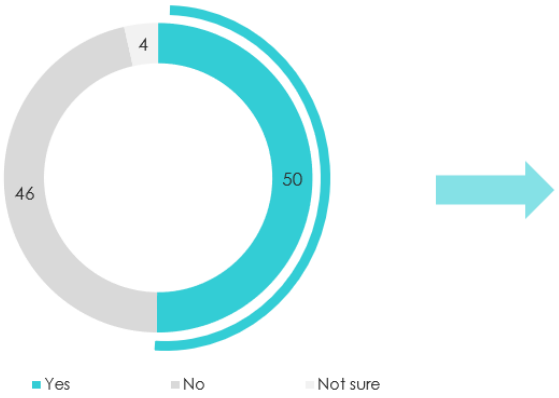
According to previous estimates, approximately half of all adults in the ACT live with one or more long-term health conditions such as cardiovascular disease (CVD), diabetes, or mental health conditions.[39]

This Pollinate survey corroborates this, with exactly 50 per cent of respondents stating that they suffered from a long-term health condition (see Figure 8 below).

An interesting finding of the survey was, however, that only 29 per cent of respondents *knew* that half of all adults in the ACT live with a long-term health condition.

In other words, there appears to be a disconnect between lived (personal) experience and the perception of others' health issues: a lot of Canberrans don't realise how many other people in the ACT are also suffering from long-term health conditions.

Figure 8 – Canberrans suffering from a long-term health condition (%)



A mental health condition	18
Asthma	13
Backpain	13
Arthritis	12
Diabetes	5
Cardiovascular disease	5
Cancer	3
chronic obstructive pulmonary disease	2
Osteoporosis	2
Chronic kidney disease	1
Other (specify)	10

As Figure 8 demonstrates, the most commonly cited long-term health condition was a mental health condition, with nearly one in five respondents stating they were suffering from such a condition.

These results are broadly in line with what might have been expected based on national statistics. Table 2 includes national data released in March 2022 by the Australian Bureau of Statistics on the most prevalent chronic conditions experienced in Australia in 2020-21.[40]

Table 2 – Prevalence of health conditions in Australia vs survey response group

ABS condition descriptor	National (%)	Survey condition descriptor	Survey (%)
Mental and behavioural conditions	20.1	A mental health condition	17.9
Back problems	15.7	Back pain	13.0
Arthritis	12.5	Arthritis	11.7
Asthma	10.7	Asthma	12.7
Diabetes	5.3	Diabetes	5.4
Heart, stroke and vascular disease	4.0	Cardiovascular disease	5.4
Osteoporosis	3.6	Osteoporosis	2.3
Chronic Obstructive Pulmonary Disease	1.5	Chronic Obstructive Pulmonary Disease	1.5
Cancer	1.6	Cancer	2.6
Kidney disease	1.1	Chronic kidney disease	0.6

The margins of error around the proportions reported in Table 2 mean that the community survey results cannot be used to draw conclusions about whether or not these long-term health conditions are more or less prevalent in the ACT than the rest of the country.

What the comparison confirms, however, is that the sample of Canberrans who responded to the survey was likely to have been a representative sample: there were no big surprises in the rates of self-reported long-term health conditions among the sample group.

Support for preventive health expenditure

The review team and the evaluation working group also thought it would be of interest and an opportunity to ascertain whether Canberrans agree with increasing expenditure on preventing illness in the ACT.

This question was put in context of the recent efforts at a national level that are attempting to raise the *share* of prevention spending as part of the health budget envelope. The following question was posed:

> *Currently, across Australia it is estimated that 2% of government health expenditure goes towards prevention. A national campaign is currently seeking to double this expenditure to at least 5% of the health budget. Do you agree with significantly increasing expenditure on preventive health, i.e., preventing illness in the ACT?*

The response to this question was overwhelmingly positive – 92 per cent of respondents answered yes. Given the high prevalence of Canberrans with long-term or complex health issues, perhaps it is unsurprising that there is high public permission to increase spend in this area.

It may be noted that the economic literature on willingness-to-pay (WTP) surveys cautions that asking people 'unbounded' WTP questions (e.g., by ignoring income constraints) can lead to an overestimation of WTP.

In this instance, potentially relevant context was provided in the phrasing of the question, suggesting that the increase in expenditure on prevention would have to come 'out of' other health spending as it was stated as an increase in the *proportion* of the health budget.

Respondents may have understood the trade-offs involved in shifting health expenditure in this way if they read the question carefully and took time to consider this when completing the survey.

It is however also possible that respondents assumed that the *overall* health budget would increase to allow other health expenditure to remain at least at current levels while allowing the share of prevention expenditure to increase.

On balance, while the responses indicate strong 'in-principle' support for increasing expenditure on prevention effort, to have complete confidence that people would accept a trade-off with other health expenditure would require further research.

Agreement with the Plan's priority areas

The community survey also tested whether Canberrans agree with the priority areas in the Plan. Respondents were shown a table similar to that shown in the introduction above (see Table 1) and then asked how important these five areas were to them.

The result was that all five areas appear almost equally important to Canberrans. A further question was put to Canberrans to see whether they agreed with focussing on these five broad priority areas, with 92 per cent responding in the affirmative.

Put together, these two sets of responses provide an important validation of the relevance of these priority areas to Canberrans.

> Among the few respondents who did not agree with the focus on these five priority areas (8 per cent of respondents), analysis by Pollinate indicated that this group would like to see more focus on mental health, and less on personal choice behaviours.

Key concerns for long-term health

The survey went into further detail on the key concerns Canberrans have about preventing long-term health issues. A list of issues or options was presented to respondents, who were asked:

> *In terms of preventing long-term health issues, which 3 concern you the most?*

Figure 9 ranks the issues by how often they were included in the 'Top 3, illustrating that 60 per cent of Canberrans consider mental health issues as one of their 'Top 3' concerns.

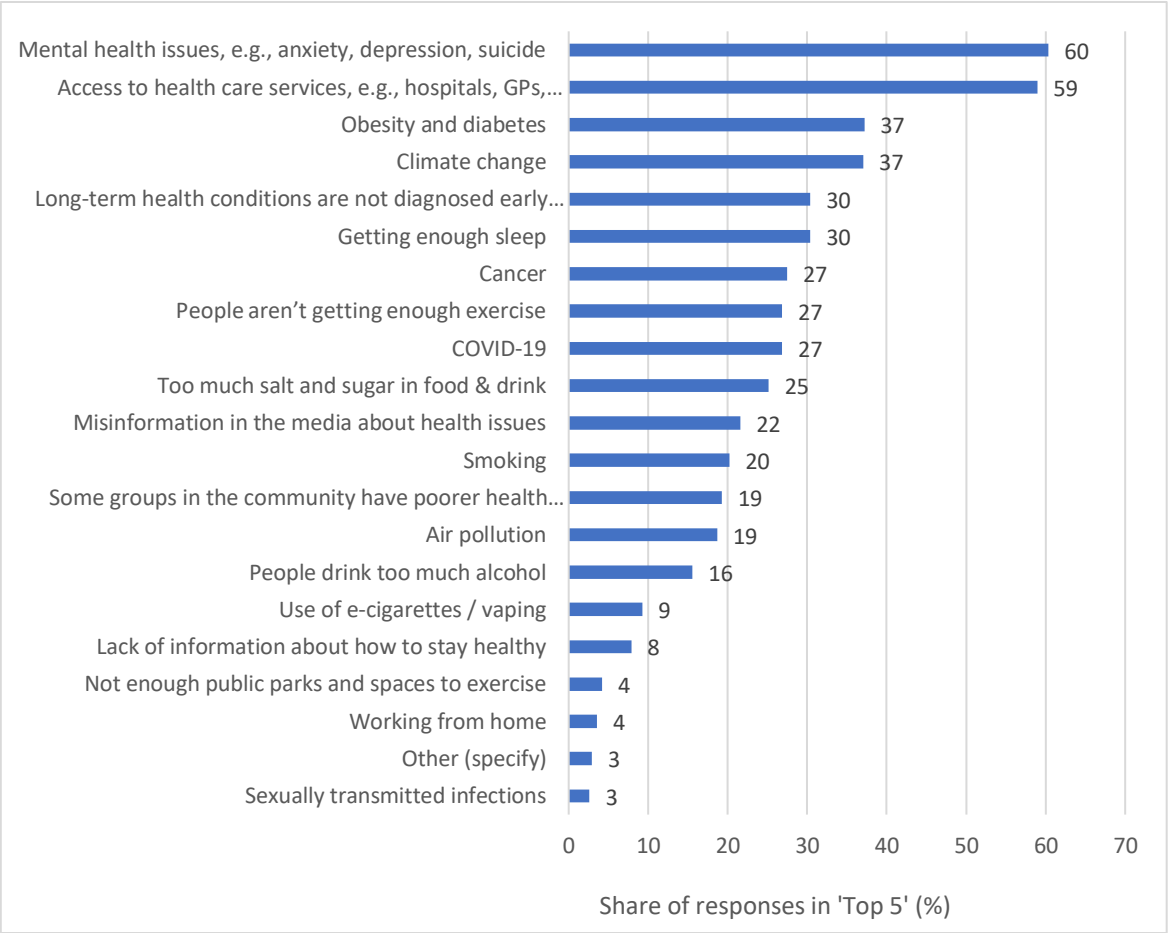
Closely following in second place with 59 per cent is the concern about access to health care services that support prevention, including hospitals, GPs and community health services. There is a significant 'step down' to third place and below in Figure 9.

It is not possible to determine from the answers themselves *why* Canberrans might have selected these issues in their responses, and there is likely to be a mix of reasons:

> For mental health issues, for example, it could be that respondents fear a worsening of their *own* mental health issues over time, or that they recognize this is a growing issue for the community.
> For access to health services, it could be that Canberrans recognize a general need to ensure health issues are detected and treated early or that they are concerned a specific health issue of their own may progress due to a lack of access to health services.

The review team was also interested in probing whether ACT Public Service (ACTPS) staff working on the Plan understood the community's priorities as discovered in this survey. The analysis of this is covered later in this report (in the section on the Social Network Analysis and internal survey).

Figure 9 – Top concerns relating to preventing long-term health issues



Who should engage in prevention activity?

To gauge opinion about who Canberrans think should be taking action by engaging in more (or less) preventive health activities, a question was included to rate this against the following:

- **Individuals** themselves,
- **Non-Government Organisations** like Cancer Council, Lifeline, Red Cross, etc
- **Big Business** like Woolies/ Coles, food manufacturers, etc
- **Small Business** like local butcher, childcare centre, etc
- The **Federal Government**
- The **ACT Government**

The outcome of this was that Canberrans thought that, first and foremost, it was individuals themselves that should be doing more (42 per cent) or a lot more (50 per cent). Together, that means 92 per cent of Canberrans think they should be doing more themselves.

This was closely followed by the two tiers of Government, with 86 per cent of Canberrans believing that these should do 'more' or 'a lot more'. More Canberrans did think the Federal Government should do 'a lot more' (45 per cent) than thought that the ACT Government should do 'a lot more' (34 per cent).

Not far behind was Big Business, which 77 per cent of Canberrans thought should do more or a lot more. 57 per cent thought NGOs should do more.

At the bottom end of the scale was Small Business with only 45 per cent of respondents thinking this segment should do more or a lot more (only 7 per cent thought Small Business should do 'a lot more').

Role for the ACT Government

The survey also presented Canberrans with a list of twelve possible actions or areas that the ACT Government could focus on and asked them to rate these on a 5-point scale from 'Not at all important' to 'Extremely important' in response to the question:

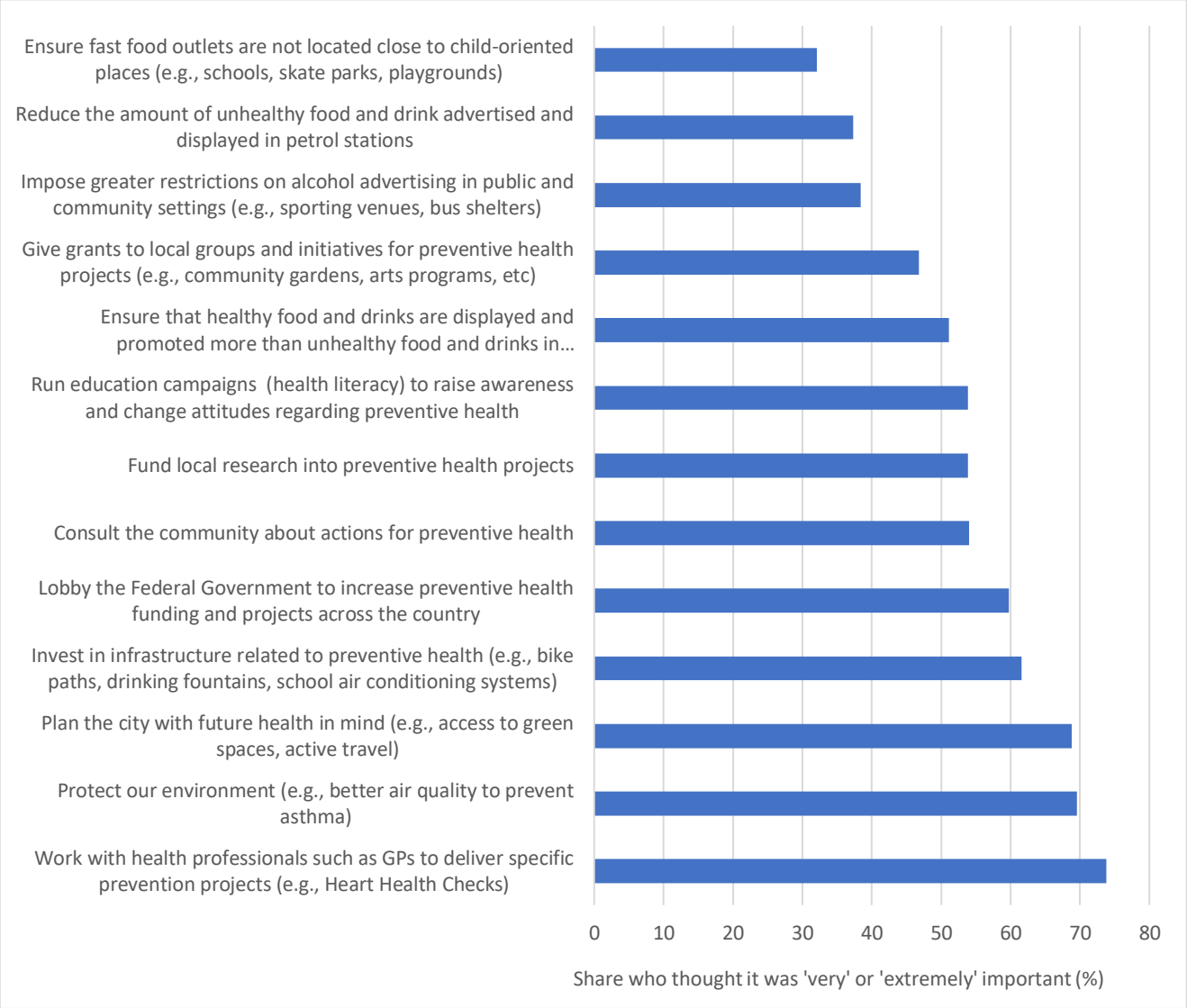
How important is it to you that the ACT Government do the following?

Figure 10 below shows the percentage of respondents that chose one of the top two levels of importance ('very important' and 'extremely important') for each of the actions:

- Of least importance were actions that impinge upon personal choice such as through the imposition of various restrictions or planning approaches that limit access to fast foods,
- 'Middle of the pack' were actions such as funding research, health literacy campaigns, consulting the community, and lobbying the Federal Government, and
- At the top of the list were working with health professionals to deliver specific prevention projects such as Heart Health Checks, protecting our environment, and planning the city with future health in mind.

The fact that interventions such as Heart Health Checks, which are among the most cost-effective interventions noted in the literature, ranked so highly for Canberrans, suggests that there would likely be strong support in the community for coordinated action on such interventions.

Figure 10 – Importance for ACT Government to take action on issues (%)



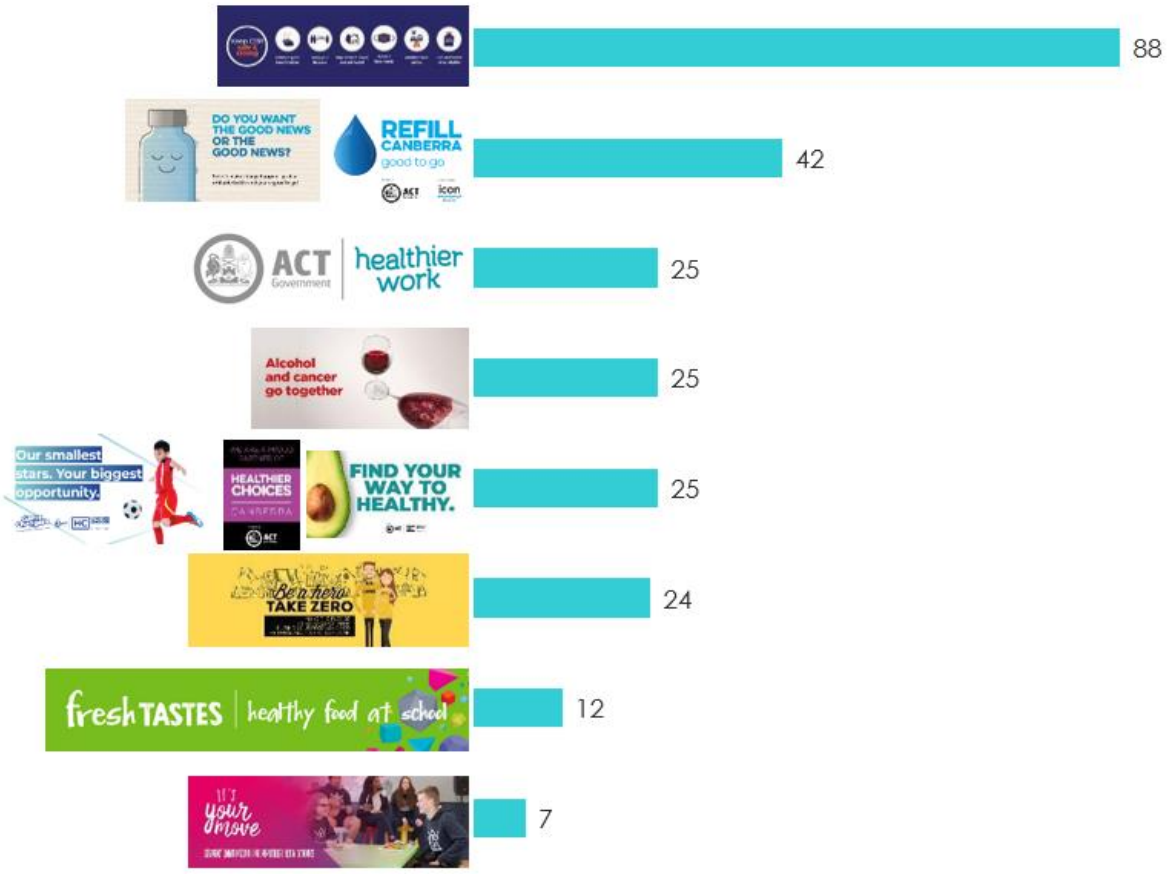
Campaign recognition

The Review identified a number of campaigns that were rolled out or financially supported by the ACT Government which carried messages that align with the Plan. Campaign recognition was tested in the survey by showing respondents an image from the campaigns.

The 'Fresh Tastes' and 'It's Your Move' school-based initiatives did not involve mass-media campaigns and therefore recognition was expected to be low.

Perhaps unsurprisingly, most Canberrans had seen the 'Keep CBR Safe & Strong' campaign (88 per cent), which promotes COVID-safe behaviours.

Figure 11 – Ad recognition (%)



As shown in Figure 11 above, close to half had seen 'Refill Canberra', with a quarter recognising 'Healthier Work', 'Alcohol and Cancer', 'Healthier Choices' and 'Take Zero'. As expected, there was relatively low recognition for the 'Fresh Tastes' and 'It's Your Move' campaigns which did not include a mass media dimension.

Pollinate provided an analysis of the performance of these campaigns, finding that there was good support for the campaigns, with Canberrans agreeing that most of them should be promoted more widely, and that they were worthwhile government campaigns.

On average, across the campaigns, the majority also agreed that they have a positive impact on the Canberra community and that they "made me think the ACT Government is taking preventive health seriously". There was less agreement that the campaigns were engaging.

Impact of advertising / survey

Perhaps most importantly, the survey found evidence that Canberrans were impacted by the advertising. Having reviewed the campaign ads, respondents were asked:

> *Do you feel differently about health prevention having done this survey / seen these examples?*

With 30 per cent responding ‘yes’ to this question, Pollinate noted that this is likely to be an underestimate as people do not always admit to being impacted by advertising.

Pollinate also found that those who had seen the advertising were significantly more likely to rate the prevention of illness as important than those who had not seen the advertising (87 per cent versus 79 per cent).

Ad recognition was also associated with higher importance placed on most of the priority actions discussed earlier, for example, 76 per cent of those who had seen the ads thought working with health professionals such as GPs to deliver specific prevention projects was important, while only 69 per cent of those who had not seen the ads thought so.

Similar percentage-point differences (7 to 13 percentage points, or around a ten-percentage point ‘bump’ on average) were seen across other actions such as planning the city with future health in mind, investing in infrastructure related to preventive health, funding local research into health projects, running health literacy campaigns, and giving grants to local groups for preventive health projects.

In other words, being exposed to additional information on prevention such as through media campaigns on prevention, is correlated with and could influence opinion regarding prevention.

Given that changing opinions and attitudes is often a first step in behaviour change, it is an indication that such campaigns likely play a positive role in supporting the Plan and may indeed increase its impact.

Pollinate concluded that ACT Government advertising in this space is welcomed, with most Canberrans agreeing these messages should be promoted more widely.

Document review and interviews

The community survey outlined the strong level of support for preventive health initiatives in the ACT. Community views expressed during the development of the ACT Wellbeing Framework also influenced the shaping of the Plan, as mentioned previously.

The background documents provided by the Plan's Project Team, and the interviews carried out for this Review, yielded a wide range of additional information relating to the design and implementation of the Plan. Interviewees were also asked to comment on the Plan's impact.

Document review

The Review Team has made it a routine part of conducting reviews and evaluations to begin a review process with a detailed document request. Whilst this is not intended to replicate an audit, it 'stress tests' an administrative area's capacity to respond, and in this case it:

- Supports a background analysis that essentially provides a useful overview of the Plan's Project Team's work and processes, and
- Yields relevant insights and data visualisations for this report (word clouds, themes, and sentiment analyses).

The following types of documents were requested from the PHP Project Team, noting that not all of these documents would be necessary to complete a document review, if they were not available:

a) PHP development documents (e.g., how the PHP and the Action Plans were developed, decision-processes around administration, team set-up etc.), including internal briefs to Executives or the Minister and business cases,
b) Previous and current team structure (i.e., personnel involved since its inception),
c) PHP Governance Arrangements,
d) PHP cross-government collaboration arrangements and Terms of Reference (if any),
e) Meeting Minutes and Actions (PHP working groups and committees),
f) PHP Progress Reports,
g) PHP Discussion Papers (e.g., including "what works" kind of papers, reports, etc., drafted by PHP team members)
h) PHP funding arrangements including staff costs / prevention related expenditures if not 'officially' in the Plan but clearly identifiable as prevention in the Project Team's opinion
i) Comms and Engagement Plans and/or Campaign materials

The detailed document request was made on 18 February 2022 by email, to be provided by early March. The Plan's Project Team at ACT Health passed the 'stress test', providing over 70 documents for inclusion in the document review within the requested timeframes.

The documents provided by the Project Team covered a good spread of administrative documents (such as meeting agendas, attendance records), concept and discussion papers, briefings, progress reports and presentations. The following were noted:

- Limited documentation was provided on b) and h) above, notably there was no specific documentation of the Project Team's internal structure and budget-related information, and on the funding of prevention in the ACT more widely, and
- There were also some gaps in documentation around the development of the Plan, and how the Project Team was set up.

Most of this information was however made available to the Review team either on follow-up or was readily available by searching databases of government records (e.g., Cabinet Submissions).

Based on an initial reading of the documents:

- The First 1000 Days project (i.e., the early years) appears to be an area of focus,
- There also appeared to be some emphasis on wellbeing, food, community, and place-based approaches,
- There was limited coverage of health conditions or diseases such as cardiovascular disease or long-term health conditions such as chronic pain,
- There did not appear to be many documents recording input from external parties such as academics, clinicians, or community sector representatives and/or health system records (e.g., hospital data), and
- A significant number of the documents related to, or commented on, the establishment of the Plan's governance arrangements.

Word clouds

Word clouds are a form of word frequency analysis, providing a pictorial 'summary' of the documents. Words that feature more prominently in these clouds appeared more often and can indicate some of the themes embedded in the documents.

For this Review, the background documents were imported into NVivo, a data analysis software which is routinely used in in qualitative research. After excluding common words such as "the", "and", etc., the word clouds shown in this report were generated.

It is perhaps a little surprising that 'services' and 'food' are among the *most* prominent words in red at the centre of the word cloud in Figure 12 below.

Also noteworthy is that 'healthy' and 'wellbeing' sit together at the centre, perhaps reflecting the link that is being made between prevention and wellbeing in the ACT. Words such as 'preventive', 'disease', and 'population' are also prominent, as expected.

Figure 12 – Word cloud for the document review

The emphasis on children and the early years that was noted in the initial reading of the background documents, appears to be confirmed in the word cloud with 'children' being quite prominent and accompanied by words such as 'school', 'education', and 'families'.

While these keywords are broadly in line with what might be expected, what is perhaps most notable from the word cloud, given the context provided in the introduction to this review, is the low level of prominence or absence of certain words:

- 'Tobacco', 'smoking', 'alcohol' and 'mental' are more or less peripheral, and
- Completely absent from the word cloud are words such as 'cancer', 'cardiovascular', 'obesity', 'salt', 'sugar', 'weight', 'obesity', 'exercise', etc.

Given this, the fact that 'food' features so prominently at the centre of the word cloud (with 'eating' additionally at the periphery of the word cloud), may indicate a particular focus within the Plan's Project Team.

Comparison with interview word cloud

The recorded interviews were also transcribed and imported into NVivo, with the word cloud allowing a quick identification of data patterns from interview responses, i.e., focus on the most salient points mentioned by the stakeholders interviewed for the review.

The questions asked, and any other words spoken by the interviewer, were removed from the transcripts prior to the analysis.

It is interesting to compare this word cloud with the one based on the background literature. The only keyword at the centre (in red) that is the same in both word clouds is 'community'.

The word cloud for the interviews was influenced by the questions that interviewees were asked: the interviews included a question on 'collaboration'; however, what emerges in addition to this from the word cloud for the interviews is perhaps a degree of *uncertainty*:

> 'Question' is found in the centre in red, and 'agree' and 'disagree' feature together in the second layer of prominence along with 'strongly', 'little', 'guess' and 'change'. In combination, this group of words conveys a sense of weighing up different ideas.

There is also an indication that higher-level, strategic issues figured much more prominently in the interviews, and again this is entirely in line with the intent of the questions asked:

> 'Priority', 'priorities', 'strategic', 'funding', 'leadership', 'principles', 'governance', 'measure', 'impact', 'success', and 'gaps' all encapsulate the high level, strategic nature of the discussion that occurred in the interviews.

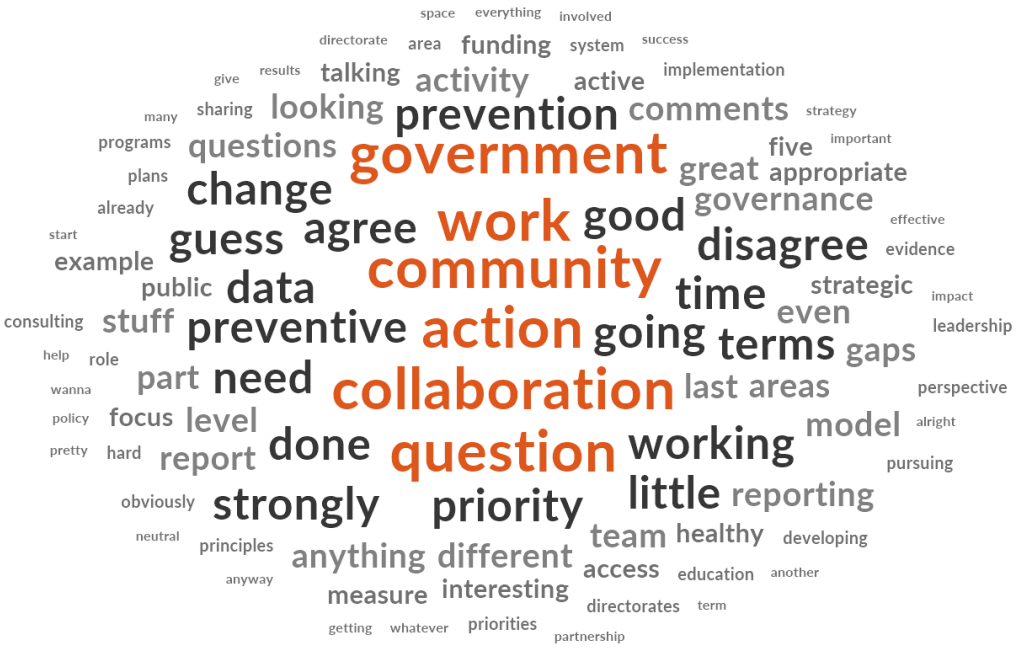
Once again, it may be noted that specific conditions or risk factors did not appear to dominate the interviews (as they potentially could have). In fact, they are completely absent from this word cloud (Figure 13 below).

It is worth drawing attention to the word 'community' that has come up very prominently in this word cloud, because (unlike collaboration) the word itself was not part of any of the questions that were part of the interview protocol.

This means that comments relating to 'community' were clearly on the interviewees minds, and this included commentary around consultation of the community, as well as discussion of expectations held by the community.

The issue of how the Plan was developed was discussed with the interviewees, and as discussed later in this section, this is where a lot of the points about the community were made by interview participants.

Figure 13 – Word cloud for the interviews



Hierarchy of themes

NVivo also produces an auto-generated 'hierarchy of themes', shown for the background documents and interviews in Figures 14 and 15 below. Detail on descriptors is not visible in these graphics, but they do provide another perspective on the documents and discussions.

For the background documents:

> The themes of 'health' and 'services' account for over half of the 'thematic weight' as judged by the amount of space on Figure 14,

> The themes of 'action', 'community', and 'plan' take up about a quarter of the 'thematic weight', suggesting focus on the PHP Action Plans and community engagement,

> Some words that might have been expected to appear in the word cloud appear in the hierarchy of themes (e.g., 'cancer' under 'services', and 'physical' under 'activity'), and

> 'Food' is once again surprisingly prominent, emerging as a significant theme in the hierarchy of themes.

For the interviews:

> There are *more* themes, perhaps a reflection of the interview questions covering a range of topics, with 'plan' and 'action plan' coming to the fore, and

> 'Government' is a key theme, while 'community' and 'services' were not a theme, again likely a reflection of the internal focus of the interviews.

Figure 14 – Hierarchy of themes for background documents

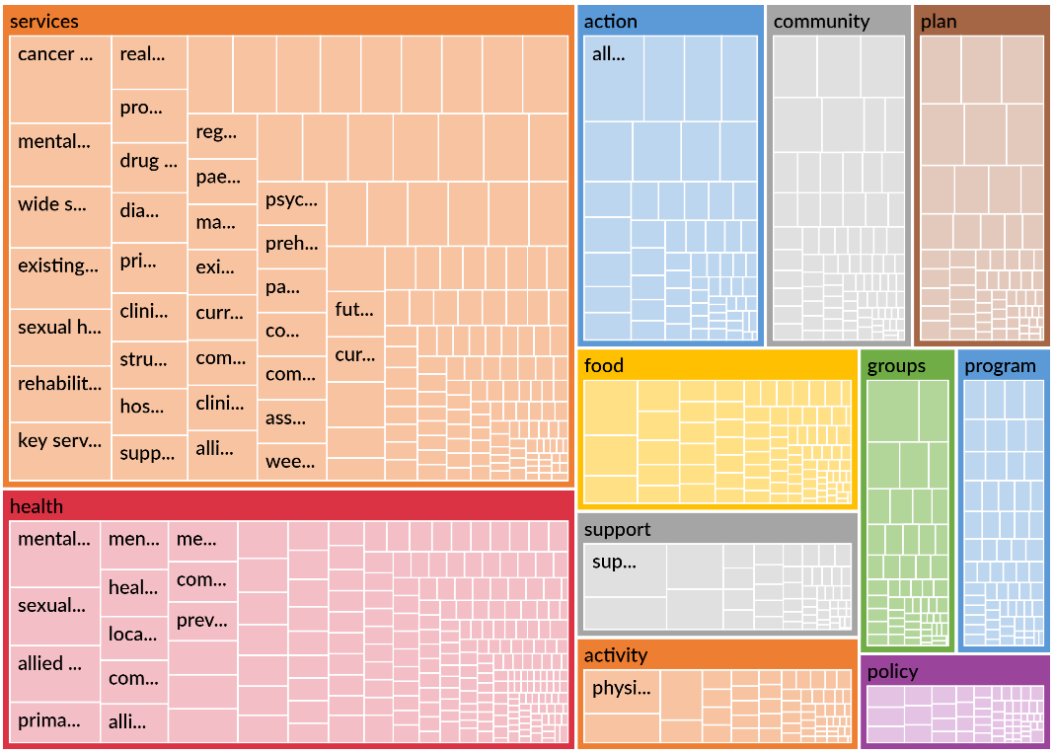
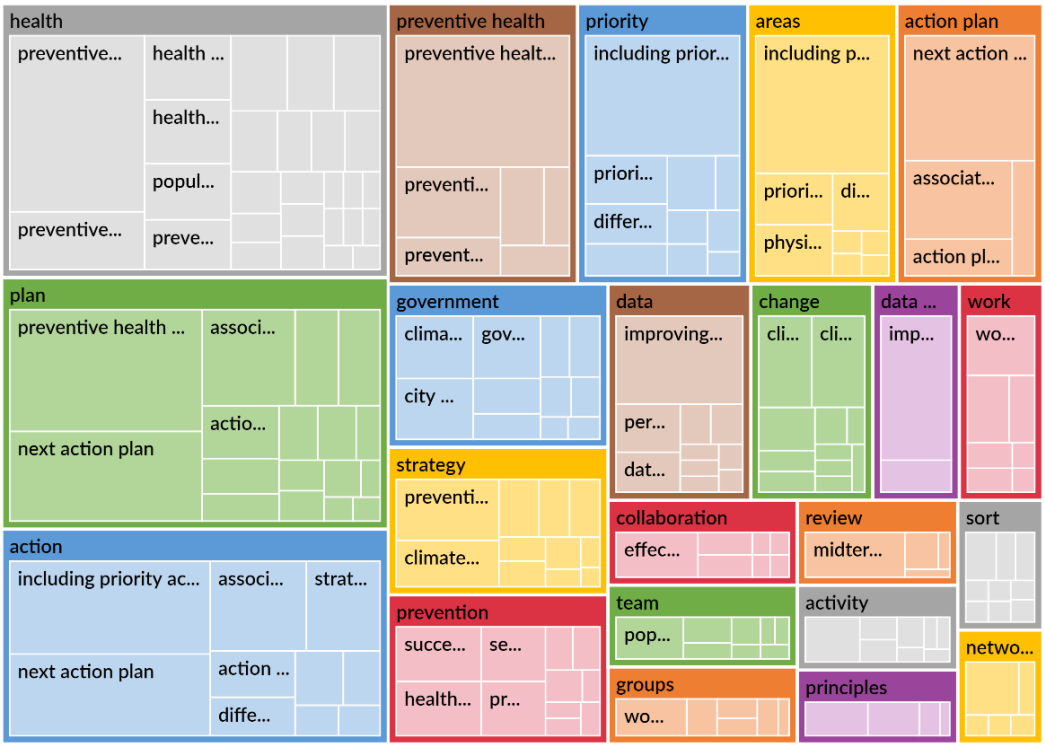


Figure 15 – Hierarchy of themes for the interviews



Sentiment analysis

A third type of textual analysis generated by NVivo is a 'sentiment analysis'. This is a research methodology that analyses text for positive or negative sentiment – in this case, the text in the background documents and in the interview transcripts.

There is some debate in the academic literature about the reliability of automated sentiment analyses, notably their ability to deliver nuanced coding or interpretations for specific sentiments.[41,42] Detailed interpretation is however not required here.

An intriguing aspect of the sentiment analyses summarised in Table 3 below is that there were an unusually high number of text references in the background documents that NVivo classed as 'negative'.

> There were nearly as many occurrences of negative sentiment as positive sentiment in the background documents (1,564 vs 1,606).

By contrast, in the interviews, positive references outweighed negative references by a ratio of well over 2:1.

It is difficult to speculate on this result because the automated scoring system which NVivo uses is a complex system that first creates a 'node matrix' and then codes content to so-called 'sentiment nodes.'

NVivo does not *classify* content according to sentiment – it essentially looks at the sentiment of words in isolation. NVivo cannot take broader context into account and cannot recognise sarcasm, double negatives, idioms or ambiguity.

Nonetheless, given that the process is a systematic one, and has been replicated many times, it is worth asking why the background documents might include so many negative text references, noting that it is unlikely that the Plan's Project Team would have used any negative language on purpose, if it was avoidable.

Table 3 – Background documents and interviews: sentiment analysis

Attitude	Number of text references	
	Background documents	**Interviews**
Positive (very and moderate)	**1,606**	**532**
Very positive	256	142
Moderately positive	1,350	390
Negative (very and moderate)	**1,564**	**241**
Moderately negative	1,126	164
Very negative	438	77

Random inspection of some of the background documents to probe this, however, provided some clues:

- The first randomly chosen two-page background document contained the phrases "there is currently no clear governance or oversight" (x2), "COVID-19 has severely impacted timelines" (x2), "there has been a delay", "the delay poses a risk", and "…has been put on hold",
- A second randomly chosen two-pager included repeated references to "systemic gaps", although in fact the paper was around finding solutions to address gaps that had nothing to do with the Plan itself, but were related to the wider system, and
- A third randomly chosen document reported progress in very neutral language, although *visual* progress indicators were positive (i.e., green or "on track"). NVivo may have classified the text as neutral, whereas human analysis of sentiment may have classified it as positive by matching textual with visual information.

Insofar as there were delays, it is a positive sign that these were addressed, or at least flagged by the Plan's Project Team, and this appears to be captured in the documentation. In that sense, the 'negative' sentiment reflects a *working* government process.

On balance, the relatively high level of negative sentiment in the background documents may be due to a combination of dealing with relatively intractable problems, external influences, and the delays in establishing governance arrangements for the Plan.

The sentiment analysis of the interviews paints a more positive picture, with positive sentiment outweighing negative by a ratio of more than 2:1.

This may have been influenced by the way in which interview questions were phrased, e.g., "how would you measure success?" can be expected to result in multiple references to "success".

Nonetheless, a ratio of well over 2:1 positive-to-negative is better than other reviews undertaken by the review team which included similar sets of questions.

Interviews

The following sections summarises in more detail the findings from the interviews conducted with 14 staff members of the ACT Public Service. The headings are based loosely on the interview questions, as these intended to cover broad thematic areas of discussion.

With interviews, it is important to remember that questions can be interpreted very differently, and answers reflect subjective views of individuals that can be influenced by a range of factors.

Development and governance

Development of the Plan

The majority of the interviewees had not been part of the development of the Plan and did not have specific insights into the circumstances under which the Plan was developed.

A number of people spoke about the Minister's 2016 commitment (noted in the introduction to this Review), and the Plan's evolution out of the *Healthy Weight Initiative* (HWI) and then the *Healthy and Active Living* (HAL) Strategy. It was noted that "a couple of approaches were tried and then it landed back with Health."

Some respondents referred to the HAL Strategy consultations and seemed at times to conflate the HAL Strategy with the Plan. Those who had a better recollection of the Plan's development thought it was a rapid process.

A comment from one of the non-Health respondents was that the development of the Plan was "a bit like putting a round peg in a square hole" – another referred to "reverse engineering."

As mentioned in the introduction, the Plan itself states that it drew on the stakeholder engagement process that was undertaken for the Wellbeing Indicators project. There was no separate, specific stakeholder consultation for the Plan itself.

Governance of the Plan

The main comment about governance was that it took a long time to finalise (until November 2021). Another comment was around the challenge of 'distributed ownership', i.e., collective governance.

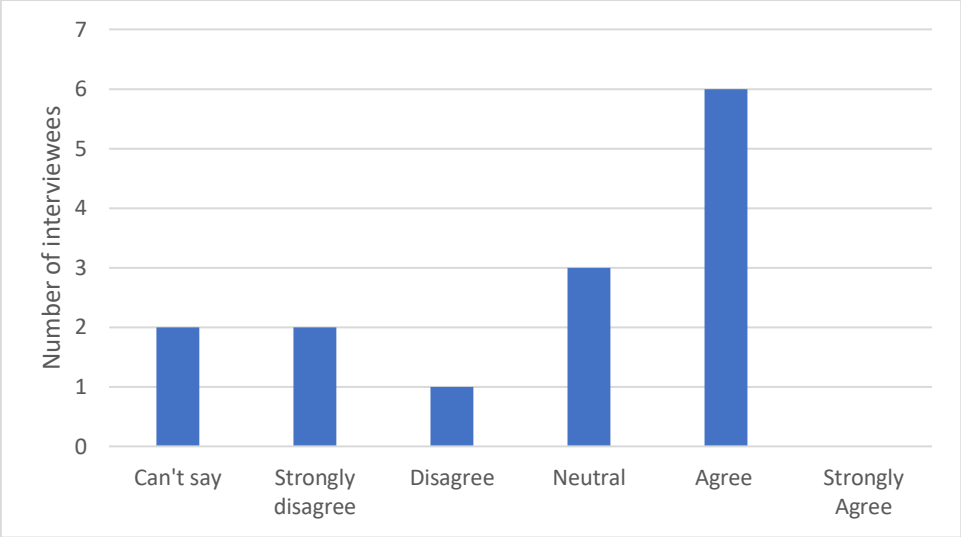
While there was a perception that governance was now "in place", several respondents from non-Health areas wondered whether their internal governance, i.e., within their respective Directorates, in relation to the Plan still needed to be addressed.

There were several comments around "leadership failure" with respect to governance, noting a "major plan" was "put out with no governance to put structure around it". One respondent reflected that the HWI had had the type of governance to bring areas together ("collaborative governance").

One respondent stated that "comms are clear but some Directorates require clearance from DGs while others don't," and that it would be useful to have clearer guidance around what can be made public. This appeared to be a comment specifically relating to the governance of the communications around the Plan.

When asked about their level of agreement with the statement that "the Plan is well governed", a minority agreed (6 out of 14). Figure 16 below shows the level of agreement among the group of interviewees.

Figure 16 – "The Plan is well governed" (level of agreement)



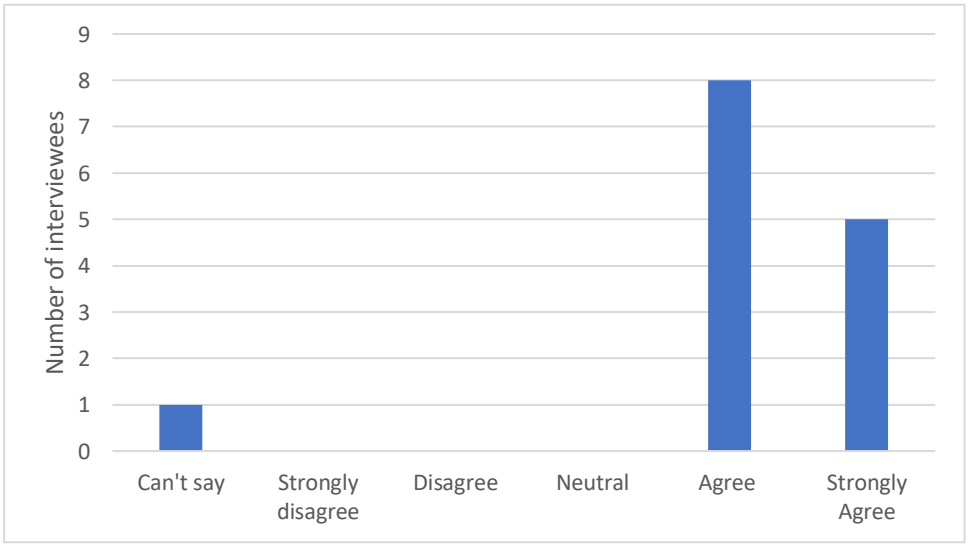
Evidence base and vision

The strongest level of agreement among the interviewees came in response to positive statements about the Plan's evidence base and vision.

There was one comment that while each of the interventions under the plan could "of course" be supported by evidence, the decision-making process around what actions to emphasise or the direction in which to take the Plan did not appear to be evidence-based.

In their view, there should be a more "transparent decision-making process" that ties the Chief Health Officer's report to a planning process for identifying actions for the Plan itself.

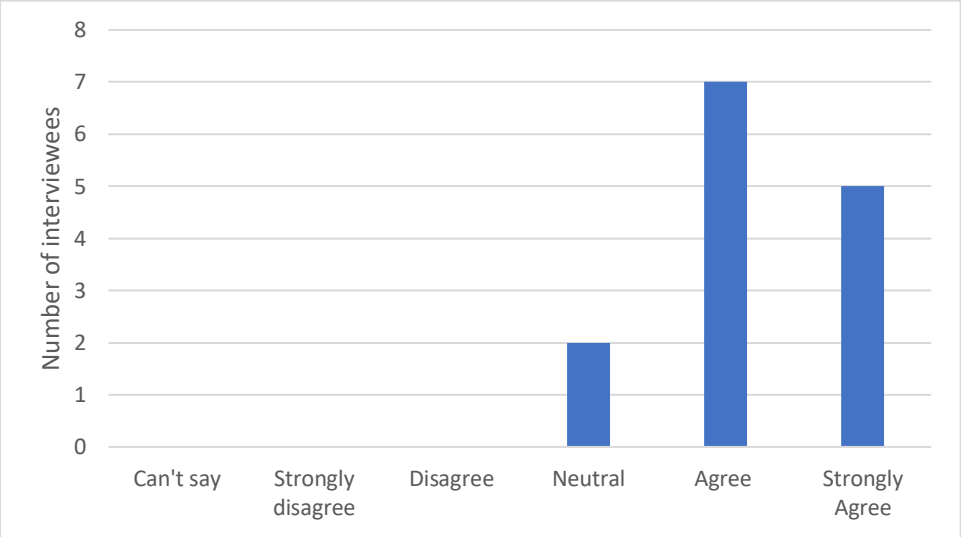
Figure 17 – "The Plan is evidence-based" (level of agreement)



Most interviewees however did not interpret this statement in this way and based their answers on their belief that good evidence supports the actions they were involved in delivering.

There was little discussion around the vision offered by the Plan, with interviewees noting that the five Priority Areas under the Plan were clear and easy to understand.

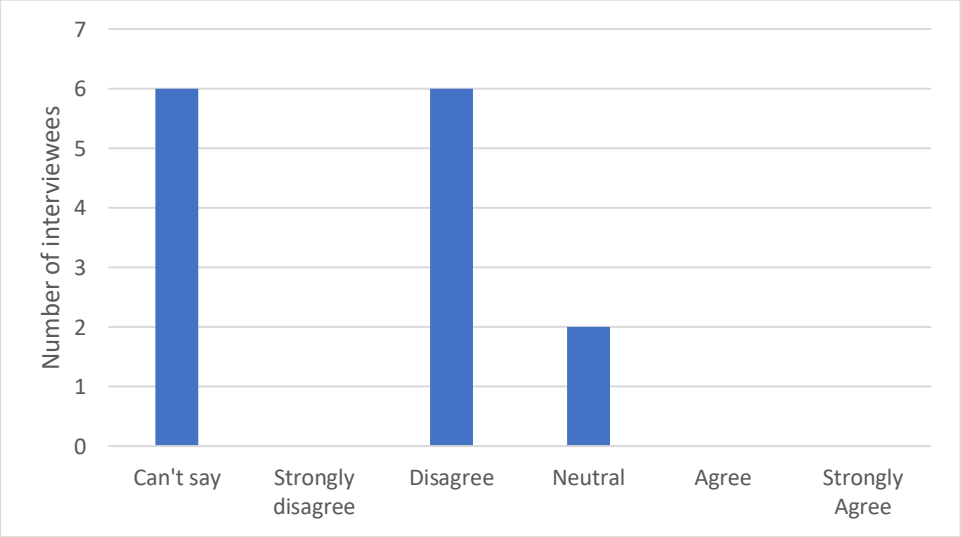
Figure 18 – "The Plan presents a clear vision" (level of agreement)



Relevance to government and community priorities

While there was overwhelming agreement in the interviews that the Plan was relevant to government and community priorities, there was no agreement that the Plan sufficiently *engages* with the community (see Figure 19 below).

Figure 19 – "The Plan sufficiently engages with the community" (level of agreement)



As has already been pointed out, the Plan itself 'borrowed' from the stakeholder engagement exercises undertaken for the Wellbeing Indicators Project. Some connections formed during the HWI and HAL projects were maintained but other were lost. Currently there is no routine or formalised mechanism for the community to feed back into the Plan.

There was one comment made that prevention is consistently raised in the Ministerial Advisory Committee on Ageing. It is possible that community views expressed through these channels are feeding back into the Plan in an indirect manner.

Collaboration

The extent to which the Plan supported collaboration was a significant focus of the Review. To address this question in more detail, an internal survey and a Social Network Analysis (SNA) were designed and implemented. These are covered separately in this report.

During the interviews, the following question was also put to the interviewees:

> *Does the plan facilitate partnerships and collaboration? Please explain why or why not.*

To support this discussion, a diagram from the NSW Collaboration Review document was shown to the interviewees (see Figure 20 below). This diagram illustrates the "Span of Collaborative Intensity" ranging from the basic levels of consultation and networking, through coordination, cooperation, and alliance, to partnership.

In general, the Plan itself was seen as facilitating collaboration at the consultation or networking level ("mostly consultation", "close to networking", "to the left of consultation", "towards the left") with some placing it slightly above networking:

- The discussion here was mostly about contact between line areas and ACT Health Directorate (ACTHD) to complete reporting tasks and sometimes exchanging relevant information.

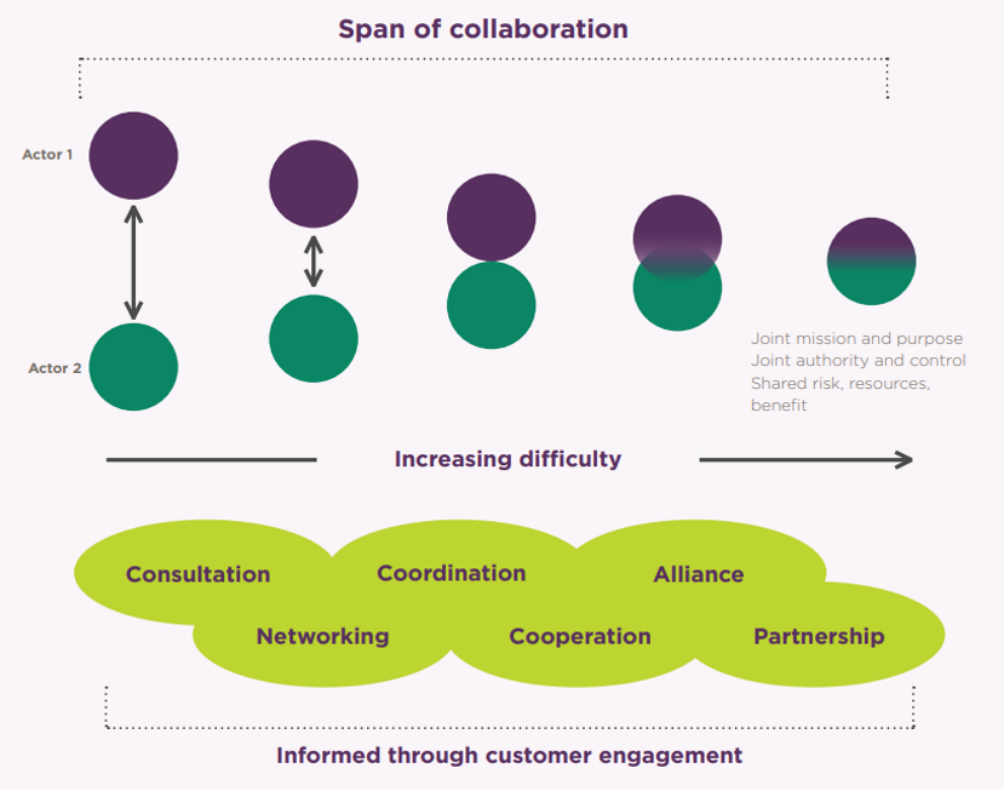
One response stated about the Plan that "it's not a facilitator [of collaboration] but in an ideal world it would be," and another interviewee said they "don't feel the alliance and don't have the shared vision or purpose."

Members of the Plan's Project Team perceived the level of cooperation at a somewhat higher level, between coordination and cooperation – one Project Team member mentioned that there are "some instances of alliance and partnership", while another said "it's a mixture".

As previously mentioned in this report, the Plan itself was seen by interviewees as covering Business as Usual (BAU). Several interviewees noted that under BAU, there are some areas that collaborate strongly anyway.

For example, in health promotion and education, especially in schools, one interviewee noted that the Education Directorate and ACTHD worked very closely together, placing this effort at the cooperation and alliance level of the collaboration span.

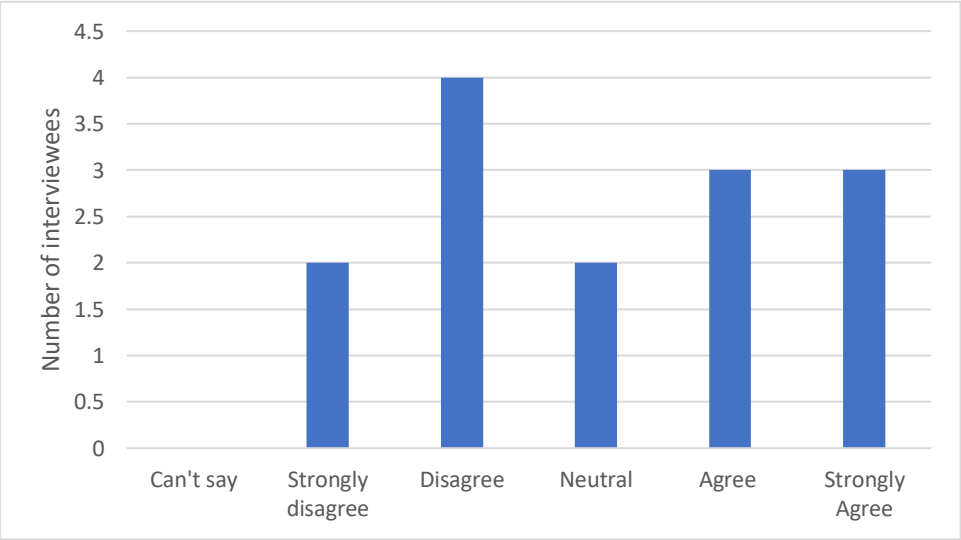
Figure 20 – The span of collaborative intensity



Source: NSW Public Service Commission (2017).

Another area which was seen as a partnership was the First 1000 Days collaboration, notably between ACTHD and Community Services Directorate, but also with other participating Directorates. It was felt that this collaboration was co-designed and branded, with everyone having the same goal and with a clear action plan attached.

Figure 21 – "The Plan supports collaboration" (level of agreement)



Also noteworthy was that internal collaboration within ACTHD was seen to be high, but the "conceptual divide" with CHS meant collaboration between the two health directorates was perceived as limited to no more than coordination.

Finally, the collaboration between the PDE team at CMTEDD and ACTHD on the Evaluation Framework was appreciated, with one respondent stating that "it was a breath of fresh air, with genuine commitment, and there is an important learning from it."

Achievements

Only four of the 14 interviewees agreed that the Plan has had an impact. None of these were from the health directorates (ACTHD or CHS). Most noted that the Plan had supported BAU, and therefore it was difficult to attribute anything to the Plan itself.

Among the positive responses, importantly in non-Health areas, the feeling was that the Plan "helped raise the importance of preventive health … but it's hard to identify any real impact." Another respondent said: "in our area the main thing was that the penny dropped, there's a formal framework for this!"

A similar response noted that the Plan was referred to constantly when arguing for a particular intervention … but that "it is actually because we value it [the intervention]", in other words it was not *because* of the Plan, but the Plan supported the argument.

Another stated that "we use it as a guide to ensure our work aligns," and that "it has a role and is useful, but its impacts are hard to tell". The same respondent thought that the Plan "has not had an impact such as the ACT Wellbeing Framework."

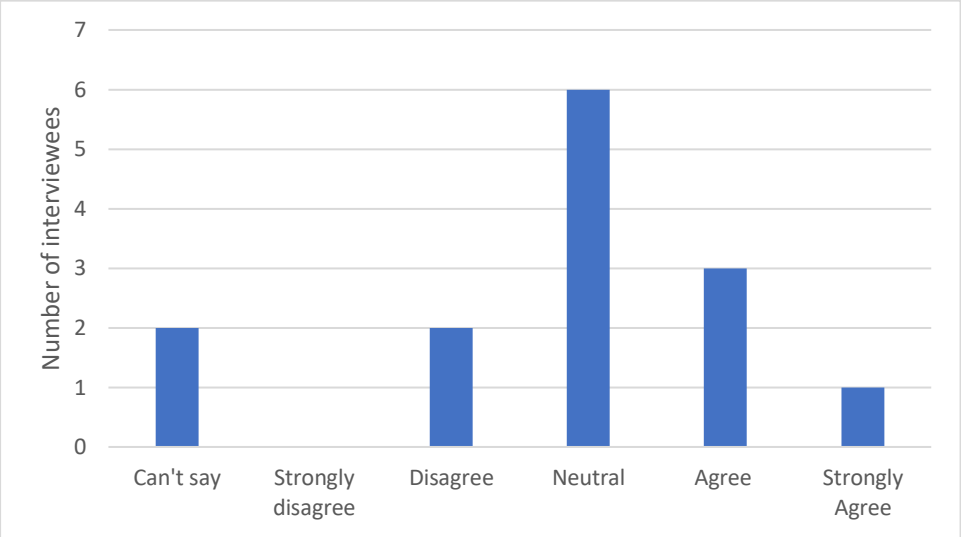
Some interviewees were uncertain, with one noting that "we haven't leveraged off the Plan … maybe there is an opportunity…," and another saying that "some actions are progressing …but they were already in train."

In the discussion about the Plan's achievements, one response stated that the Plan itself is an achievement, as ACTHD did not have a prevention strategy before this. Getting the governance structures in place was seen as another success.

Several interviewees commented on the long-term nature of the goals the Plan is trying to achieve ("preventive health is a slow burn"). It was noted that "you are not going to see enormous change quickly."

Another interviewee felt that it's "hard to talk about behavioural change or health outcomes… but we are in a better position now for the next Action Plan," citing the Evaluation Framework and Program Logics as achievements.

Figure 22 – "The Plan has had an impact" (level of agreement)



Gaps, challenges and unintended consequences

The majority of interviewees agreed that the Plan was appropriately focussed (8 out of 14, see Figure 23 below), although one respondent thought that "the Plan is so high-level, that there is non-engagement".

The Plan was not seen as a "vehicle for change." Key challenges were seen in terms of needing to generate more buy-in, and funding ("resourcing is the big gap and challenge", "lack of funding and resourcing"). One interviewee stated that "the gap is in the enabling system more than what's in the Plan."

Due to the lack of resources, the Plan's Project Team had limited "thinking space" and was "bogged down in administration." As a result, there was also a feeling that there was a lack of innovation.

Issues around data and evaluation were also repeatedly mentioned, for example, with statements such as "data infrastructure is really lacking," "we don't have a data culture," and "we need people who have expertise with evaluation."

In terms of further action areas to explore, the following were mentioned in the interviews:

- More on vaping,
- More on "older people",
- Looking at the impacts of COVID,
- Social isolation, and
- A range of organisational and environmental policies that go towards healthy eating in workplaces.

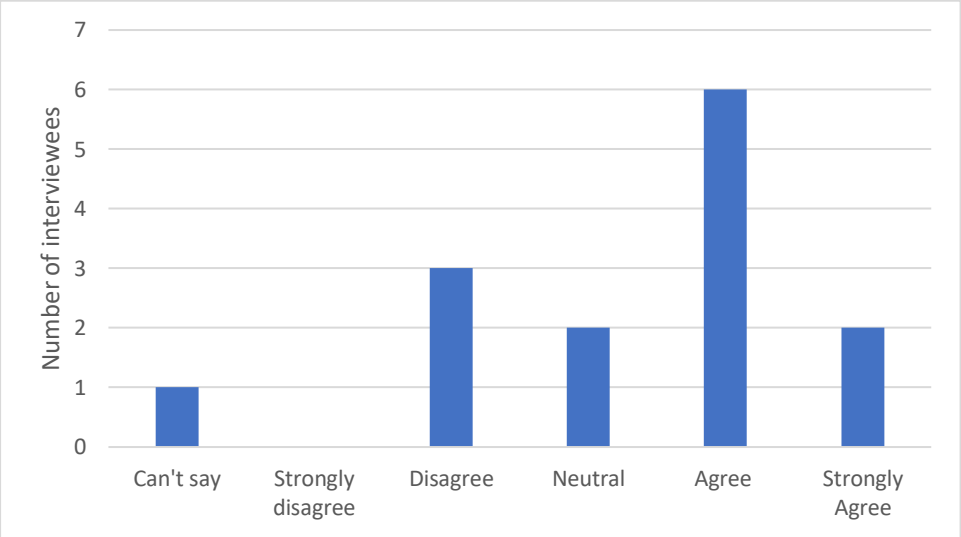
In addition, the opinion that more work still needed to be done on evaluation was expressed repeatedly in one form or another (e.g., "we still don't do good enough in evaluation").

One of the interviewees was relatively new to their job and stated that "it would be good to have some sort of introduction or guidance around what's expected."

Amongst the (few) unintended consequences mentioned by interviewees was that, in one area, engaging with the Plan highlighted some internal governance issues that needed to be addressed in the line area. The respondent saw this as a positive outcome.

One response mentioned "increased workload and frustration" as an unintended consequence. They saw the Plan as a missed opportunity and were unhappy about reporting on a Plan that they had to comply with but had little influence in developing.

Figure 23 – "The Plan is appropriately focussed" (level of agreement)



The internal stakeholders who responded to the internal survey discussed in the next chapter of this Review also provided an indication of where additional contributions to prevention could be made *in their work areas*.

Many of the comments received for the survey once again spoke about funding issues and the need to have a "back bone of structural support for preventive approaches". Some of the opportunities identified were:

- We could have more engaging activities to promote healthy lifestyles. Whether it be film clubs (for social inclusion), walking clubs (for physical exercise), etc. These initiatives should be voluntary, and without fear of further isolation for those who do not participate,
- Social and environmental sustainability actions identified through the SLA Sustainability Strategy,
- We could look at expanding data collection, and
- Working with chronic conditions NGOs to include prevention activities in their ACT Government funded activities.

Resourcing

One of the key themes that emerged from the interviews was the lack of resourcing and support, including funding for new programs and the 'backbone', including the Plan's core Project Team at ACTHD. Some of the relevant statements have already been cited above in the section on the key challenges.

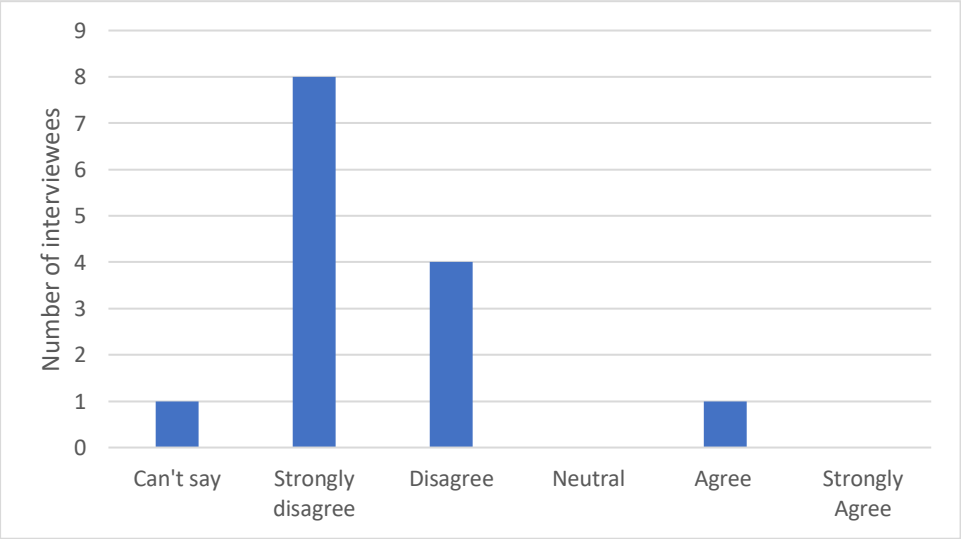
There were numerous references to aspects of this issue in the discussions. One interviewee said, for example, that "a strategy without funding or cross-directorate Executive buy-in is unlikely to have an impact."

Another interviewee stated that "it appears that stuff is happening but the Plan is not resourced … preventive health needs proper funding ... some Councils across the country have a bigger *media* budget."

From the Project Team's point of view, the lack of "built-in capacity" was clear. A Policy Officer and a Director were originally assigned the task of managing the Plan, which they had to take on in addition to existing responsibilities.

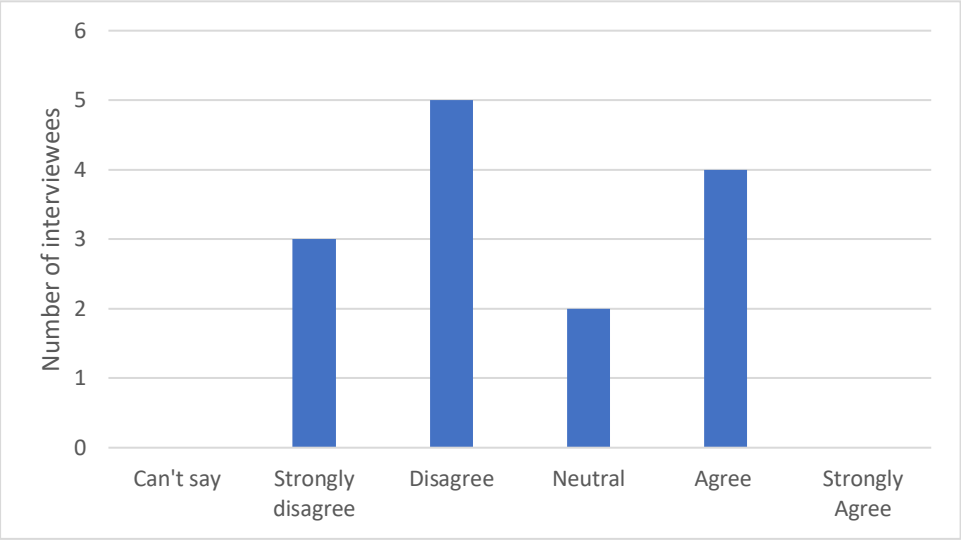
A need for a health economist was identified, "to find out how much we spend on prevention." The need for the team to include an epidemiologist was also identified.

Figure 24 – "The Plan is adequately funded" (level of agreement)



It is therefore not surprising that 12 out of 14 interviewees thought that the Plan was not adequately funded, and only 4 out of 14 agreed that the Plan was well supported (Figure 24 above and Figure 25 below).

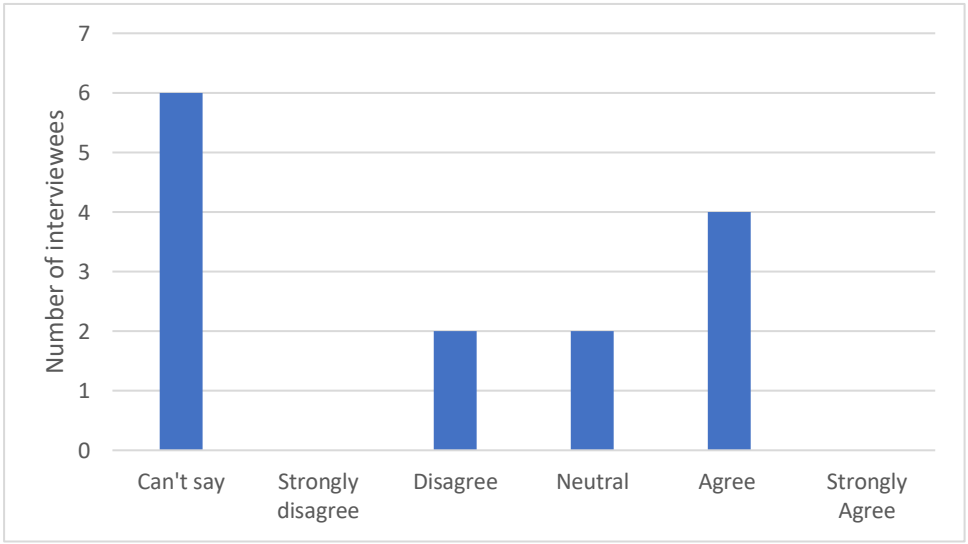
Figure 25 – "The Plan has been well supported" (level of agreement)



Overall assessment

Finally, interviewees were also asked about their level of agreement with the statement that "overall, the Plan is on track." As Figure 26 illustrates, only 4 of 14, or 29 per cent of the interviewees agreed with this statement. This is a low level of agreement.

Figure 26 – "Overall, the Plan is on track" (level of agreement)



Six of the respondents chose "can't say" as their answer. This was somewhat surprising, given that there was a feeling that the *vision* for the Plan was clear.

Some said that they couldn't judge this as they were only seeing a "part of the picture" (operating in line areas), others thought they didn't have appropriate criteria to be able to make that judgment call.

The Review team notes that this level of hesitation did not occur in other recent reviews the team has undertaken, for example, for the Office for Climate Action and the Office for Mental Health and Wellbeing, where agreement to this statement was 80 to 90 per cent.

Finally, the Review team notes that none of the interviewees from health areas (i.e., ACTHD and CHS) agreed that the Plan is on track. The four people who agreed to this statement were from non-Health areas.

Internal survey and social network analysis

A major aim of the Review was to understand the type and level of collaboration occurring under the Plan. To explore the topic of collaboration, the Review team proposed a Social Network Analysis (SNA) approach.

As the implementation of the SNA required the use of a survey, the Review team also took the opportunity to ask those completing the SNA to also answer a few questions relating to their work and collaborative efforts under the Plan.

Social Network Analysis

The use of social network theory – the theory that social network structures influence social dynamics and interactions – and associated analyses has expanded immensely in public health in the past decade.

Social network analysis (SNA) in public health initially focused mainly on transmission of infectious diseases but more recently has also been applied to assess behaviours associated with chronic conditions.

SNA can be used to measure partnership characteristics to evaluate collaboration and the effectiveness of partnerships. Given the level at which the Mid-Term Review was pitched, the PDE team identified this as a useful approach, noting however that this was somewhat experimental in nature given it is not common practice in the ACT Public Service.

The underlying *Theory of Change* is that long-term success in prevention requires action across a range of domains, and appropriate collaboration across Directorates should be able to yield more efficient and effective use of resources which in turn should translate into better outcomes for the Plan. As summarised by Reynolds et al. (2014):

> *…when an organization can see that it is part of a network of organizations providing the full range of services, and when it learns to collaborate within that network, it can gain access to and make use of information, skill sets, commodities, materials, and resources better than it can as a solitary organization... Well-coordinated networks can result in more synergies, less duplication, saved expenses, more thorough provision of services, and better health outcomes.*[43]

Social networks comprise relationships between individuals or organizations. To capture these relationships, social network analysis – here defined as the systematic analysis of relationships among a bounded group of individuals – provides techniques and tools, as well as theories, for understanding interaction.

Social network analysis is used to measure the formation, structure, and progression of relationships, and provides tools to help evaluate coalitions by showing their structure and the processes among members.

It is possible that stakeholders are not always linked *directly* to a program, project, plan, or activities, for example, but that they are linked through other “bridging” stakeholders. SNA

can yield insights by examining how stakeholder network structures, and the position of each stakeholder within the structure, may influence outcomes.

To conduct social network analysis research, data are collected and recorded on who is connected to whom and often at what level of relationship these connections occur (i.e., how well actors know each other). These data are then used to derive network measures to answer a research question.

Social network analysis is especially relevant for understanding, guiding, and improving relational processes. SNA techniques can be used to better understand collaboration networks and help recognise potential pitfalls of collaboration and find possible remedies.

MTR approach – SNA plus internal survey

Detailed planning and survey design work was undertaken prior to implementation of the SNA. One of the review team members Dr Jasmin Kientzel developed the approach, which was also presented to the Expert Evaluation Working Group. This entailed:

- Selecting the data collection method/process (the Review team settled on doing a survey in SurveyMonkey),
- Collecting data from potential stakeholders, using the snowball method starting with a core group of stakeholders (list supplied by the PHP team) and a General Notice sent to all ACT Public Service employees in May 2022, and then iteratively reaching out to new potential connections,
- Including a series of *additional* survey questions which were not strictly necessary to complete the SNA, but which were relevant to the Mid-Term Review (to avoid having to contact stakeholders multiple times for this review), and
- Importing data into KUMU, a cloud-based visualisation platform for mapping systems that also produces analytical scores (based on graph theory) to better understanding the nature of the relationships represented in the maps.

One of the unintended benefits of completing the SNA was that it allowed the PHP team to refine its stakeholder contact list, and on occasion discover new connections. This was partly due to staff coming and going in various teams across the ACT Public Service.

Participating in the SNA also served as a reminder to stakeholders about their role in the PHP, was found to be thought-provoking, and as such supported the collaborative effort led by the PHP team.

More detail on methods and findings was presented by Dr Kientzel to both the PHP Team and the Expert Evaluation Working Group in October 2021, February 2022, and June 2022.

As our approach integrated the internal survey with the SNA survey, the following sections report on both of these.

Participation

In total, 44 responses were received for the Preventive Health Plan Mid-Term Review Survey, which included the questions required to complete the SNA.

Around 60 individuals had initially been invited to participate in the survey, including by email but also in some instances through verbal invitations (e.g., some interviewees). This suggests a response rate of around 75 per cent was achieved.

Those who responded took on average just under ten minutes to complete the survey (9m:46s). 91 per cent of respondents (41 out of 44) had heard of the Plan, and 84 per cent (32 individuals) had themselves been in contact with the PHP team at ACT Health. Around three in ten (29 per cent) also said that another member in their team had been in contact with the PHP project team.

Nearly seven out of ten (68 per cent) of respondents had worked in their position for more than 12 months, with a further two out of ten (21 per cent) having working in their position for 6-12 months. Only one in ten had been in their positions for less than 6 months.

38 respondents provided their names and the Directorate they work in, with 6 skipping these two questions. In terms of directorates and agencies, the participation rate was as follows:

- ACT Health (19)
- Education (4)
- Transport Canberra and City Services (4)
- Chief Minister, Treasury and Economic Development (4)
- Environment, Planning and Sustainable Development (3)
- Canberra Health Services (2)
- Community Services Directorate (1)
- Justice and Community Safety Directorate (1)

This gives an indication (or proxy measure) of the level of engagement with the Plan across Directorates for the following reasons:

- Invitations to complete the survey were originally based on a stakeholder list provided to the review team by the PHP project team (i.e., a list of those engaging on the Plan with ACT Health in the first place),
- There was significant opportunity for greater participation in the survey from other directorates given the snowballing approach and also the all-staff message that invited anyone interested in the Plan to contact the review team, and
- If responses from some directorates were low because they did not respond to the invitation (i.e., the roughly 25 per cent of invitees who did not complete the survey), this is potentially a further indication of disengagement.

Some directorates were clearly under-represented in the internal survey and the reasons for this should be explored further.

The nature of collaboration occurring

Several questions in the survey were asked to better understand the nature of the collaborative activity that is currently occurring under the Plan.

When this survey was designed, the Review team considered including a direct question about the 'quality' of collaboration, but this was identified as potentially controversial (respondents might feel uneasy answering this question).

Type of collaborative activity

Some inferences about the 'quality' of collaboration can nonetheless be inferred by examining the answers to 'noncontroversial' questions about the frequency of contact and the type of collaborative work undertaken:

- Around 80 per cent of respondents had worked on reporting activities and/or exchanged information or ideas relevant to the Plan
- 56 per cent had attended reference group meetings, shared resources on prevention related topics, and/or worked on implementing specific actions for the Plan, and
- Around half of those who responded also indicated that they had engaged in collective decision making in relation to prevention with their main contacts for the Plan.

Frequency of contact

When providing information about the frequency with which respondents had had contact with their main contacts, there was a good proportion who had frequent contact:

- 40-50 per cent of respondents said they had had weekly contact,
- 10-15 per cent had monthly contact,
- Around 25 per cent had contact "once or twice over the last three months," and
- Around 20 per cent had contact "once or twice over the last 6-12 months."

Given the share of respondents who were based at Health directorates (ACTHD and CHS) was over half of the whole group of respondents (21 out of 38) it is possible that this group influenced the average figures cited above.

Overall, this suggests that there has been good and regular contact among the respondents and their key contacts.

Collaboration by Priority Area

The respondents were also asked which Priority Areas their communication with key contacts related to (they could choose more than one area), and this revealed that:

- 40-50 per cent selected that it related to "all" Priority Areas,
- Around one third selected Enabling Active Living,

- Around one quarter selected Reducing Risky Behaviours and Supporting Children and Families,
- One fifth to a quarter selected Increasing Healthy Eating, and
- Around one seventh selected Improving Healthy Ageing.

This potentially indicates a slightly lower level of focus on Healthy Ageing.

Creation of new links

Another question was asked to establish whether the Plan had potentially supported the creation of new links and networks, by asking whether respondents had worked with the contacts they had listed *before the Plan*:

- 70-80 per cent indicated they had worked with their contacts previously, while
- 20-30 per cent said they had not.

This indicates that the Plan did lead to some new contacts being made; however, whether those contacts were within directorates or solely in relation to reporting, or as part of a more intense collaborative effort can not be established from these data.

Use of external information sources

To explore another aspect of collaboration, the survey asked about which external information sources respondents relied on for decisions in relation to the Plan:

- 80 per cent said they rely on other jurisdictions,
- 73 per cent said they rely on Universities,
- 60 per cent said they rely on Non-Government Organisations (NGOs),
- 27 per cent said they rely on private industry, and
- 20 per cent also rely on other sources (e.g., “AIHW” and “MOOC courses”).

All States were mentioned, and State and Commonwealth Health Departments were named several times. Universities notably included ANU and other local Universities, but also a number of others around Australia, plus Oxford University and several Institutes such as the Sax Institute, Kirby Institute, George Institute, and the Doherty Institute.

A wide range of NGOs were listed, including the Heart Foundation, Cancer Council, local health providers including Winnunga Aboriginal Health and Community Services, Village for Every Child, Pharmacy Guild of Australia, obesity related centres and collectives, and Pedal Power.

In terms of private industry, this included external evaluators and health insurers.

Were existing work practice or plans altered?

The respondents were asked whether participating in the Plan involved altering their “existing work practices or plans (BAU)”. In response to this:

- Around one third stated that the Plan had changed existing work plans and practices, and
- Nearly two thirds stated that "No, it is business as usual in my area," and
- Around 6 per cent chose "Don't know."

Time spent working on the Plan

Respondents were also asked about the proportion of their time which has been spent on the Plan in their work area in the last four weeks. This produced a wide range of responses, including 0 to 100 per cent. More than half the responses were in the 0 to 10 per cent range, three responses between 10-50 per cent, and five responses above 50 per cent (80, 100, 100, 70, 84).

The median value was 10 per cent, which is likely a better representative figure for the 'average' work effort on the Plan than the mean of 25 per cent (which was skewed by the small number of larger values.)

Perception of intensity of collaboration

Finally, internal stakeholders were also asked to rank "the level of collaboration when working on the Plan with your key contacts," using the span of collaborative intensity discussed earlier in this report (see p.42). Based on 31 responses received:

- None ranked the level at "No collaboration,"
- 2 in 10 ranked it at the consultation or networking level,
- 1 in 10 ranked it at the coordination level,
- 3 in 10 ranked it at the cooperation level, and
- 4 in 10 ranked it at the alliance and partnership levels.

In other words, 70 per cent ranked collaboration with their key contacts at the level of cooperation or higher. This is quite a different result to the opinions expressed in the interviews. The explanation for the difference is likely to be a combination of the following:

- While the question asked in the interviews was a general one about the whole of the Service ("Does the plan facilitate partnerships and collaboration?"), the question in the internal survey was about *personal* collaboration "with your key contacts",
- 21 of the internal survey respondents were from Health directorates (19 from ACTHD and 2 from CHS), which means that a lot of the personal 'key contacts' were Health staff referring to other Health staff, and
- The Health directorates lead on 28 of the 40 Priority Actions under the Plan.

As noted in the discussion on collaboration in the interviews, the Plan's Project Team at ACTHD generally rated the level of collaboration higher. The results in the internal survey may therefore provide an explanation for this.

Nonetheless, the internal survey does confirm that there are active and strong collaborations occurring under the Plan.

Community versus staff perceptions

As indicated in the discussion of the community survey results, the review team was also interested in finding out whether staff members working on the Plan knew the issues that were of most concern to the community.

To gauge this, the internal survey presented the same list of issues or concerns to the respondents, asking them:

> *In terms of preventing long-term health issues, which 3 do you think concern the ACT community the most?*

29 responses were received, with 15 respondents skipping this question. One respondent stated that they could not comment on this question, and that we would have to ask the community directly about this.

It was reassuring to find that, for the 29 responses that were received, there was alignment with the Top 3 concerns that the community survey found, i.e., around mental health issues (1st), access to health care (2nd), and obesity and diabetes (3rd).

There was also a good alignment around staff expectation that climate change would be a top concern for the community, which was 5th on the staff list while it was 4th placed in the community survey.

- It is however possible some staff had seen the results of the community survey before completing their own survey, potentially contributing to the good alignment of the top four or five concerns.

Beyond this, however, there were some interesting divergences between what staff expected to be of major concern to the community, and what we found based on the community survey.

There are two 'discrepancies' that stood out in particular, in terms of how far apart the rankings from the community survey and the internal survey were on these two issues:

- Firstly, one in three of the ACTPS staff members (34 per cent) responding thought that the community would rank "Some groups in the community have poorer health than others" as a top priority; this placed the issue in joint 3rd place (alongside obesity and diabetes) for ACTPS staff; however, from the community's point of view this concern ranked only in 13th place with only one in five (19 per cent) community members listing this as a 'Top 3' concern.

This finding may reflect the fact that policy officers and decision makers within government are very much focused on addressing issues of inequality; while that is of course entirely reasonable, the findings of the community survey are an important reminder that this is not necessarily 'front of mind' for community members when they reflect on the issue of what is important to prevent long-term health issues.

- The second major divergence was that 30 per cent of community members thought that long-term health conditions are not diagnosed early enough (5th place), whereas only 3 per cent of the internal respondents thought this would be a major concern to the community (13th place).

Once again, this serves as a reminder that when asked about what concerns them in terms of preventing long-term health issues, community members make a strong link to early detection of disease. This means they make an important link to secondary prevention. It appears that ACTPS staff may currently be underestimating the strength of feeling about this in the community.

There were other issues that ranked highly for the community, but which were not reflected in the internal survey:

- For example, 30 per cent of community members thought getting enough sleep was a major concern in terms of preventing long-term health issues (5th place), but only 7 per cent of the internal survey respondents thought this would be a major concern to the community (10th place).

Finally, on divergence of perceptions, the internal stakeholders were also asked who they thought that the ACT community want to engage in more or less preventive health activities:

- There was one interesting discrepancy, which was that 77 per cent of the internal stakeholders thought members of the community would want NGOs to do more or a lot more. The community survey found, as previously reported, that only 57 per cent of Canberrans thought NGOs should do more. This may reflect an internal bias.

SNA findings

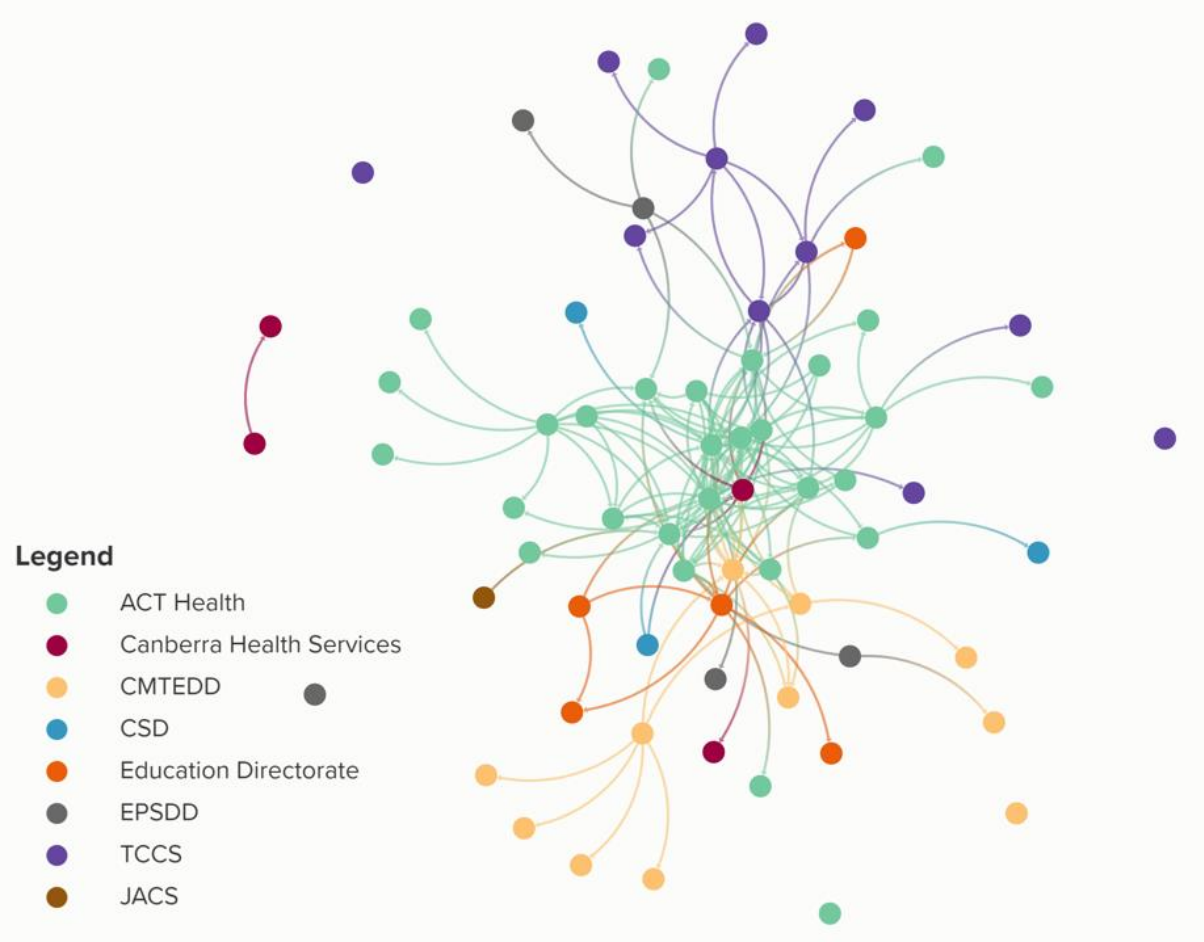
For the purposes of brevity, the main findings are summarised below:

- The survey identified 70 unique elements (people) and 147 relationships being involved in the PHP.
- Low *betweenness* scores suggest that there is little risk of key person dependency in the network, meaning that there are multiple pathways around the network. As noted, however, on an organisational basis, pathways would tend to go through ACT Health and in that sense there is an *organisational* dependency on ACT Health.
- ACT Health staff, in particular those with a direct remit related to the Plan score highest on *closeness*, suggesting that they are central to the network. This also suggests that these staff are more likely to have visibility or an understanding of what is happening across the network.
- The *indegree* score (which reflects the direction of the connection) suggests that ACT Health staff typically have the highest number of incoming connections. Typically, this is reflective of people 'coming to' that person for information, advice, or reporting.

The network map shown in Figure 27 below clearly suggest that ACT Health is very much at the 'centre' of collaborative activity on the Plan (light green dots).

Overall, while the SNA indicates that some collaboration is occurring, it appears to be largely between ACT Health and other parts of government, with relatively little occurring outside of these interactions (i.e., between parties that are not ACT Health).

Figure 27 – Social network map for collaboration under the Plan



The small number of connections identified between ACT Health and Canberra Health Services may also point to a potential gap and supports other findings of this review.

External peer review

An external peer review of the analysis was undertaken by a leading Australian expert and educator on SNA, Matt Healey from First Person Consulting (FPC). As part of this external quality control exercise the data file was reviewed and some duplicate / inconsistent entries were identified. FPC cleaned and re-reviewed the data file for accuracy.

- FPC noted that not all people identified through the survey were invited to complete it. This is likely due to the snowball approach with the final round of new contacts listing further connections that were not able to be included within the timeframe of the SNA.
- FPC also noted that not everyone who was invited to participate in the survey in turn identified names of people involved; this was outside the review team's control.
- Finally, FPC suggested an area for follow-up would be to explore the individuals on the periphery of the network (see Figure 27 above) and considering whether there is a need or value in trying to facilitate greater connectivity with these individuals.

Collective governance and impact

Towards collective governance

In 2018, the *Healthy and Active Living* (HAL) Strategy Team commissioned an implementation guide to collaborate for preventive health from Hecate Consulting.[44] This made the case for collaborative, system-level approaches for preventive health.

In its Executive Summary, the paper notes that implementing a whole-systems collaborative approach requires (with the Review team's emphasis added):

> Developing leadership models and mindsets that support systems-level, collaborative change,
> Convening the system – that is, mapping the 'ecosystem' which surrounds the issue and **bringing together all parts of the system to engage in dialogue** about the nature of the problem, the driving factors and the opportunities for change,
> Assessing the readiness of the system to work more ambitiously on a systems-level collaborative response,
> **Developing a shared agenda** which articulates the shared aspiration between key partners; **identifying those high-leverage activities that will be undertaken collaboratively**; and identifying the supporting activities that will be undertaken by the participating organisations,
> Developing collaborative governance mechanisms, which hard-wire shared decision making into the arrangements,
> Identifying the supporting functions required (e.g., communication, data systems) and **establishing dedicated backbone** capacity to provide those,
> **Developing funding models that support collaboration**, and using the strength of the shared agenda to leverage additional resources, and
> Developing and implementing a shared approach to evaluation, measurement and learning.[44]

The HAL Strategy team had commenced some of the work that still needs to be done, and it also proposed some innovative approaches, including in partnership with the research sector, which are still likely to be highly effective means by which to drive collective impact.

Some of these challenges require broader action – the need to develop the mindset that supports collaborative change, implementing collaborative governance, and the readiness to work on a systems-level response, are all issues that need to be addressed more widely.

Work on the Plan can however begin to attempt to steer the collective effort in the right direction, for example:

> Bringing together all parts of the system for dialogue to develop a shared agenda, and
> Identifying those high-visibility, high-leverage, high impact-activities.

All of this, however, can only happen when there is a serious commitment made, which includes establishing the dedicated backbone and providing funding to carry out the collaborative work:

- The Plan's Project Team is only appropriate in size, skills, and resourcing insofar as the Team's task remains a coordinating task mainly focussed on ensuring *existing* activities continue and are reported on.
- To make real progress, the backbone needs to be designed and strengthened (for example, through dedicated resourcing for data, epidemiology, evaluation, and health economic work, and project cost funding for external engagement).

Attributing collective impact

Real impact in prevention requires action at multiple levels, often over long timeframes. Various policies and strategies, legislation, regulatory regimes, technological progress, shifts in society and cultural attitudes, and environmental issues all impact on prevention.

This is no more obvious than when considering the benefits obtained from a variety of early interventions for children and young people. Each single intervention can make a difference on its own, but typically the impact and benefits are only secured for the long term if they are accompanied by a range of other actions and a supportive environment.

Individuals who are thus supported, in turn ultimately also strengthen the web of capability, opportunity and supports that sustain others and our society in the longer term – there are significant long-term co-benefits or externalities from successful prevention.

Policies and programs at a local level can contribute to making progress but must be seen in this wider context. It is often difficult to isolate and identify the contribution made by small, local programs because they build upon previous programs, and reach only small cohorts.

This has particular relevance for the Plan. The Plan's actions and programs can all point to evidence suggesting why they should sensibly be pursued. While detailed logic models may not have been drawn up in the past, this does not mean that they are bad programs – the logic by which they feed into desired prevention outcomes is often fairly obvious.

It is particularly important to recognise that current work builds on previous work undertaken in each of the areas covered by the Plan. Indeed, many of the calls to action heard today sound similar to those heard decades ago. This, for example, is from a paper on the obesity epidemic in 2000:

> *Traditional ways of preventing and treating overweight and obesity have almost invariably focused on changing the behaviour of individuals, an approach that has proven woefully inadequate, as indicated by the rising rates of both conditions. Considering the many aspects of American culture that promote obesity, from the proliferation of fast-food outlets to almost universal reliance on automobiles, reversing current trends will require a multifaceted public health policy approach as well as considerable funding.*[45]

The paper went on to recommend an obesity prevention campaign including taxes on products that provide "empty" calories (e.g., soft drinks) and on products that reduce physical activity (e.g., cars).

Recognising the nature of collective impact is important in forming judgments about the Plan. This should limit expectations around the evaluation of impact of the Plan.

An important inference to be drawn from this, however, is that it becomes more important to appropriately tailor evaluation of projects and programs in prevention.

The development of more detailed logic models is helpful, and these logic models must be tested in their local application.

As the National Preventive Health Strategy states, data, research, and evidence are important drivers. For the local ACT context, this means engaging much more actively with evaluation at the program and project level.

Final reflections

The following reflections are offered as a summary of some of the highlights that emerged from the Review:

- The Plan covers a range of activities which are clearly linked to prevention outcomes; however, these have all been ongoing (BAU) and no new initiatives or programs were funded under the Plan, and this will make attribution of impact to the Plan difficult when an impact evaluation is completed at the end of the Plan's term,
- The significant delays in setting up governance arrangements were partly due to a shift in focus caused by a combination of external events (bushfire, hailstorm, and COVID-19 emergencies), and internal events such as staff turnover,
- Impetus and collective governance for prevention that was built by the HAL Team was diverted into the Wellbeing Indicators work at CMTEDD,
- Collective governance for prevention has been limited. Over the two years, setting up the governance arrangements was a particular focus for the Project Team – this really meant that no major strategic discussions were progressed.
- The Plan's Project Team has done an excellent job with limited resources under difficult circumstances,
- There appeared to be limited collaboration between CHS and ACTHD which may reflect the Plan's focus on primary prevention,
- There is limited historical evidence on the cost-effectiveness of specific preventive health programs that were rolled out in the ACT, and
- A lack of evaluation, monitoring and data capacity and capability to provide strategic insights regarding the prevention portfolio was noted.

Recommendations

In summary, the Review makes the following eight recommendations:

1. Strengthen the backbone of the Plan through increasing capability in data, research, epidemiology, evaluation, health economic work, and project cost funding to drive preventive health action in the ACT,
2. Identify opportunities to improve collaboration across government to support delivery and evaluation of the Plan, in particular between ACT Health and Canberra Health Services and potentially those individuals identified on the periphery of the SNA,
3. In line with the Plan's existing Evaluation Framework, conduct a series of evaluation exercises linked to the Program Logics developed by ACTHD to better understand how specific programs and projects link to outcomes,
4. Develop an external engagement plan to support the next phase of the Plan's implementation through strengthening the sense of a shared agenda and reaffirming the shared aspiration between key partners.
5. Continue using media campaigns to promote preventive health and increase awareness of the prevalence of chronic disease in the ACT,
6. Increase emphasis on early detection and secondary prevention in the Plan to achieve better recognition,
7. Consider actions for the Second Three Year Action Plan that address potential high visibility, high leverage and high impact chronic condition opportunities, and
8. Continue to address inequality as a major contributor to chronic illnesses.

Next steps

It is also recommended that the Plan's Project Team hold a 'sense-making' workshop to follow up on the findings of this Review.

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ACT Government

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ACT Preventive Health Plan

Mid-Term Review

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