

Australia's National Partnership Agreement on Preventive Health: Critical reflections from States and Territories

Sonia Wutzke PhD, MPH, BSc(Psych)Hons¹ | Emily Morrice BIGS (Hons)² |
Murray Benton BSocSci³ | Andrew Milat PhD, MPH (Hons), BHMS Ed (Hons)⁴ |
Lesley Russell BSc (Hons), BA, PhD⁵ | Andrew Wilson BMed Sci, MBBS(Hons), PhD, FRACP,
FAFPHM²

¹The Australian Prevention Partnership Centre and Menzies Centre for Health Policy, Based at the Sax Institute, Ultimo, NSW, Australia

²The Australian Prevention Partnership Centre and Menzies Centre for Health Policy, Based at University of Sydney, Level 6, Charles Perkins Centre, University of Sydney, Sydney, NSW, Australia

³Inca Consulting, Sydney, NSW, Australia

⁴Sydney Medical School, University of Sydney, Sydney, NSW, Australia

⁵Menzies Centre for Health Policy, Level 6, Charles Perkins Centre, University of Sydney, Sydney, NSW, Australia

Correspondence

Sonia Wutzke, The Australian Prevention Partnership Centre and Menzies Centre for Health Policy, Based at the Sax Institute, Level 13, Ultimo, NSW, Australia.
Email: sonia.wutzke@saxinstitute.org.au

Funding information

National Health and Medical Research Council, Grant/Award Number: GNT9100001; Australian Government Department of Health; NSW Ministry of Health; ACT Health; HCF Research Foundation

Abstract

Issue addressed: Australian efforts to tackle the burden from chronic diseases through prevention have included numerous strategies, committees, policies and programs. This research reflects on this changing landscape, with focus on the most recent, and most significant, investment and subsequent disinvestment in preventive health, the National Partnership Agreement on Preventive Health (NPAPH). The purpose is to better understand the place of the NPAPH in Australia's prevention landscape, explore views from senior health department personnel on the NPAPH and identify lessons for the future.

Methods: Individual and small group semi-structured interviews were undertaken with 19 senior public health managers and program implementation staff from State and Territory health departments across Australia. A grounded theory approach was used to generate themes relevant to the research.

Results: Participants reflected positively on the NPAPH, mostly that it established a strong platform for the national roll out of programs supporting healthy lifestyles, it created core infrastructure that elevated the rigour and sophistication of prevention activities and it was achieving or on the way to achieving its desired outputs. However, despite promising potential, governance arrangements over chronic disease prevention were not clearer either throughout or post the NPAPH. While partnerships between State and Territory governments, as well as with other sectors, were seen as a strength of the NPAPH, many viewed the role of the Commonwealth in the NPAPH as limited to funding.

Conclusion: Longer term investment in, and leadership for, chronic disease prevention is necessary. The NPAPH built on positive reforms at the time, creating opportunities for implementing programs at scale, building workforce capacity and improving evaluations. Early termination of the NPAPH meant potential return on investment was unrealised, new partnerships could not always be sustained and the prevention workforce was again under threat. Furthermore, responsibility for prevention, which was never clear, became even more opaque.

This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

© 2017 The Authors. *Health Promotion Journal of Australia* published by John Wiley & Sons Ltd on behalf of Australian Health Promotion Association

So what? The NPAPH, as a national initiative for achieving improvements to the prevention of chronic disease, was a welcome investment. Disinvestment in the NPAPH, as well as other promising reforms of the time, led to a loss of credibility in outcomes focussed funding collaborations as well as missed opportunities for the future health and wellbeing of the Australian population. Australia needs a recommitment at all levels of government to investment and action in prevention and a restoration of funding in prevention commensurate with the size of the health burden.

KEYWORDS

chronic disease, health policy, Prevention, public health

1 | INTRODUCTION: THE CHALLENGES FROM CHRONIC DISEASE FAR FROM SOLVED

Chronic diseases are a serious and urgent problem¹ with significant global economic burden.² In Australia it is estimated that two-thirds of the total burden of disease across the population is from chronic conditions, including cancers, cardiovascular diseases, mental and substance use disorders, musculoskeletal conditions and injuries.³ Fortunately, at least one-third of the burden of chronic disease is preventable by modifying “lifestyle-related” risk factors, including tobacco use, high body mass, alcohol misuse, physical inactivity and high blood pressure.³ Prevention is also cost effective, with research demonstrating that a small suite of interventions could result in 650 000 fewer years lived with a disability for the Australian population, generating \$6 billion of net savings to the health system.⁴ However, despite what on face value appears to be a compelling case for investment in the prevention of lifestyle-related chronic diseases, Australia currently lacks “a sustained, comprehensive and strategic approach to prevention, together with adequate funding, coordination and monitoring”.⁵

In this article, we reflect on what we see as a “roller coaster” in the ups and downs of preventive health efforts in Australia. We set the context by briefly describing the place of preventive health in Australia’s structures and then give examples of preventive health “events” in Australia over the last four decades. We then add our own data, qualitative interviews with senior health department personnel, that reflect on the most recent investment and subsequent disinvestment in preventive health through the National Partnership Agreement on Preventive Health.⁶ We conclude with comment on lessons learnt and implications for the future.

1.1 | Preventive health: Funding and delivery in Australia

Broadly, preventive health is any action that “aims to support good health and eliminate or reduce those factors that contribute to poor health”.⁷ Whilst this inherently includes health promotion and more general public health endeavours, our focus in this paper, and the

way we use the term preventive health, focuses on activities aimed at the prevention of lifestyle-related chronic diseases. All three tiers of government across Australia have some responsibility for funding and delivering preventive health “actions”. Non-government organisations, the private sector and community groups also have critical roles in preventive health funding and delivery. There are also opportunities to promote good health and prevent illness across the continuum of health care, with the primary care sector having a key role.⁷ Government sectors outside of health, for example, education, urban planning, transport and sport and recreation, also have the potential to develop and implement policies and programs that contribute to preventive health action.

1.2 | The context

Various comprehensive reviews and commentaries have been written on the history and status of preventive health.^{7,8} In the following we do not duplicate these pieces; rather we provide an overview of the key national developments in recent decades. We present our overview across three broad categories: (i) strategies and guiding documents; (ii) national commissions, committees, taskforces and agreements; and (iii) significant infrastructure and program investments. We recognise that this distinction is arbitrary and each event does not happen in isolation. We also recognise that in taking this approach we will not have documented “all events” of relevance, in particular the various campaigns, acts and regulations that undoubtedly have significance. Our approach is taken to set context, with the view that this context provides legitimacy to our “roller coaster” description of Australia’s preventive health efforts.

Box 1 provides examples of the national strategies and guiding documents released over the last 30 years where preventive health has been either the main or part focus. Box 2 provides examples of the various national preventive health commissions, committees, taskforces and agreements that have come and gone over the last few decades. In terms of significant infrastructure and program investments, we draw attention to two periods in Australia’s history; the first between 1985 and 1993 and the second between 2005 and 2014. We have chosen these periods, as each reflects a period of significant national preventive activity in Australia, in terms of the

BOX 1 Examples of national strategy and visionary documents with the potential to influence preventive health

- 1986 Better Health Commission. Looking Forward to Better Health. Vols 1 2 3
- 1988 Health for All Australians
- 1993 Goals and Targets for Australia's Health in the Year 2000 and Beyond
- 1997 Acting on Australia's weight: strategic plan for prevention of overweight and obesity
- 1999 National Tobacco Strategy 1999 to 2002-03
- 2001 Eat Well Australia: An Agenda for action in public health nutrition 2000-2010
- 2003 Healthy Weight 2008 – Australia's Future: The National Action Agenda for Children and Young people and their Families
- 2004 National Tobacco Strategy 2004-2009
- 2005 Be Active Australia: A framework for health sector action for physical activity 2005-2010
- 2005 National Chronic Disease Strategy
- 2005 National Service Improvement Frameworks for: Asthma; Cancer; Diabetes; Heart, stroke and vascular diseases; and Osteoarthritis, rheumatoid arthritis and osteoporosis
- 2006 National Alcohol Strategy 2006-2009
- 2006 Healthy Weight for Adults and Older Australians. A national action agenda to address overweight and obesity in adults and older Australians 2006-2010
- 2008 National Preventive Health Taskforce. Australia: The healthiest country by 2020.
A discussion paper
- 2009 Final Report of the National Health and Hospitals Reform Commission
- 2009 Weighing it up: Obesity in Australia. House of Representatives Standing Committee on Health and Ageing inquiry report
- 2009 National Preventive Health Taskforce. Australia: The healthiest country by 2020. National Preventive Health Strategy – Overview
- 2010 National Primary Health Care Strategy
- 2010 Commonwealth of Australia. Taking preventative action – a response to Australia: the healthiest country by 2020
- 2011 Participation in the UN General Assembly (UNGA) and adoption of the Political Declaration on the Prevention and Control of Non-communicable Diseases
- 2013 Shape up Australia healthy lifestyles initiative
- 2013 WHO Global Monitoring Framework on Non-Communicable Diseases
- 2013 ANPHA State of Preventive Health
- 2013 Moving Australia 2030 – A Transport Plan for a Productive and Active Australia
- 2013 National Primary Health Care Strategic Framework released
- 2015 Australian National Diabetes Strategy 2016-2020
- 2016 Draft National Strategic Framework for Chronic Conditions

number of activities, size of investment and their potential for influencing change.

The Better Health Commission was established in 1985 to report on the health status of the population at the time, to identify factors underlying health problems, and to make recommendations for improvements. Following the Better Health Commission's report "Looking Forward to Better Health", released in 1986,⁹ the Health Targets and Implementation Committee (HTIC) was established with responsibility for developing national health goals and targets and planning for their implementation. The subsequent "Health for All Australians" report represented the first national attempt to compile goals and targets for improving health and reducing inequalities in health status among population groups.¹⁰ The National Better Health Program, established in 1988, provided federal-state funding of A \$39 million over 4 years to initiate strategies to achieve the targets

set by the HTIC. In 1993, noting some limitations in the conceptual framework within which the 1988 goals and targets were developed, the Commonwealth Department of Health, Housing and Community Services commissioned a report "Goals and Targets for Australia's Health in the Year 2000 and Beyond".¹¹ For the first time, this report took a comprehensive view of the social determinants of health, adopting the WHO's definition that health is more than just the absence of disease ... health is a complete state of physical, social and mental wellbeing ... and health is a product of ways of living (lifestyles), and living conditions (social and economic environment).

The second significant upswing in preventive health efforts began in 2005, largely precipitated by the Productivity Commission's Research Report on the "Economic Implications of an Ageing Australia"¹² which suggested investment in the prevention and effective

BOX 2 Examples of national commissions, committees and taskforces with preventive health included in their agenda

- 1974 Hospitals and Health Services Commission (HHSC) established
- 1975 Community Health Program established through the HHSC
- 1975 Hospitals and Health Services Commission disbanded
- 1985 Better Health Commission (BHC) established
- 1987 Health Targets and Implementation Committee (HTIC) established
- 1996 National Public Health Partnership (NPHP) established. The NPHP created a number of subcommittees, which for preventive health efforts most notably included the Strategic Intergovernmental Nutrition Alliance (SIGNAL) and the Strategic Intergovernmental Forum on Physical Activity (SIGPAH)
- 2001 National Obesity Taskforce convened
- 2002 National Obesity Taskforce abolished
- 2003 AHMAC Obesity Taskforce established
- 2006 National Public Health Partnership (NPHP) disbanded
- 2006 The Australian Health Protection Committee (AHPC) and the Australian Population Health Development Principal Committee (APHDPC) established to replace the NPHP
- 2008 National Preventative Health Taskforce (NPHT) appointed by the Commonwealth Minister for Health and Ageing, broadly to "develop strategies to tackle the health challenges caused by tobacco, alcohol and obesity"
- 2012 COAG National Healthcare Agreement signed

management of chronic disease could result in substantial workforce participation and productivity gains. Subsequent reforms through the Council of Australian Governments (COAG) substantially boosted investment in the prevention of chronic disease, initially with the Australian Better Health Initiative (ABHI), a commitment of \$250 million over 5 years from the Australian Government, matched by States and Territories. At the time of allocation, it was specifically noted as a "shift within the health system towards health promotion, prevention, early intervention and management of disease".¹³

This shift was further enhanced by the COAG Diabetes reforms with an investment of \$103.4 million (2007-2011) and the National Partnership Agreement on Preventive Health (NPAPH), the largest single investment in preventing the lifestyle related risk factors that cause chronic diseases in Australia (\$872 million over the period 2008-2014).⁶ Under the NPAPH the Commonwealth Government funded settings-based interventions, social marketing, and enabling infrastructure to be implemented through States and Territories. Initially covering the period 2008 to 2014, but in 2012 extended until June 2018, the NPAPH set out to improve the prevention of chronic disease by: (i) laying the foundations for healthy behaviours in the daily lives of Australians through social marketing efforts and the national roll out of programs supporting healthy lifestyles; and (ii) supporting these programs and the subsequent evolution of policy with enabling infrastructure for evidence-based policy design and coordinated implementation.⁶ A notable feature of the funding was that States and Territories only received a significant proportion of the funding if they achieved pre-agreed targets.

These COAG reforms were accompanied by the establishment of the National Preventive Health Taskforce in 2008.¹⁴ This taskforce authored a number of visionary and strategy documents aimed at progressing the country's preventive health agenda, including "Australia:

The Healthiest Country by 2020".¹⁵ This report received a positive response from the then Commonwealth Government, including: (i) a commitment to reduce the burden from smoking, binge drinking and diabetes; and (ii) a commitment to establish a national preventive health agency, which subsequently gave rise to the Australian National Preventive Health Agency (ANPHA), the country's first national agency solely focussed on the prevention of lifestyle-related chronic diseases. After a change in government at the 2013 election, the 2014 Australian Federal Budget included cessation of the NPAPH and abolition of ANPHA after 3.5 years of operation.^{16,17}

Following cessation of the NPAPH, the formal external evaluation of this initiative was also cancelled. In the absence of this evaluation, our research aims to better understand the strengths and weaknesses of the NPAPH from the viewpoint of senior public health managers and program implementation staff from State and Territory health departments across Australia.

2 | METHODS

Using established guidelines for qualitative research^{18,19} individual and small group semi-structured interviews were undertaken with individuals invited to participate based on their ability to provide an informed contribution to the study. Individuals were recruited using a combination of purposive and snowballing techniques. Respondents were a mix of senior policy makers and program coordinators who had direct experience with the NPAPH at the time of its implementation. Interviews were facilitated separately by two independent, experienced social researchers, who were naïve to the NPAPH and its potential implications for preventive health in Australia. Interviews were undertaken between 2 June 2015 and 14 August 2015

and where possible were face-to-face and audio-recorded. Representatives ($n = 19$) from all Australian State and Territory departments of health were interviewed with interviews lasting approximately one hour. Each jurisdiction nominated respondents based on who they believed would be best placed to provide informed comment on the NPAPH and its implementation in their jurisdiction. One interview involved one respondent, six included two respondents and one was undertaken with a group of six. Despite the differences in numbers participating in interviews, the data from each interview received equal weighting on the results.

The semi-structured discussion guide explored the views of respondents on four broad themes: achievements of the NPAPH; challenges under the NPAPH; cooperation across governments during implementation of the NPAPH; and impact of the early cancellation of the NPAPH. Responses were anonymised and audiotapes reviewed independently by each of the interviewers (MB and his colleague). Consistent with a grounded theory approach themes relevant to the aims of the research were generated from the content of the interviews rather than from a priori assumptions.²⁰ To ensure rigour and objectivity, both interviewers independently reviewed audiotapes to draw out and list themes and sub-themes and then compared their analysis. If there was inconsistency in interpretation a discussion was held with the research team (SW and EM) to review and collectively agree and refine key themes. This process was also used to agree quotations reported in the results. The research proposal was reviewed and approved by the Sax Institute low-risk research assessment committee (R2015/05/03).

3 | RESULTS

The key experiences of the NPAPH raised by participants are presented below in three areas that reflect the logic model of the planned but never completed national evaluation²¹ for the NPAPH. These were: (i) Delivering programs; (ii) Developing enabling infrastructure; and (iii) Working together for sustainable action. Views from respondents on the impact of the early termination of the NPAPH are also included.

3.1 | Delivering programs to build foundations for healthy behaviours

All respondents were of the view that funding provided through the NPAPH created an opportunity to implement a comprehensive suite of prevention activities. Multiple strategies could be in place and “layered” to encourage reach, particularly for vulnerable groups. As one respondent said: *“With that money you can layer up the programs and interventions ... not take such a fragmented approach.”* Many respondents also commented that funding through the NPAPH created an opportunity to expand and scale up existing preventive health programs. For example, one respondent noted the expansion of their existing work in primary school settings: *“We’d already been doing work with primary schools, and the NPAPH allowed us to expand that.”*

Furthermore, according to the majority of respondents the NPAPH created opportunities to develop and trial approaches, with scope for testing innovative ideas. Approaches that were supported by evidence, such as programs that had demonstrated success in other jurisdictions, could be put into practice by jurisdictions that had previously been unable to do so. This process meant that jurisdictions could learn from what approaches worked well or not in order to improve future investments. One jurisdiction, for example, learned how to better engage with previously hard to reach population groups: *“We learned a lot about how to engage particular target audiences – men, blue-collar workers etc. We can use those learnings in future programs and can be a bit more prescriptive when we’re procuring services.”*

In addition to strengthening the platform for prevention programs, some respondents commented that the scale of the NPAPH investment allowed for structural and systemic transformation. As one respondent said: *“It enabled us to reform the system... not just boost or reorient things we were already doing. We took the opportunity to do some system transformation.”* Additionally, several respondents commented that the use of settings to structure prevention activities was an important way of focusing their jurisdiction’s chronic disease prevention efforts.

3.2 | Developing enabling infrastructure for evidence-based policy

The NPAPH was viewed by most respondents as instrumental to building stronger governance. It provided a national structure with clearly identified roles and responsibilities, and coordinated goals that jurisdictions could work towards. As one respondent said: *“We were able to develop the traction, to make the initiatives sustainable from the point of view of ongoing political commitment. [The NPAPH] accelerated culture change, commitment to prevention.”*

Some respondents were of the view that the funding and focus of the NPAPH supported enhanced data collection for population health monitoring and surveillance. According to these respondents, this allowed them to invest more strategically in programs with the greatest population impact. Some respondents also noted that enhanced population health monitoring also meant that they were in a position to more precisely identify geographic areas of need. Programs therefore had the potential to be more effective, and limited resources could be used more efficiently to target areas of most need.

Furthermore, the NPAPH placed requirements on jurisdictions to develop, implement and report against robust program evaluation frameworks. Most respondents saw this as a mechanism for accountability but importantly, also as a means for building the preventive health evidence base. For some respondents, the practice that came from undertaking routine program evaluations was seen as something that provided an ongoing positive legacy. As two respondents said: *“The focus on evaluation was a significant thing – to have it formalised as it was in the NPAPH was very good”* and *“Having access to that data is embedded now in people’s expectations. So yes, the money was useful to us in advancing our [data] collection program.”*

3.3 | Working together for sustainable national action

Respondents had mixed views about the extent to which the NPAPH was successful in building partnerships. Collaboration was viewed across three main areas: (i) partnerships between jurisdictions; (ii) partnerships between jurisdictions and the Commonwealth; and (iii) partnerships with external organisations.

Some respondents felt that the NPAPH created positive opportunities for them to better collaborate with other State and Territory government agencies, primarily within health, but occasionally in other sectors outside of health. For many respondents, the partnerships with other State and Territory Government agencies was seen as the key ingredient that made the NPAPH more than just the funding attached to it. In particular, respondents considered the prevention managers' forum that was facilitated by ANPHA as an integral mechanism for jurisdictions to communicate and learn from each other. Two comments indicative of this view were: *"The technical network was really useful. . . there's no other forum"*; and *"There is definitely a legacy of continued cross government communications. The development of some personal working relationships has been a real benefit."*

Respondents, however, had mixed views about the extent to which the NPAPH facilitated coordination and collaboration between State and Territory governments and the Commonwealth. Some participants felt the NPAPH improved communication between State and Territory governments and the Commonwealth government. They perceived that avenues were provided for guidance and coordination. Yet other participants were of the view that the NPAPH had never truly built a partnership between the levels of government. For these respondents the common view was that the NPAPH was just one government body funding others. They noted that the core aspects of a partnership were absent or did not go far enough. Trust and lack of transparency were raised as specific issues.

Finally, almost all respondents felt that the process of engaging external organisations such as NGOs in program delivery created invaluable opportunities to either develop or strengthen their partnerships with organisations outside of their usual contacts. As one respondent aptly commented: *"The development of some personal working relationships has been a real benefit."*

3.4 | Impact of the early termination of the NPAPH

Respondents all agreed that the early termination meant the full potential of NPAPH programs could not be realised. Programs were often cancelled mid-implementation unless jurisdictions could secure alternate sources of funding. Nearly all respondents made comments that reflected a view that many programs were ready to show good results and help build the case for prevention, but they lost the ability to fully realise their potential once discontinued. An illustrative comment reflecting this view was: *"We got to scale. We were on track. We made all the tweaks we needed to. We had done some interim evaluation. Then the funding was cut."*

For many jurisdictions, the first programs discontinued were community-based programs, often delivered by NGOs or local government agencies. While the decision to discontinue programs considered the risks to stakeholder relationships, some participants noted the erosion of relationships with external organisations after the cancellation of the NPAPH. In some cases respondents reported that programs continued, but only the low-cost, yet visible elements of interventions such as websites were retained. On these occasions the costly and more effective elements (as viewed by respondents), such as counselling interventions were scaled back and/or discontinued.

Many participants also lamented the loss of an avenue of communication between Government agencies since the cancellation of the NPAPH. As one respondent commented: *"The national structure and the sharing that occurred under the NPAPH is a big loss."* Furthermore, the manner in which the NPAPH was cancelled demonstrated that the improved collaboration between the levels of Government, if it occurred, was short-lived and politically dependent. As one respondent commented: *"It was unceremonious – no discussion, no warning, just a letter from the Department of Health and Ageing."*

For many respondents there was a focus on the workforce. Most commented that the early termination of the NPAPH resulted in the loss of a skilled prevention workforce, which they had been able to establish through the NPAPH funding. Some respondents were concerned that for their jurisdictions it could take decades to rebuild this skilled workforce. For others, their prevention workforce was much less affected by the cancellation of the NPAPH in this regard. These respondents noted stronger political support for prevention provided by their own State and Territory governments that provided their preventive health workforce with greater security. Consequently their prevention workforce was less contingent on program based or shorter term funding provided through initiatives such as the NPAPH.

A common issue expressed by almost all respondents was that the early termination of the NPAPH reinstated a level of confusion about leadership for prevention. The clarity around roles and responsibilities with regard to prevention appeared to return to a state of confusion and lack of coordination. Two respondents questioned: *"Whose space is prevention?"* and *"What is the Commonwealth's role here? Funder? Coordinator? It's a contested space that constantly changes."*

4 | DISCUSSION

4.1 | Are their lessons for the future preventive health partnerships?

Australia has a complicated, fragmented, under-funded and ever changing preventive health landscape. There are multiple funders and providers of preventive health actions coupled with a history of numerous, time limited and diverse investments as well as periods of disinvestments in preventive health strategy, committees, policies and programs. This research elicited views from senior State and Territory health department personnel on the NPAPH – Australia's most recent and most significant direct investment in preventive health.

Overall, our research suggests that State and Territory jurisdictions viewed the NPAPH positively and believed it was achieving or on the way to achieving its desired outputs. Most were of the view that the NPAPH created a strong platform for the national roll out of programs supporting healthy lifestyles. The strength of this platform was described as: (i) supporting multiple and layered strategies; (ii) allowing for the expansion and scaling up of existing programs; and (iii) creating opportunities for developing and testing innovative ideas. The setting-based programs in particular were viewed as being on their way to positive outcomes; most pronounced in jurisdictions where existing programs provided strong platforms for expansion and consolidation. The NPAPH had scope for addressing regional needs while ensuring national consistency and application.

Respondents acknowledged that core infrastructure was developed under the NPAPH, which elevated the rigour and sophistication of their preventive health activities. The key themes that arose focussed on: (i) stronger governance; (ii) enhanced data collection capabilities; and (iii) improved program evaluation standards and accountabilities. However, despite promising potential, governance arrangements over chronic disease prevention appear to have not become any clearer either throughout or post the NPAPH. In terms of the opportunity to develop partnerships between State and Territory governments, as well as with other sectors, this was seen as a real strength of the NPAPH. However, to some participants the NPAPH never felt like a true partnership with the Commonwealth, but another Commonwealth to State/Territory funding mechanism.

Finally, this research has shown that the early termination of the NPAPH had significant but varied impacts across all jurisdictions. Broadly, this early termination was reflected across four themes: (i) unrealised potential and return on investment; (ii) weakened partnerships, communication and collaboration; (iii) diminished prevention workforce; and (iv) a return to an unclear governance over prevention.

There are major Australian successes in prevention of chronic disease, with tobacco control a prime example. The lessons learnt from tobacco control – a sophisticated understanding of the complexity of the problem is essential, it takes a long time, evidence-based, multi-faceted and cross-sectoral approaches are required, and courageous leadership, especially at the federal level, and commitment from all levels of Government are critical – need to be applied to all preventive health efforts. Changing political ideologies, potentially a key driver of a prevention agenda at the Commonwealth level, have made it difficult to sustain national prevention efforts over the time frames needed to see returns on investment. Arguably this calls for an increased focus on and evidence for the value of prevention, regardless of political agenda.

It is useful to contrast the relationships, organisation, leadership and commitment of prevention in the chronic disease space to that in communicable disease control (CDC). In CDC the roles and responsibilities of the different levels of government are clear and to a large extent incorporated in legislation. The main coordinating committee, the Communicable Diseases Network Australia,²² has persisted and provided national technical guidance and inter-organisation coordination for almost 30 years. There is strong leadership

vested through the respective Chief Health Officers of the jurisdictions. There is sustained investment in an expert workforce and program funding. It is almost unthinkable that any government would overnight cease funding for this if only because of the spectre of an acute disease outbreak. In contrast, chronic disease, which causes far more death and disability, and in many cases is as preventable, has sustained none of these attributes.

To our knowledge this is the first attempt to qualitatively describe State and Territory views of the NPAPH and its cancellation, post funding. Views included in this research were included from all State and Territory health departments across Australia, ensuring national input from groups primarily responsible for setting policy and implementing preventive health initiatives at jurisdictional levels. Using two experienced consultants to undertake the interviews meant their individual analyses of the data, especially the identification of themes, could be compared, any discrepancies discussed and consensus agreed. Furthermore, having independent consultants conduct the interviews limited bias from any existing relationships and there was no incentive to select results to fit a pre-determined position or agenda.

Conducting semi-structured interviews ensured that discussions could be adapted to each interview; this also meant the research was unable to fully quantify the levels of agreement on issues raised independently from the discussion guide. This study therefore does not allow for comparative analyses between jurisdictions. Furthermore, this analysis is restricted to the perspectives of State and Territory Governments as Commonwealth Government representatives were not available for interview at the time of this research due to organisational changes in that department. It is recommended that future research include input from Commonwealth Government personnel to compare and contrast viewpoints.

5 | CONCLUSION

The challenges resulting from chronic disease are immense and far from solved. It is evident that structures and actions for prevention of chronic disease across Australia are in an ongoing state of cyclical flux, captive to different political ideologies. This work confirms that State and Territory health departments see a need for and welcome longer term Commonwealth investment in prevention, including multi-sectoral partnerships for action. While not perfect, through its settings-based approach, the NPAPH recognised that many of the determinants of health lie in contexts outside the health sector, such as in the food, transport and housing and economic systems. Further, the NPAPH created opportunities for implementing programs at scale, building workforce capacity and establishing improved methods for evidence and evaluation. The funding certainty that the NPAPH gave allowed jurisdictions to improve or alter the way that prevention programs were organised, implemented and evaluated, in particular, recognising the complexity of chronic diseases and their risk factors. The structure of the funding arrangement, with a significant performance based component, gave greater certainty to the

Commonwealth that their investment would not be dissipated outside of prevention. Cancellation of the NPAPH has resulted in a return to a situation where there is little coordination or clarity around the roles of the different levels of Government with respect to chronic disease prevention. Like other programs in our health system, for example the Communicable Disease Network, the effective, efficient and equitable prevention of chronic disease in Australia requires a dedicated stream of funding with clear deliverables and the reinvention of an acceptable and empowered multi-party mechanism for national coordination and leadership.

ACKNOWLEDGEMENTS

This research was supported by the Australian Prevention Partnership Centre through the National Health and Medical Research Council (NHMRC) Partnership Centre grant scheme (GNT9100001) with the Australian Government Department of Health, the NSW Ministry of Health, ACT Health and the HCF Research Foundation. We are grateful to our Project Steering Committee for advice on study design and focus: Bill Bellew, Maria Gomez, Lesley King and Penny Tolhurst. We also thank Professor Don Nutbeam for sage advice during the writing of this paper as well as the interviewees who generously gave their time and candid observations that form the basis of this paper.

CONFLICT OF INTEREST

The authors declare that there are no conflicts of interest in connection with this article.

REFERENCES

- World Health Organization. Global status report on noncommunicable diseases 2010. Geneva: World Health Organization. 2011 [cited 2016 October 21]. Available from: http://www.who.int/nmh/publications/ncd_report_full_en.pdf
- Bloom DE, Cafiero ET, Jané-Llopis E, et al. The Global Economic Burden of Noncommunicable Diseases. Geneva: World Economic Forum. 2011 [cited 2016 October 21]. Available from: http://www3.weforum.org/docs/WEF_Harvard_HE_GlobalEconomicBurdenNonCommunicableDiseases_2011.pdf
- Australian Institute of Health and Welfare. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2011. Australian Burden of Disease Study series no. 3. Cat. no. BOD 4. Canberra: AIHW. 2016.
- Vos T, Carter R, Barendregt J, et al. Assessing Cost-Effectiveness in Prevention (ACE-Prevention): Final Report. University of Queensland, Brisbane and Deakin University, Melbourne [cited 2016 October 21]. Available from: https://public-health.uq.edu.au/filething/get/1836/ACE-Prevention_final_report.pdf
- Moodie R, Tolhurst P, Martin J. Australia's health: being accountable for prevention. MJA. 2016;204:223–5.
- Council of Australian Governments. National partnership agreement on preventive health. Canberra: Commonwealth of Australia. 2008.
- Australian National Preventive Health Agency (ANPHA). State of Preventive Health 2013. Report to the Australian Government Minister for Health. Canberra: ANPHA. 2013 [cited 2016 October 21]. Available from: [http://health.gov.au/internet/anpha/publishing.nsf/Content/state-of-prev-health-2013/\\$FILE/ANPHA%2041087%20State%20of%20Preventative%20Health_acc_pdf.pdf](http://health.gov.au/internet/anpha/publishing.nsf/Content/state-of-prev-health-2013/$FILE/ANPHA%2041087%20State%20of%20Preventative%20Health_acc_pdf.pdf)
- Russell LM, Rubin GL, Leeder SR. Preventive health reform: what does it mean for public health? MJA. 2008;188:715–9.
- Better Health Commission (Australia). Looking forward to better health. Canberra: Australian Government Publishing Service. 1986.
- Targets Health, Committee Implementation. Health for all Australians: report to the Australian Health Ministers' Advisory Council and the Australian Health Ministers' Conference. Canberra: Australian Government Publishing Service; 1988.
- Nutbeam D, Wise M, Harris E, Bauman A, Leeder S. Goals and Targets for Australia's Health in the Year 2000 and Beyond: Report prepared for the Commonwealth Department of Health, Housing and Community Services. Canberra: Australian Government Publishing Service; 1993.
- Australian Government Productivity Commission. Economic Implications of an Ageing Australia. Canberra: Commonwealth of Australia. 2005 [cited 2016 Oct 21]. Available from: <http://www.pc.gov.au/inquiries/completed/ageing/report/ageing.pdf>
- Australian Government Department of Ageing. COAG Health Services. Promoting Good Health, Prevention and Early Intervention. Canberra: Australian GOVERNMENT. 2006 [cited 2016 Oct 21]. Available from: <http://www.health.gov.au/internet/budget/publishing.nsf/Content/43CB719CE72A680CCA257CA0003FF4F6/File/hfact037.pdf>
- Australian Government. Taking preventative action – a response to Australia: the healthiest country by 2020. Canberra: Commonwealth of Australia. 2010.
- National Preventative Health Taskforce. Australia: healthiest country by 2020 – National Preventative Health Strategy – Overview. Canberra: Commonwealth of Australia. 2009.
- Commonwealth of Australia. Budget Budget 2014-15: overview. 2014 [cited 2016 Oct 21]. Available from: http://budget.gov.au/2014-15/content/overview/download/Budget_Overview.pdf
- Biggs A. Australian National Preventive Health Agency (Abolition) Bill 2014. Bills Digest No. 86, 2013/14. Canberra. [cited 2016 Oct 21]. Available from: http://parlinfo.aph.gov.au/parlInfo/download/legislation/billsdgs/3227268/upload_binary/3227268.pdf;fileType=application/pdf
- Daly J. Qualitative method and the curse the illustrative quotation. ANZJPH. 2009;33:405–6.
- Daly J, Lumley J. Bias in qualitative research designs. ANZJPH. 2002;26:299–300.
- Glasner B, Strauss A. The discovery of grounded theory: strategies for qualitative research. London: Transaction Publishers; 2009.
- ARTD Consultants. National Evaluation of the National Partnership Agreement on Preventive Health: Evaluation Framework and Strategy. 2012 [cited 2016 Oct 21]. Available from: <https://health.gov.au/internet/anpha/publishing.nsf/Content/COA122EA79DC82CDCA257B7E00271007/File/NPAPH%20Evaluation%20Framework%20and%20Strategy%20%28D13-21967%29.PDF>
- Australian Government Department of Health. Communicable Diseases Network Australia (CDNA) [Verified 2016 October 21]. Available from: <http://www.health.gov.au/cdna>

How to cite this article: Wutzke S, Morrice E, Benton M, Milat A, Russell L, Wilson A. Australia's National Partnership Agreement on preventive health: Critical reflections from States and Territories. *Health Promot J Austral*. 2018;29:228–235. <https://doi.org/10.1002/hpja.9>