

“What We Heard”

Full Summary – Consultation on the draft Strategic Plan
for Preventive Health Action 2026–2034

July 2026

1. Introduction

Preventive Health SA sought feedback on its draft Strategic Plan for Preventive Health Action 2026 to 2034 before the Plan is finalised. The Plan sets a long term direction for preventive health action and tests how PHSA can work with government, communities and partners to improve health and reduce preventable inequity.

Good Government Advisory conducted consultation during June and July 2026. Engagement included facilitated workshops, a structured staff survey, written submissions and the YourSAy public platform. The consultation tested five themes: clarity and accessibility; objectives and strategic coherence; roles, responsibilities and partnerships; equity integration; and implementation, accountability and measurement.

The consultation involved 173 participants representing 53 organisations and received 52 written submissions. This document reflects that feedback under the five themes it was tested against. It is a record of what was heard, not an assessment of individual proposals, a set of recommendations, or a position of Preventive Health SA or Good Government Advisory. It does not identify points by consultation channel.

Stakeholder consultation session	Attendance (individuals)
Preventive Health SA staff	72
Non-government stakeholders	43
Local, state and federal government	54
Aboriginal organisation	4
TOTAL	173
Written submission pathways	Number received
Staff written feedback	3
YourSAy public consultation	21
Written submissions	52
TOTAL	76

2. Clarity and accessibility

Participants generally regarded the Plan as serious, ambitious and grounded in evidence, and supported its systems focus. Their central concern was that the document asks readers to work too hard before its purpose, priorities and logic become clear, and that repeated use of “we” and “our” leaves it unclear who is committing to what. Feedback called for a shorter, more practical case for change, wider recognition that Plain English, Easy English and Easy Read serve different purposes, and more consistent use of terms and evidence throughout.

- Participants wanted the plan to state who it is for, what type of document it is and its decision-making authority, and to define “we” and “our” so it is clear who is committing to what.
- Feedback called for a shorter, more practical case for change that connects structural conditions to people’s daily choices, health outcomes and downstream costs, sitting economic and disease-burden evidence beside a wellbeing, generational and lived-experience account.
- Participants suggested worked examples covering language barriers, service navigation, cultural mismatch, delayed access to care and early childhood adversity, and said the repeated use of “burden” felt distancing.
- Feedback wanted the objectives infographic and Theory of Change moved to the front of the Plan, supported by an upfront roadmap and a visual Plan on a page.
- Participants proposed a layered online format, with an accessible core document and more detailed evidence, population data and supporting material available across the Plan’s eight-year life.
- Partners sought practical briefing packs, FAQs, worked examples, templates and sector lenses showing the Plan’s relevance to areas such as housing, transport, early childhood, education and primary industry.
- Participants stressed that Plain English, Easy English and Easy Read serve different purposes and should not be used interchangeably, and asked for Auslan, translated, audio and video formats so people with intellectual disability are not excluded.
- Some participants suggested using “health promotion and illness prevention” alongside or instead of “preventive health” for public audiences.
- Feedback called for consistent definitions of key terms, including priority populations, determinants of health, supportive environments, innovation labs, wellbeing impact assessments, food and nutrition terms, and mental health and wellbeing.
- Participants wanted priority populations anchored in the Preventive Health SA Act 2024, with terminology aligned to related statewide plans and recognised tools such as the Australian Dietary Guidelines.
- Feedback asked for closer attention to figure legibility, colour contrast, image choice and chart consistency, applying an established accessibility checklist such as the New South Wales Government checklist.
- Participants wanted data sources and limitations identified clearly, including where evidence is Australian rather than South Australian.
- Feedback flagged specific figures and examples for correction, including the road-safety example of proportionate universalism and visual claims that overstate correlation as causation.

3. Objectives and strategic coherence

Participants broadly accepted the five objectives as a coherent structure for a systems-level approach to prevention. Their central concern was that the objectives explain ways of working more clearly than PHSA's substantive prevention priorities, boundaries and intended contribution, and that some areas of prevention are less visible than others across the document. Feedback also raised concerns about specific objective language, including "Enable community", and sought sharper links between risk factors, determinants, actions and outcomes throughout.

- Participants sought a scope statement covering what is in and out of scope, the prevention continuum from primary through to quaternary prevention, and links with adjacent strategies, though views differed on how broad that scope should be.
- Feedback asked for sharper links between risk factors, conditions, determinants, actions and outcomes, noting the Plan sometimes combines risk factors and disease conditions in ways that obscure what PHSA intends to prevent, influence or measure.
- Participants identified areas needing greater visibility, including mental health and wellbeing, suicide prevention, communicable disease prevention, injury and trauma, oral health, diabetes and cardiometabolic risk, cancer screening, immunisation, vaping, women's health, healthy ageing, and dementia and age-friendly housing.
- Some participants argued physical activity should be a core prevention pillar, and identified general practice, occupational health, digital access and climate change as important prevention concerns alongside nutrition, food security and food environments.
- A life-course framework was repeatedly proposed, spanning pre-conception through to older age, with participants wanting families, children and young people visible in the Theory of Change and outcomes framework, and healthy ageing reflected across the Plan.
- Feedback asked the Plan to recognise tensions where prevention aims conflict with economic promotion, including alcohol.
- "Enable community" was widely seen as passive or paternalistic; participants preferred language such as "support community leadership" or "partner with community", distinguished from "Embed partnerships".
- Participants supported "Mobilise evidence" but wanted it to drive policy, infrastructure, investment, regulation and service decisions, with links to the Chief Public Health Officer's report under the Public Health Act 2011 and PHSA's proposed chronic-disease data platform.
- Feedback sought a clearer position on commercial determinants of health, including tobacco industry interference and policy levers for alcohol, gambling and food and beverage marketing, with a smaller group asking for proportionate action based on well-defined claims and recognised food guidelines.
- Participants stressed that mental health and wellbeing, mental ill health and suicide prevention are related but not interchangeable, and that blurring these concepts can weaken duties under the Suicide Prevention Act 2021.
- Feedback sought links to the National Suicide Prevention Strategy, measures such as psychological distress and social connection, and a culturally grounded approach to youth suicide prevention designed with Aboriginal community-controlled organisations.

- Across the Plan, participants wanted risk reduction balanced with protective factors including social connection, cultural identity, kinship, Country, language, belonging, resilience and community strength.

4. Roles, responsibilities and partnerships

Participants strongly supported PHSA leading through partnership and cross-government influence, but wanted this set out clearly rather than implied. Feedback called for formal governance, clear authority and public accountability rather than relationships and goodwill alone, and for the Plan to state, objective by objective, what PHSA will deliver, lead, influence, fund or expect from others. This was especially significant for Aboriginal community-controlled organisations, where participants wanted partnership grounded in self-determination and community authority rather than descriptions of PHSA building their capacity.

- Participants wanted the Plan to set out, objective by objective, what PHSA will deliver, lead or coordinate, influence, commission, fund, convene, advocate for, or depend on others to do.
- Feedback called for formal governance mechanisms such as a standing interdepartmental committee, a formal Health in All Policies approach, health impact consideration for significant proposals, and independent equity oversight.
- Participants cautioned that a forum without authority could attract delegates rather than senior participants, and wanted the Plan to explain any Premier or Cabinet backing and how PHSA will use its legislative mandate.
- Feedback asked PHSA to name existing accountability mechanisms, including Public Health Partner Authority agreements, and to clarify its relationship with SA Health's Public Health Division.
- Participants wanted the Plan to show how action complements Commonwealth programs, national strategies, state plans and sector initiatives, and to state PHSA's added value clearly.
- The phrase "building capability and capacity of our partners" attracted concern as a top-down description that overlooks organisations' expertise, community trust, governance and cultural authority; participants wanted reciprocal partnerships with shared accountability instead.
- This was particularly significant for Aboriginal community-controlled organisations. Participants said partnership must rest on self-determination, community leadership and their authority, rather than PHSA enabling or building their capacity.
- Feedback sought clear PHSA commitments, Aboriginal decision-making authority and a Cultural Governance Framework, along with a First Nations governance mechanism to oversee implementation and evaluation.
- Participants called for alignment with the Preventive Health SA Act 2024, the SA Aboriginal Health Research Accord, the four Priority Reforms of the National Agreement on Closing the Gap, and the Aboriginal and Torres Strait Islander Co-design Principles.
- Feedback called for sustained investment in the Aboriginal community-controlled sector, long-term workforce development, culturally safe institutions, independent culturally safe complaints processes and anti-racism action.
- Participants raised housing and health infrastructure, where Aboriginal community-controlled organisations and remote communities should lead, and prison health, including gaps in the Prison Health Service linked to the Closing the Gap life-expectancy target for 2031.

- More broadly, participants sought a whole-of-government public health and health-promotion workforce strategy, addressing physician capacity and rural and remote shortages, alongside long-term, outcomes-based prevention investment.
- Schools, early childhood education and care, and workplaces were identified as delivery settings, and participants wanted PHSA to name a broad partner base, including primary care, clinical networks, research partners, community organisations and lived-experience leaders.

5. Equity integration

Participants saw equity as a clear intention in the Plan, but said it needs to be a design principle across its logic, objectives, priority setting, delivery, governance, measurement and interpretation of success, rather than a standalone section. Feedback supported a universal ambition for health paired with recognition that communities face different barriers and preventable burdens, described as proportionate universalism. Aboriginal health and wellbeing featured strongly throughout, alongside calls for stronger treatment of racism, data sovereignty, disaggregated data and an explicit intersectionality lens.

- Participants rejected equity as a standalone section and wanted it embedded as a design principle across the Plan's logic, objectives, delivery, governance and measurement.
- Feedback proposed proportionate universalism, universal action with effort matched to need, alongside a universal ambition for health.
- Participants wanted Aboriginal health and wellbeing to be a cross-cutting lens through all five objectives, grounded in a strengths-based account of culture, kinship, Country, language, community governance and self-determination rather than a deficit account.
- Feedback called for cultural determinants of health in the framework and diagram, drawing on the Mayi Kuwayu Study and the SA Aboriginal Health Promotion Strategy 2022 to 2030, and for the Plan to acknowledge colonisation and structural exclusion.
- Participants wanted racism named as an interpersonal, institutional and systemic determinant of health, alongside homophobia, transphobia and stigma, and cultural safety for multicultural, refugee and asylum-seeking communities.
- Feedback said poverty, income, economic security, housing and food insecurity needed stronger treatment, and linked climate change to heat, respiratory health, housing quality and compounding inequity, referencing Premier and Cabinet Circular 007 and the SA Health Climate Change and Health Framework.
- Participants wanted specific commitments to Indigenous Data Sovereignty, including governance, data-use arrangements, dispute resolution and a clear way to assess the 2030 milestone, with Aboriginal communities guiding how data are collected, used and governed.
- Feedback referenced the SA Aboriginal Health Research Accord and asked for Torres Strait Islander peoples to be visible in data sources, collection and reporting, with some preferring "Aboriginal people in South Australia" for sovereignty reasons.
- Participants wanted outcomes disaggregated by Aboriginal status, geography, income, ethnicity, disability and gender, along with country of birth, language, visa status and SOGIESC data, treating weak data itself as an equity gap.

- Views differed on whether the Plan should name priority populations: some said naming is needed so invisibility does not hide barriers, while others cautioned that a fixed list may not adapt to changing circumstances.
- Participants identified culturally and linguistically diverse communities, refugees and asylum seekers, LGBTQIA+ communities, people with disability, older people, people experiencing poverty or homelessness, people leaving out-of-home care, and regional, rural and remote communities as groups needing explicit attention.
- Feedback wanted an explicit intersectionality lens, since preventable harm often occurs where disability, geography, poverty, gender, culture, sexuality and racism combine, and asked for co-design and lived experience to be resourced and remunerated.
- Participants also sought reference to the Bringing Them Home report and the Aboriginal and Torres Strait Islander Children's Principles, context for child abuse and neglect data, and a review of LiveLighter against weight stigma and unintended harm.

6. Implementation, accountability and measurement

Participants did not expect the Plan to operate as an implementation manual, but wanted a credible bridge between its long-term ambition and sequenced, funded, accountable action. Feedback focused heavily on the Monitoring, Evaluation and Learning framework, which participants saw as underdeveloped, and asked for equity-sensitive measurement that gives equal standing to outcomes, processes and signs of system change rather than relying on aggregate statewide data alone.

- Participants sought staged, resourced action plans with delivery pathways, partner roles, workforce and funding assumptions, review points and ways to adapt, with some proposing development within one to two years of finalisation.
- Feedback asked for a dedicated Aboriginal health implementation stream, supported by resourcing, accountability and First Nations oversight.
- Participants could not tell whether “By 2030” and “By 2034” statements are targets, milestones, examples or directional ambitions, and wanted clearer status given this matters for feasibility and accountability.
- Feedback wanted progress visible sooner through intermediate actions and KPIs every 12 to 18 months, with three- and five-year descriptions of success supporting the legislated four-year parliamentary review.
- Participants saw the Monitoring, Evaluation and Learning framework, including Appendix D, as underdeveloped, citing missing baselines, vague targets, absent data sources and lapsed 2025 milestones.
- Feedback wanted each indicator to state its baseline, trend, target, timeframe, data source, population, responsible party and link to an action and objective.
- Participants challenged an indicator set weighted toward individual behaviour, seeking measures of the social, environmental, policy and commercial determinants the Plan aims to influence, including housing, income, employment and food insecurity.
- Feedback said measurement of mental health and suicide prevention should not rely on deaths by suicide alone, suggesting indicators such as psychological distress, self-rated mental health and social connection.

- Participants wanted the framework to give equal standing to outcomes, progress, processes and signs of system change, so quantitative data does not crowd out measures of co-design, community control and cultural safety.
- Feedback suggested a Health Equity Impact Assessment in program planning and evaluation, alongside qualitative, participatory and community-led feedback sitting beside surveys and administrative data.
- Participants noted only two of 17 population-health indicators were Aboriginal-specific, and sought disaggregation across remaining indicators, plus Aboriginal measures for child development, wellbeing and access to community-controlled services.
- Feedback wanted the Plan to openly identify implementation risks, including cross-agency accountability, partner readiness, workforce capacity, sustained funding, political cycles and the limits of attributing population outcomes to PHSA alone.
- Participants requested prevention investment targets connected to MEL reporting, alignment with partners' existing evaluation frameworks, and sector briefings, quick assessment tools, action templates and worked examples.