Health promotion development in Australia and New Zealand*

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SUMMARY
This paper describes and analyses the development of health promotion in Australia and New Zealand. It argues that health promotion has become an established approach to addressing public health problems in both nations over the past two decades. The paper documents the mixed progress both countries have made in improving the health of their populations and the challenges that remain for health promotion. The paper describes the health promotion infrastructure, investment in health promotion and collaboration that has occurred. It also describes innovations in structure and practice that have been implemented. The paper argues that while there has been considerable infrastructure development over the last decade there are still weaknesses in areas, e.g. workforce development and research and evaluation. While government has been the major investor in health promotion, investment has remained relatively small, in part because decision-makers have failed to be convinced of its value. Collaboration with the public, within the health sector, and with other sectors has been a strength of health promotion activity in both nations. Overall, much has been learnt over the past two decades on which to build. Key features of health promotion include increasing use of intersectoral action, the use of public policy and the mass media as health promotion strategies, and the increasing control Maori have taken over the purchase and provision of health promotion services in New Zealand. Both countries still have significant weaknesses to address, e.g. increasing our focus on the determinants of health, implementing sustainable programs and appropriately engaging the personal health sector in health promotion. Above all, the next decade of development will require increasing emphasis on effective action to reduce inequalities in health, particularly between indigenous and non-indigenous people.

Key words: Australia; health promotion; New Zealand

INTRODUCTION
Health promotion has developed in Australia and New Zealand over the last two decades into an accepted discipline for solving public health problems. While Australia and New Zealand share much in terms of recent history, there are also significant differences—in the size and composition of the populations, and in the size of their economies. There are also similarities and differences in the development of health promotion in both countries.

This paper highlights successes, in terms of improvements in the health of the population and development of the infrastructure for health promotion in both countries. The paper also highlights challenges that remain, including the need to preserve and strengthen the capacity of both countries to solve public health problems and to promote the health of their citizens.

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HEALTH TRENDS

Progress in improving the health of the populations of Australia and New Zealand has been mixed. Both countries face major challenges to the health of the populations in this century, and consequently, to health promotion.

The major demographic trends which are having an impact on the health of the populations of Australia and New Zealand include the aging of the populations of both countries, and the growing cultural and linguistic diversity of our populations.

In 1996, 2.1% of Australia’s population of 18.6 million was indigenous, while 23% had been born overseas (in more than 120 countries) (Skinner, 1997). Of New Zealand’s population of 3.7 million in 1996, 14% were Maori, and 5.5% were Pacific people (Statistics New Zealand, 1998b).

Although relatively sparsely populated, both countries are becoming increasingly urbanized. Rural communities are experiencing significant loss of essential services and population loss as a result, largely, of economic pressures.

Over the last two decades, New Zealand experienced the fastest increase in income inequality of any country for which data are available (Hills, 1995). Similar trends are visible in Australia where an underlying redistribution of wealth from lower to higher income groups is only partly being addressed by government interventions (Nutbeam and Harris, 1997).

In 1998, 7.1% of the New Zealand workforce and ~8% of the Australian workforce were unemployed (National Advisory Committee on Health and Disability, 1998; Australian Bureau of Statistics, 1998). Young people, indigenous people, immigrants with limited English language skills, and people who have limited education are experiencing the highest levels of unemployment. By 1993 one in six New Zealanders and one in 10 Australians was considered to be living in poverty (Australian Bureau of Statistics, 1996; Kelsey, 1997). Although there has been some success in increasing retention rates at high school, the education systems in both countries fail both indigenous Australians and Maori, significantly more of whom leave school without a qualification than their non-indigenous counterparts (McLennan and Madden, 1997; National Advisory Committee on Health and Disability, 1998). In both countries in 1996 significant proportions of people had literacy skills below the levels required to effectively meet the demands of everyday life (Australian Bureau of Statistics, 1996; Ministry of Education, 1997).

The epidemiology of Australia and New Zealand reveals mixed progress toward improving the health of their populations. Life expectancy in both countries has steadily increased over the last 40 years and is now 76 and 74, respectively, for males, and 83 and 79 years for females (Skinner, 1997; Statistics New Zealand, 1998a). However, the gains in longevity have not been shared equally, and in 1996 Maori life expectancy at birth was ~8 years less than for non-Maori. Aboriginal adult mortality rates in Australia are the highest in the world apart from regions gripped in war (Ring, 1995).

In New Zealand the infant mortality rate (IMR) declined throughout the 1980s but levelled off in 1992 at a rate of 6.7 per 1000 live births. The Maori IMR is now more than twice that of non-Maori (National Advisory Committee on Health and Disability, 1998). The overall IMR in Australia continued to decline throughout the 1990s to a level of 5.7 per 1000 live births in 1995, but indigenous IMRs are typically two–three times higher than the rate observed for the total population (Skinner, 1997).

In both countries over the last three decades there have been significant declines in mortality from cardiovascular disease, cervical cancer, lung cancer among males, and from asthma (Pearce et al., 1995). There have been significant decreases in deaths and injuries resulting from motor vehicle crashes (National Health and Medical Research Council, 1997; Ministry of Health, 1998b). The HIV/AIDS epidemic has been contained for almost a decade (Commonwealth Department of Health and Family Services, 1998; Ministry of Health, 1998b), and there have been reductions in deaths from sudden infant death syndrome (Australian Institute of Health and Welfare, 1998; Ministry of Health, 1998b).

Patterns of risk behaviours also show mixed progress. The prevalence of smoking has declined among the populations of both countries, but young adults have a high rate of smoking with a socioeconomic gradient (Gray, 1998; Ministry of Health, 1998b). In both countries there have been some signs of positive changes in nutrition (Australian Institute of Health and Welfare, 1997; Russell et al., 1999). Slightly increased proportions of Australians are engaging in physical activity at recommended levels (Australian
Institute of Health and Welfare, 1997), but there are no trend data for New Zealand. Obesity is an increasing problem in both countries (Australian Institute of Health and Welfare, 1998; Russell et al., 1999).

In both countries alcohol consumption has declined since the early 1990s (although there are signs that the decline may have plateaued in New Zealand). Influenza immunization coverage for the high-risk population has increased in New Zealand (Ministry of Health, 1998b). In Australia there has been a slight increase in the proportion of children fully immunized at 1 year old since 1996 (Australian Institute of Health and Welfare, 1998).

At the overall population level, in both countries there have been significant declines in premature mortality from major causes of death. Analysis of the epidemiological data suggests that Australia is faring better than New Zealand. However, the health status of indigenous Australians and of Maori is significantly worse than that of the rest of the population of each country. Gains in the health of indigenous Australians have been much more limited and much slower than those achieved among Maori and the indigenous population of the United States (Kunitz, 1994). The behavioural indicators point to mixed progress, while the social indicators are showing increasing proportions of the populations of both countries experiencing risks to health—unemployment, poverty, limited literacy, to name but a few.

**TRANSNATIONAL FEATURES**

With their relatively small populations, the economies of both Australia and New Zealand depend upon extensive international trade. Changing patterns of communication, faster flows of money and new mediations of power, mean that global trends now dominate our economic, political and cultural environments (Legge, 1998). The last decade has been characterized by deregulation, privatization of state functions, removal of trade barriers, currency devaluation and other actions aimed at ‘getting prices right’ by removing fetters of the free play of market forces (Porter, 1996; Kelsey, 1997).

The late 1990s has seen significant reductions in growth of the economies of our major trading partners. The benefits that have resulted from economic reform are not evenly or equally distributed across the populations of New Zealand and Australia. There is a growing gap in the distribution of wealth, and between the rich and poor (Raskall, 1993; Hills, 1995). There are rising levels of poverty, and growing concerns about issues, e.g. child abuse, violence, rates of youth suicide, overcrowded living conditions, and a general sense of decline in social cohesion (Newby, 1993; Kelsey, 1997; Pusey, 1998). Australians are showing signs of distrust of universal values or solutions, a loss of faith in religious or political institutions, and a rising sense of risk, anxiety and danger (Wiseman, 1996). In New Zealand, increasing alienation and scepticism about electoral politics and parliamentary democracy has been observed (Kelsey, 1997).

More positively, there is a relatively high level of access to new global communications technologies, and the access to information and the increased capacity to build national and international networks are significant benefits. In addition, both countries have influenced and been influenced by the development of international responses to global issues, e.g. the advancement of women, the environment, global warming and economic development. Also, both are contributors to and beneficiaries of the development of information on and international standards for human rights and social justice.

Australia has experienced significant environmental degradation, with depleted soils, extensive erosion and soil loss, and degradation of waterways. Declines in air quality in major cities and the depletion of the ozone layer (also a concern in New Zealand) are additional environmental concerns. In 1998 major cities in New Zealand and Australia experienced significant disruptions to the systems (water, electricity, gas) that sustain life and industry, reinforcing the need for sustainable public health infrastructure as a prerequisite for population health.

Both countries are linked increasingly with transnational trends that have resulted in profound social, economic and physical environmental changes affecting the lives of our populations. While there have been some benefits from these changes there are also potentially harmful implications for the health of the populations of both countries, and for the health of the physical environment.
INFRASTRUCTURES AND STRATEGIES FOR HEALTH PROMOTION

Infrastructure refers to the systems for policy development, priority setting and resource allocation, monitoring and surveillance, research and evaluation, workforce development, and program delivery that direct and support action to promote, protect and maintain the health of the population (National Health and Medical Research Council, 1997).

Organizational and administrative structures

Australia is a Federation. All three tiers of government have some responsibility for funding and providing components of the nation’s public health services. The States and Territories have principal responsibility for public health/health promotion policy, funding, and program design and delivery, although the Commonwealth health authority and the local government also undertake significant health promotion.

Health promotion programs are ‘delivered’ through specialist health promotion services, community health and primary health care services, hospitals, and general practice. In addition, the private sector, non-government organizations and community organizations also fund and/or deliver health promotion. Other government sectors develop policies and programs that contribute to health, e.g. occupational health and safety legislation, urban planning, or waste management regulations and programs.

The plethora of funders and providers of health promotion has resulted in some confusion about roles and responsibilities, and about leadership. A National Public Health Partnership has been established in an effort to develop a more consistent, comprehensive approach to identifying and solving public health problems.

New Zealand is a unitary state. Government funding for health promotion is largely provided by the national government, although local government also contributes. The institutional arrangements for public health in New Zealand have undergone frequent change in the past 10 years. In 1993 the government sought to improve the efficiency of the health and disability sector by separating the functions of policy, purchase and provision of services.

Within the Ministry of Health, the Public Health Group advises on health promotion policy and legislation and participates in preparing the Government’s Crown Statement of Objectives for the Health Funding Authority, the Crown agency which funds health and disability services. Health promotion services are delivered by contracted providers. They are public (e.g. public health services which are part of hospitals), non-government organizations (e.g. AIDS Foundation, Mental Health Foundation), Maori tribal and non-tribal organizations, and community groups. A wide range of organizations is now engaged in providing health promotion ‘services’—with the Health Promotion Forum (a national peak body) including more than 200 member organizations amongst its constituents. Other sectors of government, e.g. the Land Transport Safety Authority, also develop policies and programs, which promote health.

There has been concern that the separation of policy, purchasing and service provision in health and disability services has led to fragmentation of effort, and some reduction in investment in infrastructure development. But there have been advantages, e.g. better information about what is purchased, increased focus on health outcomes, and the development of Maori purchasing and provider organizations.

Currently, in further restructuring, the recently elected Labour Government is collapsing the policy and purchasing functions of the sector by merging the Ministry of Health and the Health Funding Authority. The exact nature of this merger is unknown at the time of writing.

Policies, laws and regulations

In both countries public health legislation defines responsibilities and sets standards in a range of areas including water quality, air quality, food safety and communicable disease control. Legislation and policy have also been significant elements of comprehensive health promotion efforts. Examples include legislation governing blood alcohol levels in drivers; bans on tobacco advertising and sales to minors; and school policies to reduce children’s sun exposure. These experiences have confirmed the importance of community-wide education to build health literacy about public health issues, to build and ensure high levels of community support for policy or legislation (Vulcan et al., 1992; National Health and Medical Research Council, 1997), and to ensure support for enforcement or
reinforcement measures that support the policy or legislative changes.

**Strategic approach**

Both countries developed health goals frameworks in the late 1980s (Health Targets and Implementation Committee, 1988; Minister of Health, 1989) and revised them in the 1990s in part because new governments chose to revisit them (Nutbeam *et al.*, 1993; Commonwealth Department of Human Services and Health, 1994; Public Health Commission, 1994; Ministry of Health, 1997). New Zealand’s current goals framework is broad and enables people involved in health promotion to choose priorities according to the needs of the community, the resources and expertise available, and the context of their work (Ministry of Health, 1997). The national priorities include reducing unintentional injuries, diabetes and hearing loss; optimizing the safety of food and drinking water; immunization; safe use of alcohol; and reducing the adverse health effects of unemployment and income inequalities.

Australia’s health priority areas are cardiovascular health, cancer control, injury prevention and control, mental health, and diabetes mellitus. A range of national public health strategies is linked with the achievement of these goals. At state and local levels the mix of specific programs being implemented in relation to each of the priorities is dependent upon local/regional/state needs, priorities and the resources available.

This strategic approach has provided a valuable framework for health promotion in both countries, assisting in determining priorities for public health sector investment, co-ordinating action to implement these priorities and focusing on health outcomes to measure effectiveness. However, there is need for the priorities to reflect more accurately socioeconomic, cultural and environmental determinants of health, and for the strategies to emphasize action to address these. New Zealand has begun to do this; Australia has not, yet, done so.

**PRIORITY HEALTH PROMOTION PROGRAMS**

Over the last decade, comprehensive programs have been developed across the priority health issues in both countries. There has been greater emphasis on using advocacy, policy and intersectoral action to change the environments and structures that influence or determine the health choices of communities. In addition, both countries have been effective in using community development, the mass media and community education to inform, educate and mobilize communities to take or support action to promote health. There has been some progress in working in settings. The most successful of this work has been health-promoting schools which has developed into a strong movement in Australia (National Health and Medical Research Council, 1996; Australian Health Promoting Schools Association, 1998), and has been growing in strength in New Zealand, where the ‘Healthy Schools—Kura Waiora’ program has been endorsed by schools and health sector agencies (Public Health Commission, 1995c).

Maori and children are the priority population groups in New Zealand (Public Health Commission, 1995a; Ministry of Health, 1998a). Mainstream providers are required to be responsive to Maori needs and provide culturally effective services. Increasingly, Maori are developing and providing services to meet the needs of their own communities (Ministry of Health, 1998c). A key child health program, the ‘well child-tamariki ora program’, delivers a wide range of health promotion and disease prevention services in primary care settings (Public Health Commission, 1995b). In Australia, priority populations have been identified in relation to each of the national health priority areas, but there is a worrying lack of priority given to the health of adolescents.

Positive changes have been achieved in health literacy, environments, policies, structures, and in some cases, the reorientation of health services. These have, in turn, resulted in reductions in the prevalence of risk behaviours and in premature mortality from a range of conditions (National Health and Medical Research Council, 1997; Ministry of Health, 1998b). The priority programs have enabled comprehensive approaches to develop over sufficient time in which to achieve changes in the health of the population. The challenge lies, now, in achieving equity in health outcomes across the populations in each country. The focus of priority programs must change to address equity rather than specific health problems if success is to be achieved.
CAPACITY BUILDING FOR HEALTH PROMOTION

Workforce development

Both countries have been working to build the workforce required to design and implement effective health-promotion initiatives. Specialized education programs in health promotion, environmental health, mental health and health economics have been developed, in addition to broadening the range of tertiary education in public health (Commonwealth Department of Health and Family Services, 1997; Ministry of Health, 1997; Salmond and Bowers, 1997). However, in New Zealand this investment in workforce development has not been sufficient to meet demand, particularly for Maori. And in Australia a great need remains for programs to extend the health-promotion skills of community members, Aboriginal Health Workers, and professionals in sectors other than health. Within the health sector, too, many health professionals do not have access to adequate education in public health and health promotion.

Research and development

In Australia, the national peak body responsible for medical and public health research and policy advice recently restructured and reduced its capacity to fund the research that is necessary to guide effective health promotion interventions and to provide policy advice. The Health Research Council of New Zealand is the major government-funded agency responsible for public health research. Its current priority areas are child health, Maori health, mental health, and the social and economic determinants of health.

In both countries, the increased focus on evidence-based practice has pointed to the need for increased investment in intervention research, evaluation research, dissemination research, and for active programs to encourage the early inclusion of research results in policy and programs (King et al., 1995; Ministry of Health, 1997).

Evaluation and monitoring

Both countries report regularly on progress in relation to national targets (Australian Institute of Health and Welfare, 1997; Ministry of Health, 1998b), and are continually improving the information systems required for this. For example, New Zealand has recently conducted behavioural research in nutrition and drug taking, to enable measurement of progress toward the national targets in these areas (Field and Casswell, 1999; Russell et al., 1999). The measurements of progress have been limited, on the whole, to mortality, morbidity, and to some behavioural and biomedical risk factors.

In Australia, efforts are now being made to develop valid, reliable indicators of environments and contexts that determine health choices (Nutbeam, 1996; Eckersley, 1998). As yet, there is no systematic measurement of the inputs to, or quality of health promotion. These are future challenges, as is the need to develop better methods and measures and to assess the effectiveness of comprehensive health promotion programs (Speller et al., 1997; Green and Tones, 1999).

INVESTMENTS FOR HEALTH DEVELOPMENT AND HEALTH PROMOTION

More than two-thirds of funding for health expenditure in Australia in 1996–1997 was provided by governments (Australian Institute of Health and Welfare, 1998). A 1.5% levy on taxable income provides all citizens with free access to medical and hospital services. Estimated public expenditure on dedicated health promotion infrastructure and programs represents only ~1–2% of recurrent health expenditure (National Health and Medical Research Council, 1997). However, this underestimates, significantly, total national expenditure on health promotion —particularly when the contributions of sectors other than health, including the private sector, are included (National Health Strategy, 1993).

Less than 2% of New Zealand’s tax-based health budget is allocated specifically for the development of public health policy advice and the purchase and provision of public health/health promotion services. Encouragingly, the proportion of the health budget invested in ‘public health’ has increased slightly in recent years (Durham, 1998).

Both countries have relied, largely, on government investment (from the health budget) to fund health promotion infrastructure and programs. However, toward the end of the 1980s, several state governments in Australia imposed special taxes on tobacco products, a proportion of which was used to establish health promotion...
foundations. At one point, six states had established foundations, one of them applying a tax on alcohol to fund a major alcohol intervention program. The funding available through the foundations is approximately equal to the amount of state/territory government funding for health promotion in each of their respective states, representing a considerable additional investment.

New Zealand has a similar organization, the Health Sponsorship Council, established in 1990. Its focus has been on sponsorship of sporting and cultural events promoting smoke-free, sunsmart and safe driving messages.

The foundations have, undoubtedly, made significant contributions to health promotion in both countries. Their boards include research, business, government and community representatives from a range of sectors. Through their replacement of tobacco sponsorship, they have been able to reach a wide variety of organizations to introduce health-promoting policies and practices, e.g. smoke-free football stadia, or nutritious food served at recreational venues (Clarkson et al., 1998). The funding has also enabled the development of a range of innovative programs in Australia in areas, e.g. mental health promotion, healthy communities (in partnership with local government), and indigenous health promotion. Furthermore, the Australian foundations have contributed to the intervention research that is a necessary feature of effective health promotion.

However, Australia’s experience has also demonstrated the need for the foundations’ roles to complement the roles of government, with the latter having responsibility for overall policy direction, and the establishment of state-wide priorities. The foundations have strong roles in implementation, particularly in achieving structural change through their work with other sectors, in community education, in research, and in advocacy. Where the relationship with government health authorities has not been clearly delineated, the government authorities have, on occasion, withdrawn almost completely from health promotion, leaving a policy vacuum and leading to a weakening of infrastructure support.

The non-government (NGO) sector also invests significantly in health promotion, addressing a range of both health-specific issues (e.g. sexual health, heart disease) and population groups (e.g. older people, immigrants). As the pressure on government funding increases, the NGO sector is likely to become an increasingly important partner in the overall national investment in health promotion.

In both countries there are examples of effective private sector investment in health promotion. But both countries have adopted a cautious approach to collaboration with the private sector as the potential for conflict between the goals and products of some private industries (e.g. tobacco) and the goals and products of health promotion is explored. Nonetheless, the knowledge and reach of business, and the financial and political power that some private industries command, mean that there is likely to be more effort to develop effective relationships between the private and public sectors to promote the health of our populations in the future.

**COLLABORATION AND PARTNERSHIPS FOR HEALTH**

Collaboration has been important in the success of health promotion in Australia and New Zealand; collaboration with the public, within the health sector, and with other sectors.

Both countries have strong traditions of collaboration with the public in health promotion. At the local level, community development is a commonly used strategy, informing the process of community needs assessment that is one of the starting points for most local programs. Public consultation is also routine in the development of health promotion policy. In New Zealand, consultation is a statutory obligation of the Public Health Group of the Ministry of Health. A key development in practice in New Zealand has been the increasingly active engagement of Maori in defining their own public health problems, and in developing and delivering effective solutions to them (Ministry of Health, 1998c).

Over the last decade, several health promotion networks comprised of government and non-government agencies have formed to lead action on specific issues. Some of these include the Coalition for Gun Control (Aus); an advocacy group for tobacco control ASH (Aus and NZ); and Agencies for Nutrition Action (NZ). Professional networks, e.g. the Australian Indigenous Health Promotion Network, the Health Promotion Forum (NZ), the Australian Association of Health Promotion Professionals, the Public Health Associations of Australia and New Zealand are examples of networks of individuals
and organizations that support health promotion practice.

Collaboration between health promotion agencies and health care services is not as strong, although in some states in Australia, the principal delivery mechanisms for health promotion at the local level are primary health care agencies. New Zealand is currently undertaking an initiative, Action for Health and Independence, to strengthen the role of the health and disability sector in public health (Signal et al., 1998). Collaboration with other sectors has contributed, e.g. to reductions in transport-related deaths and injuries, and to reductions in the prevalence of smoking. In New Zealand, the ‘Strengthening Families’ initiative is a joint program of the health, education and welfare sectors, providing support to families at risk (Ministry of Health, 1998a). There are many other examples of successful collaboration and a growing understanding of the factors that enhance collaboration between sectors (Harris et al., 1995; Ministry of Health, 1997).

The collaboration has been achieved by different kinds of relationships between organizations. Some have been relatively short-term alliances, dissolved when a specific project has been completed (Graham-Clarke et al., 1998). Others have been long-term partnerships, established when there are shared goals which are achievable only through action by each or all partners. Examples include the Australian Health Promoting Schools Association, or the Ministerial Committee on Drugs which brings together health, corrections, justice, Maori development, police, transport and education to address the issue from a range of perspectives (Signal, 1997).

Working with other sectors requires health promotion agencies to build the capacity needed to form effective working relationships. Experience in New Zealand and Australia has shown that it is possible to develop such relationships, but that it is not simple, particularly when the area of overlapping interests between organizations is small.

To meet the complex challenges to the health of populations, the health sectors in both countries must build their capacity to collaborate with other sectors, including the private sector. It will also require the development of tools and programs to ensure that other sectors include health and well-being among their assessment of costs and benefits when making decisions about investments.

OVERALL ANALYSIS

Health promotion as a discipline has been established in both Australia and New Zealand in the last two decades. Both countries have demonstrated that comprehensive, sustained programs that address determinants of major public health problems can succeed in improving the health status of the population (National Health and Medical Research Council, 1997; Ministry of Health, 1998b).

Both countries have defined national priority health areas or goals and targets and report, regularly, on progress toward these. A significant proportion of health promotion funding and activity is now invested in programs linked to the priorities, and there is increasing effort to develop nationally co-ordinated approaches.

Much has been learnt from this work upon which we can build. There are several striking features of health promotion practice in Australia and New Zealand, as follows.

- Increasing use of intersectoral action and the development of partnerships to promote health.
- A range of public policy and structural changes implemented to protect or promote health.
- In New Zealand, Maori are increasingly taking control over the purchase and provision of their own health promotion services.
- Use of media as a vehicle for public health advocacy, particularly in Australia. Some of the methods have included paid advertising, soap operas, and talk back radio (Chapman and Lupton, 1994).

In all, the last decade has seen significant progress in building the evidence base for health promotion, in building systems to direct, design and deliver effective policies and programs, and in developing the institutional capacity that is needed to support health promotion. These systems need to be maintained and strengthened.

However, in terms of health promotion knowledge and practice, significant weaknesses remaining in 2000 are our limited success in the following.

- Ensuring that the health impact of decisions made by all sectors is assessed and acted upon routinely.
- Disseminating and implementing sustained programs that incorporate current knowledge of 'best practice'.

244 M. Wise and L. Signal
• Engaging the personal health sector in action to promote health.
• Acting to strengthen factors that enhance good health (Ryff and Singer, 1998), in addition to reducing risk factors.

In Australia there are some signs that the success in achieving policy and legislative changes across a range of sectors has led to some concern that the importance of health education as a vital component of comprehensive health promotion programs is being overlooked.

The infrastructure support for health promotion in both countries has seen considerable development over the last decade. But in both countries there are constant reminders of its fragility. The instability caused by constant restructuring within the health sector militates against the sustained investment in comprehensive programs that is needed for effective health promotion. There has been limited investment in the workforce, research, and evaluation that are necessary components of the capacity of the health sector to direct and guide effective health promotion action. There has been limited investment in identifying indicators that can be used to measure the progress of populations toward health and well-being (Mathers and Douglas, 1998).

Decision-makers across the public and private sectors have failed to be convinced that significant investment in health promotion will add life to years and years to life and possibly reduce expenditure on personal health care. The evidence of success has not, yet, been sufficient to convince governments (nor even the health sector) of the potential benefits to be gained from investment in health promotion.

Improving the health of indigenous peoples will require significant commitment from governments and from non-indigenous populations working in partnership with indigenous people to address the issues that affect their health. In New Zealand, the Treaty of Waitangi has provided a foundation from which Maori populations have been able to argue, successfully in some cases, for the return of control of lands, fisheries and forests, and/or for monetary compensation where this has been impossible. In Australia there was some progress in the early 1990s toward recognition of land rights, reconciliation between indigenous and non-indigenous Australians, and recognition of the harm caused by the policies and practices of governments in relation to Aboriginal affairs. However, in the latter part of the 1990s progress has slowed.

Looking to the future

Many of the challenges ahead are shared across the globe; some are particular to our region. Both countries have, for the last decade, pursued neo-liberal economic policies that have economic development as the principal goal of government. Such policies have already resulted in reduced access by significant proportions of the populations to the resources they need to achieve and maintain good health. Both countries appear to be experiencing rising levels of factors known to be associated with poor health—poverty, poor education retention, high unemployment, social isolation and environmental degradation.

If it is to be possible to reduce inequity in health status across population groups, it will mean persuading governments of the need to build (and rebuild) social capital—to overcome the widespread sense of loss of social cohesion, greater sense of uncertainty and distrust of public institutions and party political processes. A further challenge will be that of ensuring the health of the physical environment, linking the future of the populations of both countries to the future of the planet.

In Australia, reconciliation between the indigenous and non-indigenous populations is a continuing challenge for the future of both groups. In New Zealand, while there have been gains on the part of Maori in determining their future, there is still a significant distance to travel before equity in health outcomes is achieved. In both countries, the health of immigrant populations is under threat as they experience high levels of unemployment, poverty, and limited access to the social and economic support they require to maintain good health.

Implications for health promotion

Many of the challenges to the health development of the populations of both countries are the result of decisions made by sectors other than health. For health promotion to succeed in the future, the priority health goals and targets will need to include the determinants of health, e.g. income, education and employment. This will provide a mandate for broadening the base from which action to promote health is taken, to
include all government sectors, but also, the non-government, private and community sectors. It will also ensure that there is a much greater emphasis on reducing inequalities in health.

Priority will need to be given to restoring or building a sense of social cohesion and a sense of well-being across the population—to creating social capital, and nations will need to invest in both institutional and community capacity to promote health (Hawe et al., 1997). Within the health sector there will be need for greater and sustained investment in the infrastructure and action needed to promote health. Information, money and a skilled workforce are necessary components of effective action to promote health, along with leadership and clear direction. In addition, the role of the personal health care sector in health promotion must be expanded. As a major employer, and in terms of population reach, health care services have the potential to contribute extensively to promoting the health of the population (Mullen et al., 1995).

Creative use of the new communications technologies has the potential to extend community participation in health promotion, to expand and share the information base, and to expand opportunities for community and professional development.

There is a considerable base for health promotion in both countries upon which to build in the future. However, in the face of declines in public sector resources in both countries, maintaining investment in the infrastructure, policies and programs needed to promote health appears likely to be a significant problem. It will be necessary to ensure that there is powerful advocacy to secure continuing investment in action to promote, protect and maintain the health of the population.

There will be need for further development of a wide-ranging series of strategic alliances between the health sector and other sectors. It will mean the health sector identifying the organizations and sectors with whom it shares interests, and developing the skills and programs necessary to achieve shared benefits.

Health promotion has contributed to the health development of the populations of Australia and New Zealand. The challenges facing the health of our populations in this new century will require strengthening of commitment to and investment in health promotion to ensure that individuals and communities have access to the resources they need to achieve health and a sense of well-being.

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