Health promotion in Australia: twenty years on from the Ottawa Charter

Vivian Lin[1,2] and Sally Fawkes[1]

Abstract: Australia has a longstanding history of promoting health through programs that reflect the principles of the Ottawa Charter and recognising the importance of social determinants of health. Health promotion programs are delivered by a wide range of organisations, in a wide range of settings and sectors for, or with, multiple groups. Since the mid-1980s aspects of infrastructure and capacity for health promotion, such as human and financial resources, have been put in place including the establishment of health promotion foundations via tobacco hypothecation. Following neo-liberal reforms in the 1990s, however, government policies have increasingly focused more narrowly on specific diseases and risk factors. Chronic disease has become the new banner under which health promotion, social determinants and efforts to address health inequalities fit. While the importance of social determinants is often recognised within and outside the health sector, health promotion practitioners are seldom at the centre of policy development. (*Promotion & Education,* 2007, XIV (4): pp 203-208)

Key Words: health promotion policy, infrastructure, workforce capacity, achievement

Résumé en français à la page 264. Resumen en español en la página 278.

Key Points

- Australia has a longstanding history of implementing health promotion programs that incorporate the Ottawa Charter principles.
- Health promotion programs are delivered through a wide range of organisations, settings and sectors, and with diverse groups.
- Government policies in the past decade have focused more on specific diseases and risk factors.
- The importance of social determinants is often recognised within and outside the health sector but health promotion is seldom at the centre of policy development.

Australians are fortunate that many of the fundamental pre-requisites for health have been in place over the last twenty years. In relative terms Australians have benefited from high levels of employment, generally good social infrastructure, low risk of natural disasters and civil conflict, a robust social safety net, compulsory primary and secondary education, strong regulatory frameworks for health protection, good housing, universal health insurance coverage through Medicare, with publicly funded primary care, high standards of health professional education, active non-government organisations (NGOs) in the health sector and many clinicians and community organisations interested in prevention (see Table 1). International conventions, treaties and other obligations with a bearing on population health have played a part in stimulating responses to issues such as rights of the child and the environment. The structure of the health system means that funding pressures for hospitals and general practitioners (GPs) dominate the policy agenda. Total government expenditure on public health activities is limited to 2.5 to 3.5 percent, and is generally consistent with the OECD average (see Table 2). In 2003, Australia ranked eighth among selected OECD countries for expenditure on public health and prevention.

The Australian federal system and the Constitution place the main responsibility for service delivery with the states and territories. Consequently, infrastructure, capacity and support for health promotion programs vary across the nation. National approaches depend on funding initiatives from the federal government which has taxation powers and can tie policy actions to funding offers. As such, national policies and programs often serve a leadership and agenda-setting role, accelerating developments at the state level.

Within this context health promotion began to receive attention during the 1980s, a period of renaissance for public health in Australia. Significant infrastructure investment in public health occurred, in workforce education, research, consumer participation and health statistics, along with new policies. These were followed by federal and state cost shared programs covering drug use, women's health, Aboriginal health, cancer screening and HIV/AIDS prevention.

The WHO Health for All agenda put health promotion on the national map through a sequence of reports and program initiatives. The Better Health Commission (1986) suggested that further health gains could be made through intersectoral partnerships in prevention. The subsequent Health for All Australians report (Health Targets and Implementation [Health for All] Committee, 1988) proposed the adoption of health goals and targets as the strategy for advancing health. These reports gave recognition to social determinants of health and offered rhetorical commitment to tackling health inequalities.

Australia's hosting of the 2nd Global Conference on Health Promotion in 1988 further provided momentum for health promotion across the national health priorities at that time, which were cancer, hypertension, nutrition, injury, and health of older people. States initiated large scale health awareness and behaviour change cam-

1. La Trobe University, School of Public Health, Australia. Correspondence to Vivian Lin: School of Public Health, Faculty of Health Sciences, La Trobe University, Victoria 3086, Australia. (v.lin@latrobe.edu.au)
2. IUHPE Vice-President for Scientific and Technical Development

Table 1. **Population and health status in Australia today**

70 percent of Australians live in metropolitan areas, mostly near the coast.
In 2001, the population of Indigenous origin was 2.4 percent.
Over 50 percent of Australians are either born overseas or have at least one parent born overseas.
Mental ill health is the leading cause of the non-fatal burden of disease and injury in Australia.
In 2004-05, an estimated 2.5 million adults were obese and a further 4.9 million estimated to be overweight but not obese.
In 2004, about half of Australia's adults did not undertake physical activity at levels recommended for health benefits.
In 2003-04, Australians aged 15 years and over consumed 9.8 litres of pure alcohol per person per year, ranked 14th highest among OECD countries.
About 70 percent of Indigenous Australians die before reaching the age of 65, compared to approximately 20 percent for non Indigenous Australians.
The health of Australians in rural and remote areas is generally worse than those living in major cities. This partly reflects the generally worse health of Indigenous Australians.

Data sourced from AIHW (2006a) ABS (2007)

paigns, along with local settings based programs, such as healthy cities/localities. Local level agencies implemented small scale health promotion programs targeted to specific groups associated with the nominated health priorities.

Innovation in financing health promotion was introduced in 1987 when the Victorian Parliament passed legislation (Tobacco Act, 1987) to establish the Victorian Health Promotion Foundation (VicHealth) with hypothecated taxation. This was followed by similar legislative initiatives in two other states, bringing a significant injection of resources into health promotion programs and research (Davis & Lin, 2003). This helped position Australia as a leading international force in health promotion, offering a new model for financing applicable to developing and developed countries. At the same time, however, health promotion professionals engaged in lively debates about the relative merits of different strategies given that the evidence base, at this time, was relatively weak in terms of demonstrating what interventions work to improve health and how to sustain these improvements. This prompted scepticism in the mainstream health system about the value of the seemingly substantial increases in health promotion funding.

The 1990s saw a proliferation of new vertical programs such as skin cancer prevention, hepatitis C and sexual health, added to earlier nutrition, tobacco control and injury prevention programs; but funding support was often limited (Lin & King, 2000), particularly under conditions of recession, a general embrace of market ideology and reduced public sector spending in all jurisdictions. The already limited public health and health promotion expenditure came under severe scrutiny.

In the late 1990s the vertical programs became the flagships for health promotion, despite some continuing rhetorical support for community strengthening and settings-based initiatives such as health promoting schools. As the cost of medical care and labour force productivity became dominant, concerns for government decision makers, chronic disease prevention increasingly became a way for health promotion to find policy space.

The paradox in Australia is that, while there have been many successes in promoting health over the past 20 years, as demonstrated in policy statements, program funding and increased health awareness and behaviour change, health promotion as a field has neither figured strongly in the public health landscape, nor been credited for stimulating or fostering these historical developments. The Ottawa Charter is recited and extensively used by local level practitioners yet unknown or derided by many key decision makers.

Health promotion policy

In the past, some politicians saw the word promotion as offering a media opportunity, while others equated health promotion with the social marketing of health messages. Notwithstanding these narrow perceptions, health ministers have been known to be interested in and committed to health promotion, but unable to reconcile

Table 2. **A Snapshot of Australia, from the Ottawa Charter to 2006**

Australia	Circa 1986		Recent	
Total population	1986	16.0 million	2006	20.5 million
Health expenditure as a proportion of GDP	1986	7.8 percent	2004-05	9.8 percent, ranked 11th amongst OECD countries.
Total health expenditure (A$)	1986	$17.2 billion	2004-05	$87.3 billion
Estimated total government expenditure on public health	1984-85	$121 million - 0.8 percent of Government recurrent health expenditure	2003-04	$1266 million, 2.5 percent of government recurrent health expenditure. (1.7 percent of total recurrent public health expenditure from all funding sources)
Doctors/1000 of the population	1986	2.1	2003	2.5
Average life expectancy at birth	1986	Females 79.2 years Males 72.9 years	2002-04 2004	Females 83.0 years Males 78.1 years
Infant mortality per 1,000 live births	1986	8.8		4.7 However the infant mortality rate within the Australian Indigenous population is about 3 times higher.

Data sourced from AIHW (2006a) ABS (2007)

this with pressures to attend to crises in the acute health system. Despite these tendencies, public health advocates have been able to secure many innovations.

Intersectoral action for health was legislatively mandated through amendments to the Health Act in Victoria in 1988 that introduced health impact statements; although it was never proclaimed, the idea stayed alive and was incorporated into legislative change in Tasmania in 1996. Municipal public health plans were seen as a vehicle for local-level intersectoral action; they were initially mandated in Victoria in 1988 and are now undertaken in some other states. Intersectoral approaches are generally recognised in all public health policy statements, including vertical programs, and are a necessary part of program implementation.

Despite the incorporation of health promotion principles within policy rhetoric, the prevailing ideology emphasises individual responsibility and has seen prevention being funded through clinical services, for example, by expanding allied health coverage and lifestyle counselling through Medicare. Notwithstanding its limitations, this approach does start to embed some elements of health promotion practice within the core business of the health system.

Recently, interest in prevention has increased as governments and their officials grapple with the seemingly intractable financial and political problems facing the healthcare system. In 2006 the Council of Australian Governments (COAG), which brings together all heads of governments, adopted a national reform agenda which includes a human capital stream alongside reforms in competition policy and regulation (COAG, 2006). This potentially has the effect of injecting the social dimension back into economic development, with a concern for the impact of aging, health and disability on labour force participation. Human capital thus links health issues with education and labour market reforms, based on a life-course perspective, opening a new dialogue between sectors. While this is a relatively new development in Australia and implementation is still nascent, there is undoubtedly a new policy space for health promotion emerging.

Ironically these debates may occur without much explicit discussion of health promotion as such. Historically the Australian policy approach to health promotion has been highly pragmatic. There is no national health promotion policy, no statement on social determinants of health, nor a national strategy on health inequalities, yet there have been many effective programs to improve health and Australia's health status overall generally reflects this. The policy process, particularly over the past decade, is essentially one of problem solving once an issue is on the policy agenda, rather than broad statements of strategic intent or grand, national plans. The actions that are taken often reflect the Ottawa Charter's multi-level approach, the national tobacco strategy being a prime example, but without explicit reference to the Charter or even health promotion.

Despite early recognition of social determinants of health, little activity has been undertaken under that general banner. Indeed, some senior bureaucrats and conservative politicians have otherwise tended to see the terminology of social determinants as ideological and lacking in an action or results orientation. However, social determinants of health are addressed as they relate to specific health issues (such as housing in Aboriginal communities) and through government-wide programs vested in other portfolios (such as housing, community welfare and education), even though the policies are not framed in population health terms. Moreover, acceptance of the importance of social determinants can be found as core components of such programs on early childhood development, mental health promotion and crime prevention.

Health promoting services

While Australians are fortunate to have national health insurance and universal access to health care, it also means that governments tend to be preoccupied with hospitals, general practitioners, and health insurance issues. Consequently, the significant potential for the health sector to develop responses to health inequalities and advocate for healthy public policies is largely unfulfilled.

Health promotion has tended to be coordinated by discrete service/program units rather than integrated with the core business of health services. Within some states there are well organised units at central and regional or area levels (such as New South Wales), while in other states they are dotted across a broad range of health services agencies, such as community health centres, NGOs, divisions of general practice, and even hospitals (such as in Victoria). Some states have adopted core programs based on state-wide coordination (including tobacco, physical activity, nutrition), while other states tend to build programs within each agency either in response to locally expressed needs or to requirements stipulated by funding bodies.

While health promotion had its early roots in community health centres, attention has shifted to strengthening preventive services across the health system, particularly in the general practice setting through such measures as self-management of chronic diseases and lifescripts based on the SNAP (Smoking, Nutrition, Alcohol and Physical activity) formula. As well as specific programs, system reforms such as normalising participation by consumers and communities in service planning and delivery reflect Ottawa Charter thinking, even if governments' rationale for supporting them are not explicitly concerned with health.

Over time there has also been increasingly strong participation by local government and NGOs in health promotion, reflected in the growth in health promotion jobs. Place management (also known as neighbourhood renewal and other terms) has become a vehicle for whole-of-government coordination. However, these efforts are seen as services, not as part of coordinated sectoral efforts to maximise the health impact of their activities.

Sustainability of health promotion programs, be they centrally coordinated efforts or discrete services in community settings, is problematic, given the need to seek renewal of government commitment to public health programs at regular intervals. On the other hand, having health promotion programs embedded within clinical services means that that funding can be continuing and tied to activity level. As there is a need for health promotion measures to be integrated in the normal operations of the health system as well as being undertaken as specific initiatives, a significant question remains about how to fund health promotion and link health promotion and health service delivery more strongly.

Health promotion resources

The passage of legislation for hypothecated tax to be used for health promotion has clearly been important to secure funding support. Figure 1 shows the extent to which Victoria and Western Australia (being the two states still with health promotion foundations) are advantaged by these arrangements.

Since a 1996 High Court case ruled tobacco hypothecation at the state level as unconstitutional, state health promotion foundation funding is integrated into the state budget process. Figure 2 illustrates how public health, which captures health promotion activities, remains a minute component of Australia's overall health expenditure.

Securing health promotion program funding has mostly relied on advocacy from outside government, which tends to support specific health issues, rather than for health promotion per se. For instance, the Cancer Council of Victoria has a long his-

tory of using a structured and systematic approach to piloting, evaluating and advocating for programs on an issue by issue basis (ranging from tobacco control to skin cancer prevention to screening for various cancers), and governments have been responsive to this form of evidence-based advocacy. Australian decision-makers, espousing interest in evidence-based practice, appear yet to be convinced that there is good evidence underpinning health promotion practice related to addressing social determinants.

In relation to workforce development, there is a wide range of opportunities across Australia for continuing education as well as for gaining formal qualifications. Health promotion has been distinguished as a core specialty within Master of Public Health (MPH) programs, and is increasingly the focus of a number of undergraduate public health programs. The main professional association for health promotion, Australian Health Promotion Association, has been developing competencies for health promotion, along with a successful mentoring program. Many universities offer short courses on specific issues, for example health impact assessment or healthy cities, while some governments (for example Victoria) have funded health promotion short courses for staff in community health centres. Despite a lively professional association and successful annual conferences, the recent national review of MPH programs (Durham & Plant, 2005) recommended that intervention science, rather than health promotion, as a core competency for postgraduate public health education.

Community participation in health

Community participation was put on the health policy map nationally in 1986 with the federal government funding the Consumer Health Forum, although community participation occurred previously in selected states through such mechanisms as community-elected boards of management for community health centres.

It is now standard practice that consumer voices be represented in policy and planning processes at both state and federal levels, whether through consumer representatives on committees, or through consultative processes. The legislation underpinning the National Health and Medical Research Council (NHMRC) also requires the presence of consumer and community representation. Community advisory committees are now mandated in legislation in some jurisdictions for health services. For a time, federal funding supported a national resource centre for community participation in health. The Cochrane Consumers and Communication Review Group receives funding from federal and state governments to encourage the development of an evidence base for consumer participation, health communication and responsiveness to consumer interests. Some training programs have developed in various jurisdictions to support community consumer representatives to gain insight, knowledge and confidence so they can be effective.

Based on these developments, it is possible to conclude that not only is the importance of community participation recognised in Australia through enabling policies, but there is infrastructure supporting participatory approaches. Over the 20-year since Ottawa, however, there has also been some scepticism about who the true representatives of consumers are, and whether the representation model is tokenistic and dated. Some groups are promoting new approaches of consumer engagement, such as the citizens' jury (Lin et al., 2006; Mooney & Blackwell, 2004).

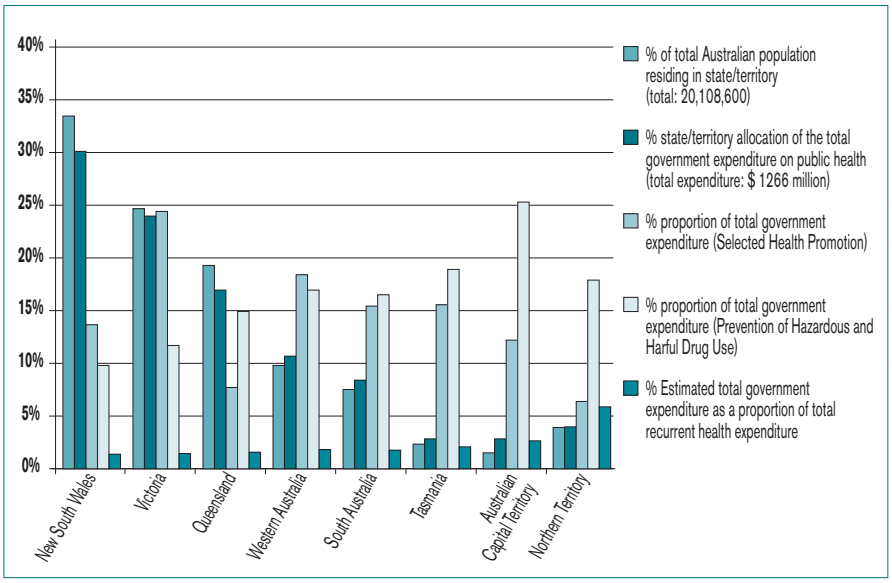

Figure 1. **Proportion of government health expenditure for states and territories with comparison to population, Australia 2003-2004**

Research and information

Australia is well endowed with health information systems and health surveys. Unfortunately, investment has been disproportionately directed to single issue, one-off surveys, or state specific surveys which are not comparable. Although many states have done periodic comprehensive reports on their health status for some years, accessibility to data for further analyses by academic and community organisations has varied across jurisdictions. The relatively weak links between data analysis and health promotion program development and evaluation means the evidence base for program effectiveness becomes limited.

Since the 1990s, there have been coordinated efforts to improve national comparability and reporting across all health services and many health issues, under an intergovernmental agreement. States have also cooperated to align their CATI (Computer Assisted Telephone Interview) surveys, which tend to be more useful for health promotion program planning and evaluation than other data collections. Unfortunately, the skill base and interest of health promotion program planners to use this data still appear to be limited.

On the other hand, for a couple of decades, health promotion program planners have been fostering the development of a common data base, QUIPPS (Quality Improvement Program Planning System). This now functions as an e-library (www.quipps.com) to capture what programs are in place, as a mechanism for mutual learning and to assist in not reinventing the wheel. A broad scope of issues are covered by programs captured in this database such as food security, family wellbeing, promoting use of an equity lens in assessing program operations, preschooler oral health and safe partying for young people.

Where program evaluation is occasionally well integrated with program delivery, such as in tobacco control, HIV/AIDS, and road safety, perceptions have been generated of real successes in health promotion. However, there is generally limited funding for health promotion research and evaluation, both from government and research funding bodies other than in some program areas, in particular GP settings, Aboriginal health and chronic disease self-management.

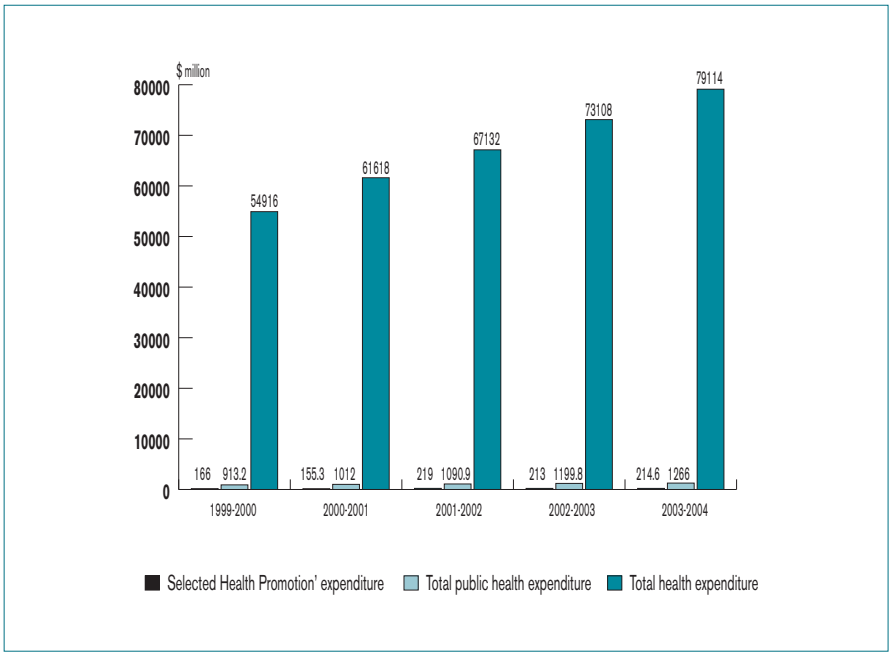

Figure 2. **Expenditure Australia 1999-2004 in AUS$ million, current prices**

Health promotion programme exemplars

Thousands of health promotion programs have been implemented at different levels over the past two decades across Australia, but not evaluated or scaled up to produce significant public health benefits. The *Health Australia Review* (NHMRC 1997a; 1997b) pointed to three major successes in Australia, HIV/AIDS, tobacco control, and road safety, based on such contributing factors as strategic policy leadership, technical guidance, and supportive implementation structures. The evidence base for other programs is more limited and the full impact of the developments of the past two decades awaits systematic evaluation.

Road injury prevention

Road injury is a leading cause of premature mortality in Australia. In the early 1980s, road fatalities averaged 3200 per annum, 1350 associated with drivers having high blood alcohol levels. Road injury prevention interventions have contributed to a steady decline in fatalities and hospital admissions (NHMRC, 1997b). In 2005, there were 1636 road crash fatalities (ATSB, 2005).

Public safety initiatives commenced in 1970 with the mandatory fitting of seat belts. Other measures have included enforcement of seat belt use, traffic light and speed cameras, improvements to road and vehicle safety systems, and education programs designed to promote safe driving (NHMRC, 1997b; NPHP, 1998a; Abelson, 2003).

Federal and state agencies have funded extensive media campaigns to raise community awareness of the dangers associated with drink driving and combined this with the introduction of random breath testing (NHMRC, 1997b). It is estimated that road safety programs saved governments AUS$750 million a year in the late 1990s (Abelson, 2003).

Reduction of tobacco consumption

Tobacco smoking is the largest single preventable cause of death and disease in Australia causing over 19,000 deaths annually (Cancer Council Australia, 2006). The highest rates of tobacco consumption exist within the Aboriginal and Torres Strait Islander populations and people from lower socioeconomic groups (NHMRC, 1997b; ABS, 2006).

Since the early 1970s, tobacco consumption has fallen considerably. With the decline attributed predominantly to the combined impact of government funded mass media anti-smoking campaigns such as QUIT, regulations restricting the promotion and use of tobacco products, and the introduction of taxes which increase the price of cigarettes (Pierce et al., 1990; Tan et al., 2000; Abelson & Taylor, 2003).

A National Tobacco Campaign was implemented in 1997 (National Expert Advisory Committee on Tobacco, 1999). Planning for the campaign involved extensive collaboration between Commonwealth, state and territory governments, NGOs, professional health bodies, and the anti-smoking lobby (NPHP, 1998b; Wakefield et al., 1999).

Nationally, a range of community-based activities and health promotion strategies have included telephone hot lines, kits for smokers wanting to quit, and school teaching materials (NHMRC, 1997b). A combination of diverse strategies recognises the complex causes of the problem and the need to implement a range of effective methods for preventing uptake and reducing smoking prevalence (NHMRC, 1997b).

Reduced tobacco consumption has led to significant health benefits and reductions in premature deaths (Abelson & Taylor, 2003). In terms of public finance, expenditure savings for government provides about AUS$2 of savings for every AUS$1 spent on programs to reduce tobacco consumption, a net benefit of around AUS$1.975 billion between 1971 and 2000 (Abelson & Taylor, 2003).

Control of HIV/AIDS

Around 15,310 people are estimated to be living with HIV/AIDS in Australia (NCHECR, 2006). After HIV testing became available in 1985, annual diagnoses peaked in 1987 at 2773 cases (ABS, 1997), after which the incidence declined to 660 cases in 2000, but then increased to 930 cases in 2005 (NCHECR, 2006).

Australia's response to HIV/AIDS has three main components (NPHP, 1998c):

1. Recognition of the social context and impact of HIV/AIDS;
2. Cooperative partnerships between all levels of government, community organisations, health professionals, clinical and social researchers and people living with HIV/AIDS; and
3. Non-partisan political support for a pragmatic and open approach to HIV/AIDS.

The main public health responses have been securing the blood supply, introducing needle and syringe programs for injecting drug users, and educating the population about the virus and consequences of infection. Education campaigns have targeted high-risk groups as well as the general population.

Australia's policy towards HIV/AIDS recognises that the only effective way to slow the spread of HIV is to facilitate behaviour change (NHMRC, 1997b). Cooperative partnerships have facilitated control of the spread of HIV and minimised social and personal impacts of the disease. Further, non-partisan political support has facilitated Commonwealth parliamentary mechanisms such as multi-party liaison groups and a consultative approach to policy development (Feacham, 1995; NPHP, 1998a). Community-based organisations advocate for the needs of the homosexual community and sex workers, including access to services and information about legal, welfare, medical and political matters (NHMRC, 1997b). However, in light of the recent increase in HIV incidence, greater

engagement with affected communities may again require policy attention and support.

Conclusions

There have been considerable achievements in promoting health in Australia over the past 20 years. However, persistent challenges remain, particularly in relation to improving the health of Indigenous Australians and addressing other gaps in health equity. Although significant programmatic effort over the past 30 years may be producing some results (Thomas et al., 2006), increased and sustained efforts are still required. Continued development of the infrastructure and capacity for health promotion will be needed to consolidate and enhance the pragmatic, productive, intersectoral partnerships that have been developed to date. With newly found interests in health, Treasury and other parts of government may become important allies for protecting and scaling up significant program achievements.

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