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The Eberhard Wenzel Oration: 'Tradition to Innovation, Making it Matter'

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I begin by acknowledging the traditional custodians of the land, the Nyoongar People, and pay my respects to Elders, past and present.

I would like to thank the Australian Health Promotion Association for inviting me to speak to you this afternoon. It is a significant honour, and recognises the contribution of Eberhard Wenzel to health promotion.

Dr Wenzel was only 51 when he died in 2001. He is remembered as a strong advocate of the socio-ecological view of health promotion, and particularly for co-founding the Public Health section of the World Wide Web Virtual Library in 1997, which during the period in which he moderated it, earned a rating of the best in the field by the medical journal *The Lancet*.

This was almost 20 years ago, and was soon after the commercialisation of the internet, and before the release of Windows 98 – a visionary work given the explosion of the internet, and the massive repository of information that is now available on-line.

It's possible that there are some people here today who have grown up with the internet as a constant in their life – just always been there! Technological growth in our generation has been extraordinary, and this will be a theme I'll come back to later.

I would like to talk with you about the evolution of health promotion related to the Ottawa Charter, touch on a few historical milestones, the opportunities we have in the future, and will draw on some examples from the NSW context which I am most familiar with.

Let's go back to 1986 – some of you definitely weren't around then! Ronald Reagan was US President, Tom Cruise starred in the movie *Top Gun*, Sir Joh Bjelke-Petersen was Premier of Queensland, Bob Hawke was Prime Minister, *Crocodile Dundee* release, the year of the Chernobyl nuclear disaster, NASA's *Challenger* space shuttle explodes, 5lbs of potatoes cost \$1, and Hawthorn defeats Carlton in the 1986 VFL Grand Final to win the 90th VFL premiership.

In the health context, it's the time of the Community Health Program, a Whitlam era initiative like Medicare, which was a community based, multi-disciplinary approach to community health outcomes. In NSW this morphed into Area Health Services – which significantly did include in its remit that one of its aims was to protect and promote the health of the population.

Of course, it was also the year the Ottawa Charter was released. Those of you who were working at the time – where were you when you first heard of it or had a photocopy passed around? The Ottawa Charter has had enormous influence on health promotion. It helped to broaden our understanding of what health promotion is (not just health education), increased our acceptance of policy and environmental strategies, and community action, and prepared us for understanding the social determinants of health.

Since the Ottawa Charter there have been seven global conferences on Health Promotion:

- Ottawa Charter (Ottawa, 1986)
- Healthy Public Policy (Adelaide, 1988)
- Sundsvall Statement on Supportive Environments for Health (Sundsvall, 1991)
- Jakarta Declaration on Leading Health Promotion into the 21st Century (Jakarta, 1997)
- Health Promotion: Bridging the Equity Gap (Mexico City, 2000)
- Health Promotion in a globalized world (Bangkok, 2005)
- Call to Action (Nairobi, 2009)
- Health for All Policies (Helsinki, 2013)

Another is planned for Shanghai, China, in 2016, focused on Health Promotion in the Sustainable Development Goals. However, in my view, none have had the impact that the Ottawa Charter has had.

The mid-80s was also a time of management by objectives, with national reports released with a compilation of health risk data highlighting the problems of heart disease and cancer, their risk factors, and the potential scope for prevention. A myriad of planning and evaluation models were being released around this time. The focus on planning and evaluation helped to build a culture of using evidence in planning and accountability.

There were also investments in mass media programs to address HIV (eg the grim reaper), and also smoking. In NSW this was also the time when investments in human resources for health promotion began, with funding to Area Health Services for the positions of Directors of Health Promotion and for Research and Evaluation Coordinators. This was the beginning of developing an infrastructure for health promotion.

In 1992, I was involved in reviewing existing health promotion programs in South West Sydney. There were 66 discrete projects which were analysed by what strategies of the Ottawa Charter were being implemented. Most were focused on changing personal behaviour, particularly those run by Community Health staff, with health promotion workers more involved in re-orienting health services. It would be interesting to see what the distribution of Ottawa Charter strategies would be now if the study was repeated. These days there is much stronger recognition of the need to have multiple strategies and complex program interventions.

To some extent this is a reflection of where the health promotion workforce is employed. Each of us has a role to play – many of us are practitioners employed to work with communities, some in health services, some do research, some work in bureaucracies, some in politics. Where we are in the system affects our ability to contribute in different spheres, but this investment in the workforce and where it is positioned, does affect program implementation.

The focus on social determinants of health by Marmot and Wilkinson identified areas other than those managed by the health sector that impacts upon health. These include:

- Income and income distribution
- Education
- Unemployment and job security
- Employment and working conditions
- Early childhood development
- Food insecurity
- Housing
- Social exclusion
- Transport

The Global Commission on the Social Determinants of Health (2005-2008) sought to gain international agreement to addressing them:

1. Improve daily living conditions
2. Tackle the inequitable distribution of power, money, and resources
3. Measure and understand the problem and assess the impact of action

National Partnership Agreement on Preventive Health (NPAPH)

The Commonwealth investment in health promotion from 2008-2014 was the most substantial investment ever seen in Australia. It was a bit of a sociological experiment, in that it was a novel experience to consider how this money could be spent to achieve positive health outcomes. The NPAPH saw different jurisdictions allocate their resources differently. For example, in Victoria there was a greater investment in local government, in other states contracts were made with Non-government organisations or other agencies, and in NSW there was investment in staffing. There is no right or wrong answer about this, and it is possible the same outcomes were achieved everywhere.

What the new investment of money from the NPAPH allowed us to do was to scale up the interventions to be delivered at a whole population level. From this experience, new guides for considering scaling up have been produced in NSW (<http://www.health.nsw.gov.au/research/Publications/scalability-guide.pdf>).

NSW Example

In NSW, the existing NPAPH provided funding for health promotion infrastructure and staff to be enhanced, to deliver core programs universally across the state. Taking childcare centres as an example, additional staff were employed in each Local Health District to organise training for childcare centre educators about overweight and obesity, and to work with each centre to achieve a list of 'practices' identified in previous research as being associated with health eating and active living by children at the centre. Progress on achieving the practices is recorded by local health promotion officers in a central data base (PHIMS) that allows local management of key contacts and follow-up schedules, and also state-wide uploading of data and state-wide reporting.

To further support implementation, the Chief Executive of each Local Health District has a performance agreement with the NSW Ministry of Health (which provides the funding) specifically in relation to the health promotion practices in childcare centres (as well as in relation to health promotion in schools and the Go4Fun program). This ensures high level executive engagement with health promotion practices and significantly raises the profile and expectations about health promotion.

The fact that 91% of childcare centres across NSW are participating in the healthy eating and active living childcare program, and most of these services have achieved 80% of the 'practices' is a significant population level impact. It has also been replicated in NSW primary schools with 84% of schools participating.

Having demonstrated clear accountability and outcomes using local health promotion infrastructure has been important in highlighting the credibility and effectiveness of health promotion in NSW. This has supported the Minister for Health in advocating to the NSW Premier that the reduction of childhood overweight and obesity by 5% over 10 years be a Premier's Priority. A reduction of childhood overweight and obesity by 5% is an ambitious target, and will require more than just doing what we are currently doing. It will require new and bold initiatives.

The NSW Healthy Eating and Active Living Strategy is the guiding document for the state's response to obesity prevention. The four main strategies include addressing the food and physical environment, implementing state-wide programs, a consistent response from the health system, and information and education. When these are compared to the strategies of the Ottawa Charter a similarity can be seen, illustrating how the Ottawa Charter is still relevant today.

Going forward, technology will feature in all aspects of health promotion. The apps of today are like the brochures and posters of the past, only more interactive, more visual, and more fun. There is much more to be learned, but technological advances offer us considerable potential to have massive benefits. Eberhard Wenzel would have been one of the first to want to use the power of technology to address the social determinants of health, and he would have asked the questions about how effective the strategies were?

Thank you.