

CHAPTER 1 Health Promotion and Public Health

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Key issues within this chapter:

- Health promotion is a key element of public health practice.
- Health promotion involves a combination of health education, service improvement and advocacy.
- Many health workers, professional groups, community-based workers and volunteers have a role in health promotion.
- Health promotion is an evolving discipline with many ongoing debates concerning principles and practice, including the balance between health education and legislation, the role of individualistic and structuralist approaches, the levels at which to operate, the nature of the core values/ethical principles, and the balance between coercive, persuasive and health empowerment approaches.
- A systematic approach to planning health promotion needs to take into account assessment of needs and influences on health, and involves decisions on target groups, methods, settings and timing of activities.





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By the end of this chapter you should be able to:

- understand the history of prevention, public health and the evolution of health promotion
- define health promotion and its component parts – health education, service improvement and advocacy
- have considered the debates in health promotion, including approaches and core values/ethical principles, and assessed your own personal approach
- apply principles of health promotion to planning a health promotion intervention.

What is health promotion?

The starting point for any discussion of health promotion is the Ottawa Charter, which in 1986 set out the concept of health promotion (WHO, 1986). Alongside the five key areas of action, summarized in box 1.1, the Ottawa Charter also reaffirmed the importance of community participation and introduced the goal of empowerment – a concept of which we will say more later in this book.

Box 1.1 Extracts from the Ottawa Charter for Health Promotion

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to wellbeing.

HEALTH PROMOTION ACTION MEANS:

Building Healthy Public Policy – Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels. It directs policy makers to be aware of the health consequences of their decisions and accept their responsibilities for health.

Health promotion policy combines diverse but

complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments.

Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice.

Creating Supportive Environments – Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable. Systematic assessment of the health impact of a rapidly changing environment – particularly in areas of technology, work, energy production and urbanization – is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and



Box 1.1 continued

the conservation of natural resources must be addressed in any health promotion strategy.

Strengthening Community Action – At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies. Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation and direction of health matters.

Developing Personal Skills – Health promotion supports personal and social development through providing information, education for health and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their health and environment, and to make choices conducive to health. Enabling people to learn

throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

Reorienting Health Services – The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health-care system that contributes to the pursuit of health. Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health services, which refocuses on the total needs of the individual as a whole person.

Health education:

A process with intellectual, psychological and social dimensions relating to activities that increase the abilities of people to make informed decisions affecting their personal, family and community well-being. This process, based on scientific principles, facilitates learning and behavioural change in both health personnel and consumers, including children and youth. (Ross and Mico, 1997)

Service improvement:

Promoting change in services to make them more effective, accessible or acceptable to the community.

Advocacy: Activities directed at changing policy of organizations or governments.

Putting health promotion into practice – regrouping the five dimensions of the Ottawa Charter

Two of the action areas in the Ottawa Charter's concept of health promotion (box 1.1) – *Developing personal skills* and *Strengthening community action* – can be seen as different dimensions of health education. The action area *Reorienting health services* can be broadened to encompass other sectors such as schools, environmental services, community development and social services. *Building healthy public policy* and *Creating supportive environments* both involve advocacy. A practical approach to health promotion is to regroup the five components in the Ottawa Charter into the three areas of action: *health education*, *service improvement* and *advocacy* for policy

Activity 1.1

For one of the following, or a health topic of your own choice, apply the HESIAD approach and suggest contributions of health education, service improvement and advocacy: reduction of injuries among children from road traffic; promotion of measles immunization; prevention of falls in elderly people; reduction of sexually transmitted infections among young people; promotion of breast cancer screening among Asian women.

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changes (HESIAD) (see figure 1.1). In box 1.2 we show how the HESIAD framework can be applied to different health topics.

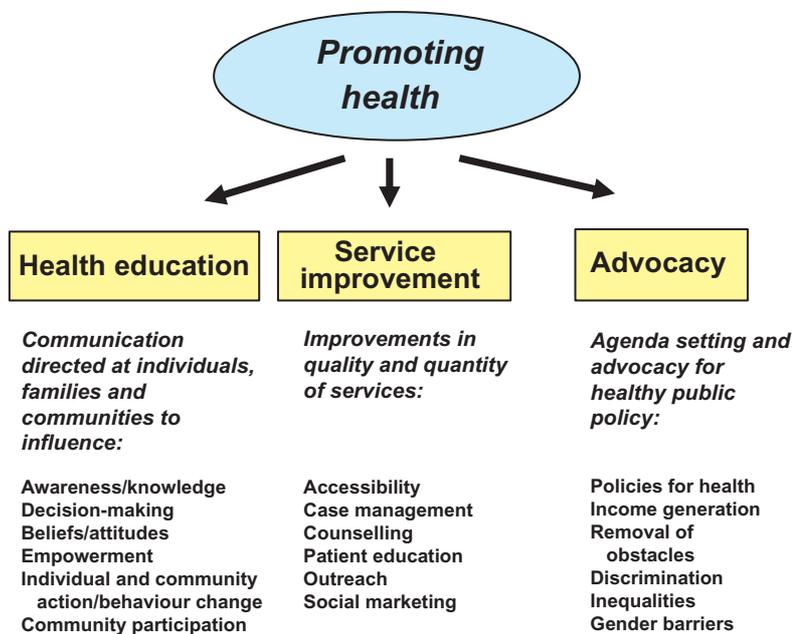


Figure 1.1 The HESIAD framework for health promotion

Box 1.2 Examples of application of HESIAD

Three components of a comprehensive health promotion strategy			
Health topic	Health education	Service improvement	Advocacy
Physical exercise	Promotion of benefits of exercise, understanding of the kinds of exercise that will improve health and skills in specific exercise methods	Improved leisure/exercise facilities, exercise promotion within primary care – e.g. provision of personalized tailored advice on exercise, GP exercise referral schemes to local gyms or exercise programmes targeted to specific groups (middle aged or elderly people within day care and institutions etc.)	Develop local policies for exercise facilities especially for socially excluded groups, subsidies for exercise programmes, partnerships to increase exercise opportunities etc.
Tobacco smoking	Promotion of increased awareness of the risks of smoking, the benefits of quitting and practical skills in resisting peer pressure, refusing cigarettes and different ways of stopping smoking	Developing anti-smoking within primary care, stop-smoking clinics, availability of stop-smoking aids (e.g. nicotine patches)	Enforcement of controls on tobacco promotion, sales to young people and smoking in public places; subsidies for stop-smoking aids

Box 1.2 *continued*

Alcohol abuse	Directed at young people, young adults and other age groups on appropriate alcohol use, self-monitoring of alcohol consumption, resisting peer pressure etc.	Development of services for helping persons with chronic dependency	The initiation of public policies affecting the pricing and availability of alcohol to different age groups; extending licensing laws in the hope of reducing the pressure to binge drink
Nutrition – promotion of fruit and vegetable consumption	Using schools and mass media to promote awareness of the health benefits of eating fruit and vegetables	Ensuring that schools and workplace canteens provide fruit and vegetables; collaborating with shops in deprived housing estates to increase stocks of fruit and vegetables	Subsidies for farmers to grow fruit and vegetables; actions to reduce sales prices of fruit and vegetables (e.g. subsidies for shops, transport costs); guidelines on meals provided in schools, institutions, etc.

Health promotion as a multi-disciplinary activity

Health promotion is a core part of the work of many different groups inside and outside health services – see box 1.3.

Box 1.3 Who does health promotion?**Health services**

Nurses
 School health nurses
 Health visitors
 Community public health nurses
 Midwives
 General practitioners
 Doctors
 Physiotherapists
 Occupational therapists
 Dietitians
 Exercise counsellors
 Pharmacists
 Opticians/optometrists
 Speech and language therapists
 Ambulance services

Local authorities and non-statutory agencies

Youth workers
 Teachers
 Play workers
 Community workers
 Social workers
 Environmental health officers
 Prison workers

Private sector and voluntary agencies

Occupational health doctors and nurses
 Trade union safety representatives
 Pressure groups, e.g. Action on Smoking and Health (ASH), the Royal Society for the Prevention of Accidents (RoSPA)

Media

Health correspondents

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A wide variety of professionals and volunteers are involved in health promotion, each with an important role to play. Inter-professional working is often a key aspect of planning and implementing health promotion activities.

Prior to recent changes, most health authorities in the United Kingdom had specialist public health/health promotion services. These specialists were located within Primary Care Trusts, but are now located in local government as a result of the NHS restructure. Many universities offer postgraduate diplomas or master's degrees in public health or health promotion, which are recognized qualifications for specialist public health/health promotion personnel. The role of these specialist support services is in a state of change; in some areas the name 'health promotion' is still used, in others the more generic term 'public health' or 'health improvement' is used with a strong focus on health promotion in their expected roles. This confusion in terminology led to a publication called 'Shaping the Future of Public Health: Promoting Health in the NHS' which encouraged efforts to re-classify the roles of 'specialized health promotion staff' working across health and local authority sectors (Department of Health and the Welsh Assembly Government, 2005).

National bodies provide strategic support for health promotion. In England the Health Education Authority evolved into the Health Development Agency and later

became absorbed into the National Institute for Health and Clinical Excellence. In Scotland the main national body was the Health Education Board for Scotland which has now been absorbed into NHS Health Scotland. Strategic support for health promotion is provided at the national level in Wales by the Health Promotion Division and in Northern Ireland by the Health Promotion Agency.

The rationale for health promotion

The scope for prevention of ill health and promotion of health

The rationale for health promotion comes from the scope for prevention of ill health and promotion of health. Data from The Office for National Statistics, for example, shows that the leading cause of death for people living in England and Wales is circulatory disease (such as heart disease and strokes), which accounted for approximately one-third (32 per cent) of deaths during 2010. Twenty-nine per cent of all deaths registered in 2010 were attributed to cancer (Office for National Statistics, 2010) and in 2009 lung cancer was the most common cancer for both men and women. For men, lung cancer was the second leading cause of death and for women the fifth main cause (Office for National Statistics, 2009).

Chronic illnesses, as well as injuries, mental illness, oral health and substance abuse represent a considerable burden both on the quality of life of individuals and also the cost of treatment for the health services. The application of epidemiology to the study of causes of ill health shows that much of the current burden of disease can be prevented or alleviated by appropriate action. As well as improving people's life expectancy and quality of life, there is also an argument that 'prevention is cheaper than cure' and well-designed health promoting interventions may save health care costs. The promotion of a healthy lifestyle has become a key element of health policy, as indicated in the government White Paper *Healthy Lives, Healthy People: Our Strategy for Public Health in England* (see box 1.4).

Box 1.4 *Healthy Lives, Healthy People: Our Strategy for Public Health in England (2010)*

This White Paper from the Department of Health for England outlines a commitment to protecting the population from health threats and helping people live longer, healthier and more fulfilling lives. It advocates a 'radical new approach' that will empower local communities.

The strategy aims to tackle the causes of poor health and the approach will be:

- responsive – owned by communities and shaped by their needs
- resourced – with ring-fenced funding and incentives to improve
- rigorous – professionally led, focused on evidence, efficient and effective
- resilient – strengthening protection against current and future threats to health.

(HM Government, 2010)

Historical overview of health promotion

The setting up in the United Kingdom of the National Health Service in 1947 was a time of great hope. The general assumption was that, with universal and accessible health care, the health of the population would improve, thereby reducing the need for health services.

By the 1970s it had become evident that this approach with its faith in medical science and technology was naïve, that many health problems persisted, and that there was a need to 'refocus upstream' (see box 1.5).

The emergence of health promotion as a distinct, organized field in health policy and practice can be traced to a Canadian strategy document. The publication in 1973 of the report *A New Perspective on the Health of the Canadians* by the then Minister of National Health and Welfare of Canada Marc Lalonde is recognized as one of the fundamental documents in the development of health promotion. Central to this report was the Health Field Model. This argued that – far from being determined by health services – health was determined by human biology or genetic endowment, environment and human behaviour (see figure 1.2). The report was effective in providing a justification for developing health promotion initiatives for improving public health, as it proposed that health care organizations would be unable to meet this need. The term *lifestyle* entered the discourse as a key determinant of health. The Lalonde report inspired health promotion initiatives in the United States and Australia. It also stimulated a series of conferences under the leadership of the WHO, beginning with the Alma Ata declaration in 1978. However, and as already discussed, it was not until 1986 that the first dedicated international conference on health promotion was hosted in Ottawa, Canada.

Lifestyle: The sum total of behaviours that make up the way people live, including leisure and work.

Box 1.5 Refocusing upstream

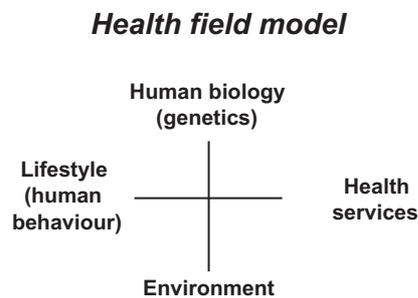
I am standing by the shore of a swiftly flowing river and hear the cry of a drowning man. I jump into the cold waters. I fight against the strong current and force my way to the struggling man. I hold on hard and gradually pull him to shore. I lay him out on the bank and revive him with artificial respiration. Just when he begins to breathe, I hear another cry for help.

I jump into the cold waters. I fight against the strong current, and swim forcefully to the struggling woman. I grab hold and gradually pull her to shore. I lift her out on the bank beside the man and work to revive her with artificial respiration. Just when she

begins to breathe, I hear another cry for help. I jump into the cold waters. Fighting again against the strong current, I force my way to the struggling man. I am getting tired, so with great effort I eventually pull him to shore. I lay him out on the bank and try to revive him with artificial respiration. Just when he begins to breathe, I hear another cry for help. Near exhaustion, it occurs to me that I'm so busy jumping in, pulling them to shore, applying artificial respiration that I have no time to see who is upstream pushing them all in

(A story told by Irving Zola, but used in McKinlay, 1981)

Figure 1.2 The health field model (Lalonde, 1973)



Activity 1.2

Apply the health field model and suggest possible human biology, health services, environment and lifestyle influences for one of the following: coronary heart disease, diabetes, breast cancer, road traffic injuries. Which of the four components do you feel have the most influence on the health topic you have chosen?

In the UK in 1976 a discussion paper, *Prevention and Health, Everybody's Business*, and a White Paper, *Prevention and Health*, were published and resulted in an expansion of health education services throughout the United Kingdom. On the international stage in 1977 the World Health Organization convened its meeting of the World Health Assembly in Alma Ata (then in the USSR, now in Kazakhstan), which issued its landmark declaration on primary health care. This declaration affirmed the importance of prevention but at the same time introduced other key concepts: social justice, tackling poverty, appropriate technology, community participation, and the need for economic and social action to address the determinants of health.

Criticisms of health education and the emergence of health promotion

By the early 1980s there was increasing disquiet among the health community. While accepting the importance of lifestyle, many felt that not enough attention was being given to the social and economic factors that influenced it. In England, Sir Douglas Black produced a damning report that highlighted the persistence of inequalities in health. In Scotland, similar inequalities were documented by one of the present authors in a chapter in Gordon Brown and Robin Cook's book *Scotland, the Real Divide* (see Hubley, 1983), the editors of which later became key figures in the New Labour government.

Many health educators became critical of what they saw as an over-reliance on a medical model of health and a 'victim blaming' approach which put most effort into persuading individuals to change, while ignoring powerful influences in the family, the community and society. They saw a need for political action to influence local and

Box 1.6 A timeline of important events affecting the development of health promotion in the United Kingdom

- 1948 WHO constitution, with its definition of health as a complete state of physical, mental and social wellbeing
- 1965 Publication of McKeown, *Medicine in Modern Society*
- 1972 Publication of Cochrane, *Effectiveness and Efficiency*
- 1973 Lalonde Report, *A New Perspective on the Health of Canadians*
- 1976 Publication of Illich, *Medical Nemesis: The Expropriation of Health*
- 1976 Publication by DHSS of discussion paper *Prevention and Health, Everybody's Business* and White Paper *Prevention and Health*
- 1977 World Health Assembly issues Alma Ata Declaration on Primary Health Care
- 1979 Launch of journal *Radical Community Medicine* (later to become *Critical Public Health*)
- 1980 Black, *Inequalities in Health: Report of a Research Working Group* (DHSS)
- 1981 Publication of McKinley, 'A case for refocussing upstream'
- 1981 *Scotland, the Real Divide* – review of poverty in Scotland
- 1984 *Radical Community Medicine* publishes special issue on public health
- 1985 European region of World Health Organization sets targets for Health for All by the year 2000
- 1986 *Ottawa Charter for Health Promotion* produced at the WHO's first International Congress for Health Promotion
- 1988 *The New Public Health*, published by the Open University
- 1992 Rio Earth Summit on sustainable development
- 1998 Publication of the Acheson Report *Independent Inquiry into Inequalities in Health*
- 1998 Society of Public Health Medicine opens membership to non-medical practitioners and changes name to Society of Public Health
- 1998 *Better Health: Better Wales* (Welsh Office)
- 1999 *Saving Lives: Our Healthier Nation*, White Paper (Department of Health, England)
- 1999 *Towards a Healthier Scotland: a White Paper on Health* (Scottish Office)
- 2003 *Improving Health in Scotland* (Scottish Executive)
- 2004 *Choosing Health* (Department of Health, England)
- 2005 *Shaping the Future of Public Health: Promoting Health in the NHS* (Department of Health and the Welsh Assembly Government)
- 2010 *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010* (Marmot)
- 2010 *Healthy Lives, Healthy People: Our Strategy for Public Health in England* (HM Government, England)

national governments to introduce policies that promoted health. The early 1980s had also seen an unprecedented global mobilization to introduce international guidelines to limit the marketing of infant formulas in poor countries, which included actions such as consumer boycotts of Nestlé. Particularly aggressive programmes in Australia were pushing conventional health education to the limits, with hard-hitting anti-smoking television advertising which challenged commercial interests. Pressure groups such as ASH in the UK and street action movements such as BUGA UP in Australia were challenging the tobacco industry through pressure group techniques and direct action.

These concerns about the limitations of health education led to the conference in 1986 in Ottawa which set out the concept of health promotion discussed earlier in this chapter.

Victim blaming: An approach to health education which emphasizes individual action and does not address external forces that influence the individual person.

Social exclusion: A term to describe the structures and dynamic processes of inequality among groups in society. Social exclusion refers to the inability of certain groups or individuals to participate fully in life due to structural inequalities in access to social, economic, political and cultural resources. These inequalities arise out of oppression related to race, class, gender, disability, sexual orientation, immigrant status and religion. (Definition adapted from Galabuzi, 2002)

Inequalities in health

One of the most important criticisms was that health education approaches, based mainly on behaviour change of individuals, were failing to address inequalities in health. Figure 1.3 shows that anti-smoking programmes in the 1960s had successfully reduced levels of smoking in Great Britain. But the decline had been greater in the professional groups, leading to a widening of the gap between rich and poor. Health education, as it was then being practised, was reaching mainly better-off groups in society. It was conclusions such as this for smoking and other health problems that led to a rethinking of health education and the emergence of the broader notion of health promotion.

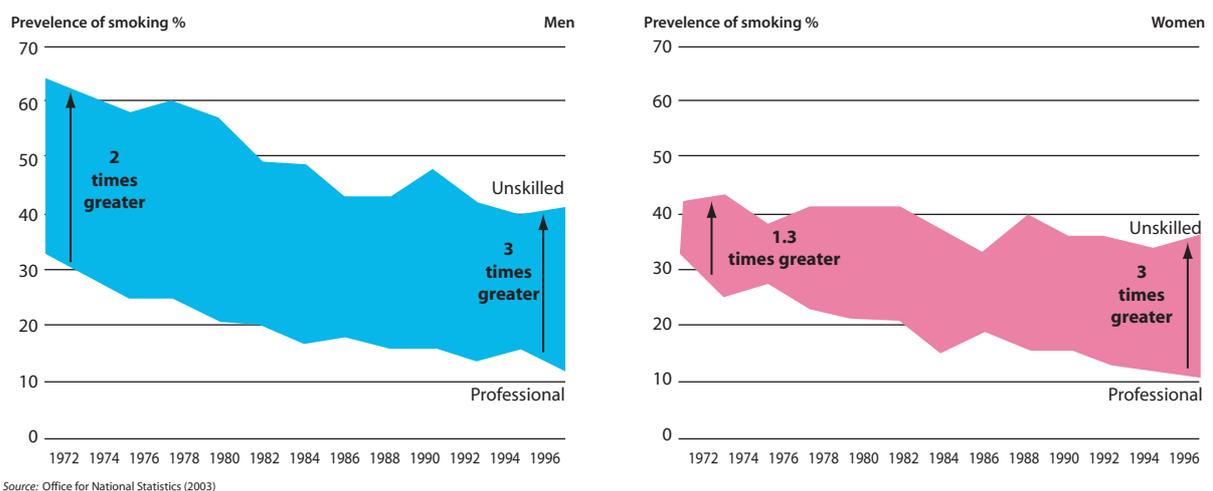


Figure 1.3 Increasing inequalities in smoking in Great Britain (men and women aged sixteen and over)

The main determinants of health

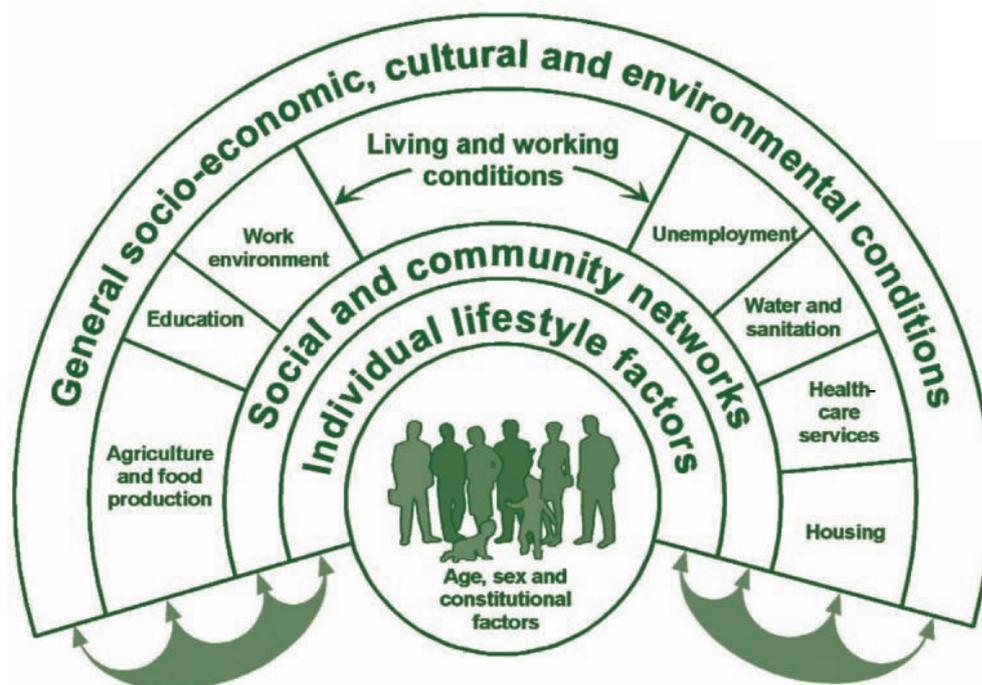


Figure 1.4 The rainbow model to explain inequalities in health (Dahlgren and Whitehead, 1993)

The issue of inequalities in health and social exclusion became a central feature of the health policy of the New Labour government that came into power in 1997. A series of reports exposed the inequalities in health between geographic regions, social classes and ethnic groups. The most significant of these was the Acheson Report in 1998, which drew on the 'rainbow model' of Dahlgren and Whitehead (1993) (figure 1.4) to show that inequalities were a result of an interaction of many factors in society and called for the following actions to tackle inequalities:

- breaking the cycle of inequalities
- tackling the major killer diseases
- improving access to services
- strengthening disadvantaged communities
- targeted interventions for specific groups.

More recently, Professor Sir Michael Marmot in his report *Fair Society, Healthy Lives* (2010) reiterated the link between health and social groups, demonstrating that the lower a person's social position, the worse his or her health. Marmot argues that a reduction in health inequalities requires the following action:

- Give every child the best start in life;
- Enable all children, young people and adults to maximize their capabilities and have control over their lives;