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Health promotion: concepts and principles

A selection of papers presented at the Working Group on Concepts and Principles, Copenhagen, 9–13 July 1984

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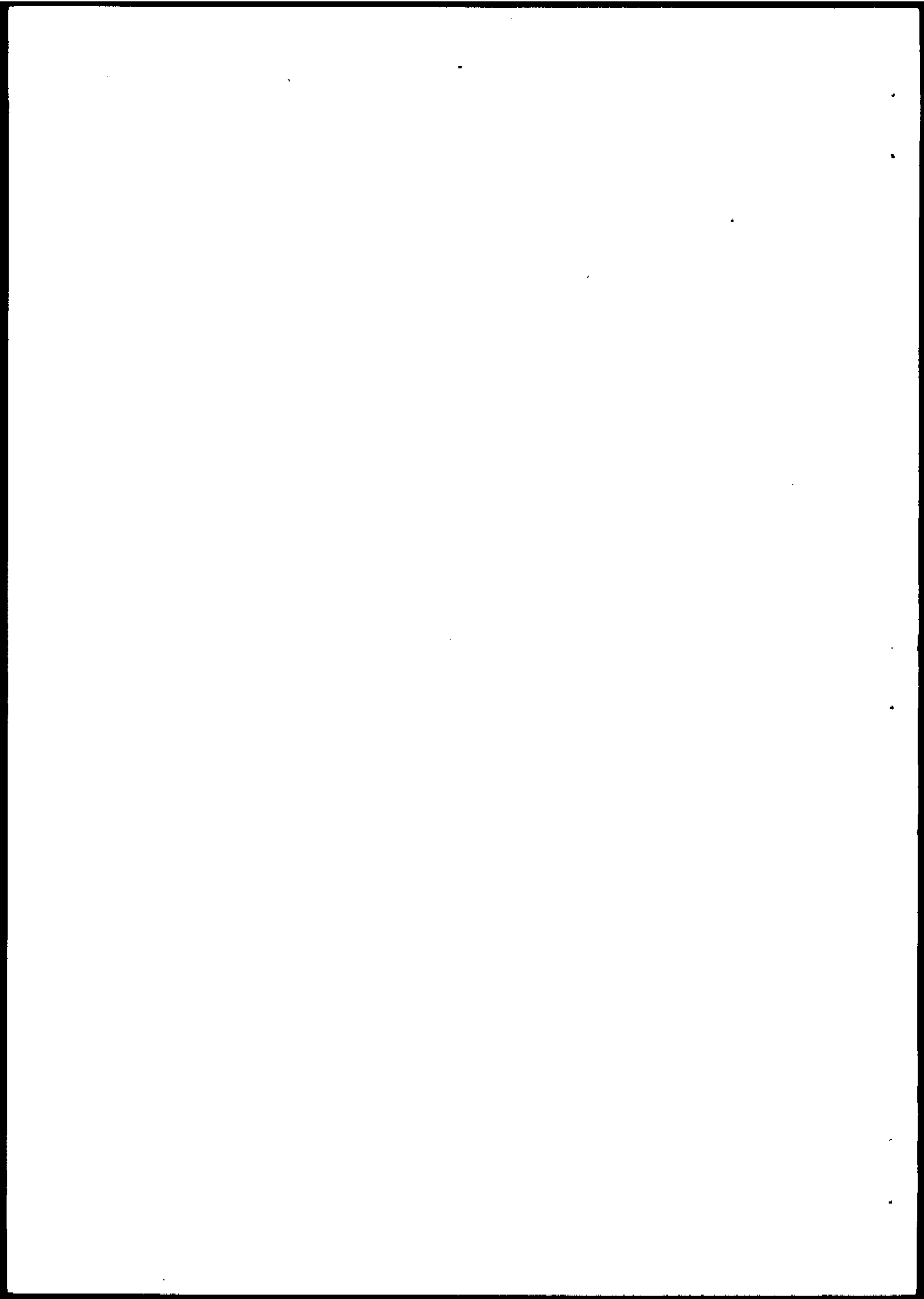

BACKGROUND

In January 1984 a new programme on 'Health Promotion' was established in the WHO Regional Office for Europe. It is the first programme of this kind in WHO and its development has had strong support from Member States. Planning began in 1981. Since then a number of meetings, bringing together people from various professional groups, academic disciplines and consumer groups, have helped to clarify the special and unique approach of such a programme. This work has been documented by the Regional Office in a number of working papers and publications, a list of which is attached in Annex II.

As part of the continuing process of programme development, a working group met in July 1984 to discuss 'Concepts and Principles of Health Promotion'. This brochure is a result of that working group, and it is hoped it will clarify some of the most important issues in relation to the development of policy and programmes in health promotion. It is intended as a focus for discussion in a rapidly developing field.

The development of priorities and practices for health promotion depends upon the prevailing economic and cultural conditions. In each country, region and district, health promotion should involve the full participation of all people in the development of their health.

INTRODUCTION

At a general level, health promotion has come to represent a unifying concept for those who recognise the need for <u>change</u> in the ways <u>and</u> conditions of living, in order to promote health. Health promotion represents a mediating strategy between people and their environments, synthesising personal choice and social responsibility in health, so as to actively create a healthier future.

Basic resources for health are income, shelter and food. Improvement in health requires a secure foundation in these basics, but also information and lifeskills; a supportive environment, providing opportunities, goods, services and facilities for making choices for health; and conditions in the economic, physical, social and cultural environments (the 'total' environment) which enhance health.

The link between people and their environment constitutes the basis for a socio-ecological approach to health and this provided the conceptual framework for discussions by the working group. The discussions of the working group were organised around four main themes - principles, subject areas, priorities for development, and dilemmas in health promotion.

This brochure contains four papers. First the opening remarks by Dr Ilona Kickbusch. Their purpose was to stimulate the participants by posing, rather than attempting to answer, questions. A typology of health promotion concepts with special emphasis on the comparison of the various focuses is attempted.

Next, is a paper presented by Robert Anderson. This is an update of his report, Health Promotion - An Overview, from 1983. One of his observations is that the concept of health promotion has been diluted and modified by "the bandwagon popularity of the term".

Following this are some comments and observations made by Professor Lowell Levin on the closing day of the workshop. He warns health professionals that with the gradual eradication of disease there is a danger that zealous efforts could lead to regard health as the ultimate disease.

Finally, the discussion document on the Concepts and Principles of Health Promotion, which is the result of the working group. It is short and succinct and outlines the principles, subject areas, priorities and dilemmas of health promotion.

HEALTH PROMOTION. A TYPOLOGY

By Ilona Kickbusch

Introduction

Before reflecting with you, the many different ways the term health promotion is used by people with completely different orientations, I want to pay tribute to a personality who died two weeks ago and who has heavily influenced my thinking. Michel Foucault has laid open the history of medicine of the last 200-300 years and has described within an "archeology of knowledge" how the "medical gaze" expanded to dominate our view of health and the body. He explains how the discourse, "the talking about things", is organized in societies and I believe his work is gaining increasing importance in understanding two processes; first, why we have become so medicalized in our thinking; second, why it is that within the last years our societies are talking so much about health. Foucault would ask insistently about the things we do not talk about. Are those perhaps the really important things?

Typology of Health Promotion Concepts

What is health promotion?

Is it a concept?
Is it a principle?
Is it a perspective?
Is it a strategy?
Is it a goal?
Is it a policy?
Is it a movement?
Is it a social force?

The list indicates that most authors who have set out to define health promotion remain vague in their final application of the term.

This is reminiscent of the self-help debate in the early seventies when in a similar way, a new concept, a new way of thinking about health and health care started to enter the medical field. A number of authors believed self-help to be a strong social movement and social force spreading around the world and challenging medicine. By now we have become more precise and realistic in our thinking on self-help and self-care[1]. I hope that within the near future the thinking generated by the European office of WHO - of which this group is a part - will help clarify the term "health promotion".

Health promotion has become a symbolic word for people who want to express that they are aiming to do something different from what has been done so far in health education. I have tried to compile some of the orientations within the health promotion debate, not as a final classification but as an orientation for our discussions

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[1] Stephen Hatch and Ilona Kickbusch. Self-help and Health in Europe. WHO Regional Office, Copenhagen, 1984.

TABLE 1

Typology of health promotion concepts

Type		Description
Type 1		Living conditions Life chances Health promotion as basic principle of social policy "The new public health"
	Focus:	Reduction of inequalities (in health)
Type 2		Starts from disease categories and epidemiological data - but includes both social and individual measures
	Focus:	Reduction of morbidity/mortality ("major killers")
Type 3		Starts from major killers, classic risk factors and individual behaviour change
	Focus:	Eliminate negative health practices
3A		Notes environmental influences and buffering factors but stays with "behavioural deletions"
	Focus:	Expansion of medical model
Type 4		Mediation between social responsibility and individual behaviour (philosophical synthesis)
	Focus:	Empowerment and participation
Type 5		Equates health promotion with positive health/holistic health
	Focus:	Enhance health and wellbeing
Type 6		Start from positive health action
	Focus:	Power of definition Sharing Caring
Type 7		Interplay between environmental and individual factors
	Focus:	Mediating supports and structures

Type 1 is the broadest approach to health promotion, starting from living conditions, pre-requisites for health and life changes, and understanding health promotion as a basic principle of social policy and public health. One of the slogans often used is "the new public health". This type focuses on reduction of inequalities, but it is usually unclear if this refers to inequalities in society as a whole or inequalities in health. That is where the major problem with this approach lies: health is used as an entry point to change society and to promote a different type of public policy as a whole.

Type 2 starts from disease categories in epidemiological data and from the "major killers" but does aim beyond traditional epidemiological models of risk behaviour. It stresses that one has to include social measures and measures of public policy to ensure health. The difference to Type 1 is that Type 2 underlines the need for an economic policy that prevents poverty but its focus is to provide conditions and opportunities for healthy behaviour rather than reduce inequalities. The critical point is the focus on the "major killers", i.e., the acceptance of what are defined as the main health problems in society (we will see that some other approaches question this) and that intervention is introduced to reduce the rate of one particular disease, i.e., heart disease or cancer.

Type 3 also starts from the so-called "major killers". This vocabulary in itself is revealing: a lot of the health vocabulary is a vocabulary of war, and this is reflected in the approaches chosen for intervention. This is something which needs to be discussed in addition to health promotion: is it a strategy of war on disease of the old type, or is it a new type of change strategy towards health?

Type 3A has various oscillations. One focuses on individual behaviour change and on the elimination of negative health practices through interventions with very strong educational components. Another type notes environmental influences such as "buffering factors" but finally remains set on behavioural deletions. Health promotion as it is seen here means an expansion of the medical model to include behavioural change, i.e., a continuation of the medical and the behaviouristic model.

Type 4 aims at a synthesis between, as one author has called it, social responsibility and individual behaviour. The focus here, and that is different from the approaches I have mentioned so far, is empowerment and participation of the people concerned. This type refers to basic conditions of work and basic conditions of housing, for example, and will focus on work and work-related diseases. It tries to develop how, for example, a change of working conditions based on enpowerment and how they can positively influence the health of the people.

Type 5 more or less equates health promotion with positive health and holistic health. It usually excludes everything that has to do with disease and states very clearly that the focus is to enhance health and well-being towards an ideal state of health.

Type 6 starts from positive health action. It is an approach that has been developed in the context of the women's health movement[2]. Three components of health promotion are developed: 1) the power of definition, that is the possibility to participate, to be involved, to define the problem; 2) the sharing principle, i.e., the mutual aid approach, and 3) [and this is something we find in practically no other approach] the caring principle.

Type 7 focuses on the interplay between environmental and individual factors and the mediating support and structures that oscillate between the two. This approach will be discussed at this meeting to some extent since it has been reflected in a number of health education programme background papers[3].

Prevention - Promotion

One of the issues that Robert Anderson already took up in his "Health Promotion: An Overview"[4] was the differentiation between prevention and promotion. I would like to share with you the differentiation that Richard Jessor has made to give you an idea where the discussion stands[5].

TABLE 2

Prevention - Promotion

Disease Prevention	Health Promotion
At risk individual	Population as whole
Conserving health	Enhance health
Maintain status quo of health (minimal health)	Departure towards "ideal" state of health
	-Variety of methods
	-Includes environmental change

The major question is: is there a continuum between prevention and promotion or are we talking about two exclusive approaches? If we take the seven types of health promotion concepts a number of authors would underline that health promotion is something basically different from disease prevention. They see the prevention approach reflecting a medical model.

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[2] Sheryl Ruzek and Jessica Hill. Positive Approaches to Promoting Women's Health. Unpublished manuscript. Copenhagen, 1984.

[3] EUR/RC33/Tech.Disc./1. Lifestyles and their Impact on Health.

[4] Robert Anderson. Health Promotion: An Overview. European Monographs in Health Education Research. No. 6. Edinburgh, 1984, pp: 1-126.

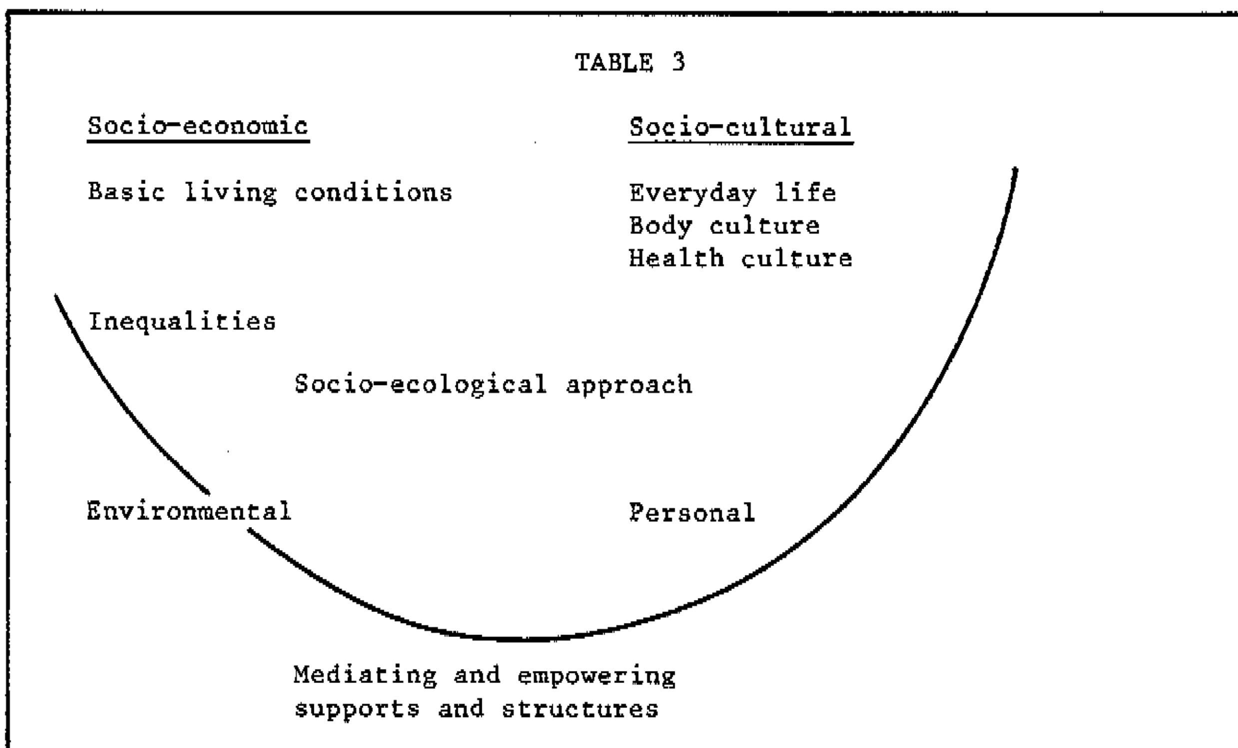
[5] Perry, Cheryl and Jessor, Richard. The Concept of Health Promotion and the Prevention of Adolescent Drug Abuse (mimeo). Unpublished manuscript. University of Minnesota, University of Colorado, Sept. 1983.

There are others who, some for political reasons, others by conviction, believe that it should be a continuum, and in the literature some authors move from promotion to prevention along a dynamic line that continues into treatment and rehabilitation. Jessor stresses that disease prevention deals with individuals or particularly defined groups at risk, it aims at conserving health. It has no positive vision of health that moves ahead, but seeks to maintain the status quo. Health promotion, on the contrary, starts out with the population as a whole, not selected people or groups. Its goal is to enhance health. It is a departure towards an ideal state of health with a variety of methods, and, contrary to medical approaches to prevention, includes environmental change.

Health as a goal

Basically we should aim to move towards an approach that tries to combine the socio-economic and socio-cultural factors that constitute health. The socio-economic factors that most influence health are, of course, the basic living conditions which reflect themselves in major inequalities. The socio-cultural factors are the way everyday life is structured, the forms that body culture takes and the way in which health itself constitutes a culture within society. A socio-ecological approach would try to bring the two constituents together through mediating and empowering structures and support.

TABLE 3



But what is health? Is it a resource and a product of life, or is it a primary goal? Health has been moved out of everyday life, it has become a primary goal defined in medical terms, moving towards what Foucault calls the imperative of health: you have to be healthy. To a certain degree this has made health become a metaphor for self-control and health promotion a basically middle-class enterprise. Individual approaches to health promotion reflect middle-class thinking, and it is worth considering in more detail how the middle class can gain its identity through health, an identity that it cannot gain through work anymore. Health becomes a means to create a collective identity in a post-industrial world.

Health can also stand as a symbol for release. Being healthy is defined as living a life you enjoy, and the result is that you can do anything as long as you enjoy it: that in itself will ensure a buffering function against disease. People who are very critical of health promotion actions of any type will insist that it is the basic enjoyment of life that will keep you healthy. Here lies a dangerous turning point of positive health notions toward a proclamation of "happiness for all". Both the control and the release approach carry in themselves the seed of totalitarian possibilities.

But beyond control and release health and the body can become a source of resistance. For example, it is within the women's health movement that health became a central political issue reflecting the resistance to medical and social control over women's bodies. This might be true of other groups in the context of a new type of political health discussion[6].

A social process

If we say that health promotion is a social process and not a medical enterprise then this implies the de-medicalisation of health. I very explicitly say de-medicalisation of health because it is one of the basic dilemmas of health promotion that it indirectly expands the medical model making health the ultimate disease[7]. What are possible strategies to bring health back into everyday life, and to have it become something that flows out of everyday life. If a given society and a given culture do not provide for health then you have "to do something" to be healthy. Health is prescribed: you have to put an effort into being healthy. This begs the question, who can afford that effort. It turns health into a luxury: you have to make time available and you have to have resources; you have to add something to your life, which makes it necessary to reorganize your life in order to be healthy. People who are involved in this type of health behaviour define themselves as healthy because they jog, eat no meat, meditate, etc.

TABLE 4

Health Promotion

- a social process

Implies:	
De-medicalization of health	
Part of "Culture"	Vs. Prescription
Flows out of everyday life	Vs. Something extra added
Future oriented within socio-economic context	

[6] Crawford, Robert. A Cultural account of Health "Self-Control, Release, and The Social Body". Unpublished manuscript. University of Illinois, Chicago. February, 1983.
[7] Lowell Levin. "Health - The Ultimate Disease". A comment 1984. (in this brochure).

Similarly, the place which we give to health in our lives, as compared with other concerns, may differ from person to person; and the place which a whole society gives to health may differ from society to society. In late industrial societies, health tends to be given a secondary place and to play a passive role. Personal concern with health is usually in response to ill-health; and our so-called health services and health professions are mainly employed to deal with injury, sickness and disease. A changed society and a changed set of personal values might put health in a primary position, and give top priority to creating and maintaining good health. A shift in that direction is one possibility for the future. In that scenario, the achievement of good health would be given higher priority than today. Considerations of health would play an active part in decisions about work, housing, planning, energy policy, economic policy, and other aspects of life.

The three following sections should, therefore, be understood as linked as shown in the diagram, with the arrows indicating the direction of influence between one sphere and another. In today's industrialised societies arrows 1,3 and 5 are strong, and arrows 2,4 and 6 are weak. In a possible future society in which health requirements strongly influence personal lifestyles and the social environment, and in which personal values strongly influence the social environment, arrows 2,4 and 6 would be stronger, and arrows 1,3 and 5 would be weaker.

If we say health promotion is a social process we must also be future-oriented. We cannot say that society will continue to develop as it has up to now and it is within this social and economic context I want to remind you of a scenario paper produced for this office by James Robertson[8].

James Robertson has discussed five scenarios:

Business as usual
Disaster
Authoritarian control
Hyper expansion
Sane, humane, ecological

One could say that at least four of these are reality in the European region in different countries and that some countries are heading towards some of these scenarios more than others. When discussing notions of health and health promotion we must keep in mind the overall picture of society at present and the other major issues being discussed in society at the moment. If we discuss health, what about the crisis of work? If we discuss about health policy, what about the crisis of the welfare state? If we discuss about the medical model, what about the crisis of patriarchal thinking?

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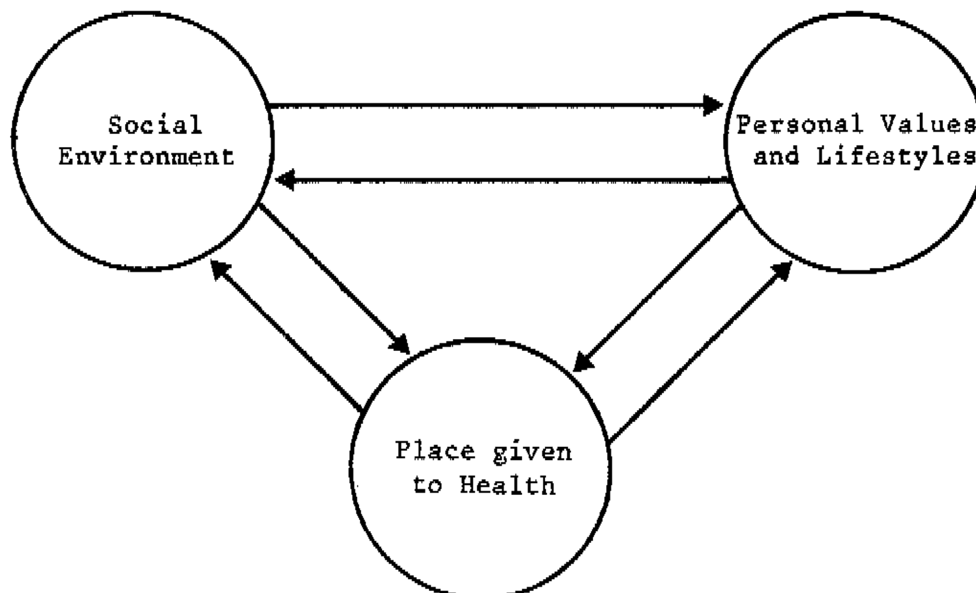
[8] James Robertson. Scenarios for Lifestyles and Health. European Monographs in Health Education Research. Edinburgh, 1984, pp. 151-172

James Robertson has put together this flow of how the social environment and personal values and the place given to health in the society move:



If we say health promotion should focus on reducing inequality, i.e., closing the health gap, that it has to move between social responsibility and public involvement, then strategies would aim for four issues:

1) power of definition
2) regaining the social, i.e., putting health back into life
3) non-addictive and non-medical coping strategies
4) caring.

This is a political process and this political process needs platforms, needs the possibility to be developed, needs support to turn into health.

I will not go into detail on these four issues at this stage as I do not want to prestructure the discussions at this meeting. They will be the focus of a paper that is in preparation.

TABLE 5

Reduce inequalities
Close the health gap

Social responsibility | Public involvement

Strategies would aim for:

- Power of definition
- Regaining "the social"
- Non-addictive/non-medical coping strategies
- Caring

Political process: Platforms

I would like to end with a few questions:

If we take a new look at health as outlined here, what for example does this mean for illness? What does it mean for chronic disease? Does it imply a new look at the three areas of prevention, for example? What in this concept is the role of the professions, who deals with health, do they have any role at all, and what is the role of the various non-medical professions? What finally is the role of national policy in securing basic social security and basic health services on the one hand, and on the other hand a supporting policy to be able to organize a decentralized structure of developing health promotion and decentralizing any services and platforms that might be necessary.

Finally, I would like to remind you again of what do we not speak about. When we were discussing social support, the consumer representative at the Regional Health Development Advisory Committee asked the group: "Why do you call it social support? Why not call it love?". You might wish to reconsider the terminology we use. Why do we talk about health, why do we not talk about other things? Why do we not use old words like to love, to touch, to care and to heal? How much of the terminology we use already reflects how far the medical eye and the medical view have advanced upon and into us and how much society is reflected in us itself.

HEALTH PROMOTION: STATE OF THE ART

By Robert Anderson

One of the initiatives WHO has taken in Health Promotion is to bring together for working groups people from different disciplines - political scientists, community physicians, health educators, health visitors, nutritionists, government advisers and social scientists. I belong to the last group.

About a month ago I was thinking of a career change, so I scanned the journals. In the British Medical Journal I landed at "Community Medicine" where there were eight jobs. Five of the advertisements made specific reference to Health Promotion. Community physicians were needed to support and coordinate new and exciting and developing policies in Health Promotion! In one case further reading illuminated this role as preventive policies and screening programmes; in another as responsibility for health education; in other cases the description was too vague or unspecific such as responsibility for the development of health promotion services (whatever they might be). Anyway, I am not medically qualified so I cannot apply for these jobs, but I found them "interesting".

A few days later I looked for Public Service jobs in one of our national newspapers. There I found two new posts, one at regional and the other at district level as "health promotion" - to support new and exciting and developing initiatives in health promotion. At the same time there was one job advertised for a Health Education Officer. I wondered what the difference was between these jobs. But it was all academic because I do not have a diploma in health education.

So it looks as if I will remain an academic, but now there is new hope. A new and exciting research trust is offering £ 3000 000. to support (yes) "Health Promotion". The problem is that the money comes from the profits of the tobacco industry; and my research must not include any reference to the use of tobacco. The industry negotiated this deal with the government as part of a package to trade off against their advertising costs.

I have selected these three developments because they illustrate some of the recent rapid growth of health promotion as an area of policy, practice and research, and also because they concern important problem areas - defining professional roles in health promotion, dangers of medical or other imperialism, the double-edged sword of political support and the nature of the subject and of scientific evaluation - all of which depend upon the concept used.

In 1980 I carried out a preliminary survey in some of the countries in the European Region of WHO about the use of the concept and term "Health Promotion". I went around asking people in health education, community medicine, social research and so on what they understood by the term "Health Promotion". I also did a wider postal survey[1]).

Most people had problems to identify or specify health promotion as a concept which was meaningful on its own - when it was not linked to or subsumed by disease prevention, health education or environmental protection.

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[1] Robert Anderson. Health Promotion: An Overview. European Monographs in Health Education Research, No. 6. Edinburgh, 1984, pp. 1-126.

People in the health and social services, people in sports promotion, organization of social and cultural events, designers of home and work places - these people recognized that their work had implications for health but did not view it primarily in terms of health promotion.

In 1980 it seemed that the term "health promotion" was part of the vocabulary of North Americans but was employed by relatively small numbers in European countries. Over the intervening years to 1984, the term has been employed more widely in Europe, and for someone like me in the United Kingdom the words have become relatively commonplace. The issue though is whether the term has become more meaningful, more specific and identifiable, or whether it has been used only to displace other terms, like health education and disease prevention, which have become less fashionable or appealing.

Speaking in 1980, Horace Ogden noted: "... in the United States in the last few exciting years, there has been a proliferation of terminologies. Old familiar terms like prevention and health education are being given new connotative meanings. Relatively new terms, like health promotion are being widely used in ways which blur distinctions. In fact, in some of the rhetoric now being generated, prevention, health education, and health promotion are being tossed around interchangeably"[2].

I want to suggest that in many cases the term "health promotion" has been employed because it is as yet a new and not discredited form of work - that the concept of health promotion has been diluted and muddied by the bandwagon popularity of the term (everyone has taken it on board), by a lack of concern about specific meaning, by a lack of clear thinking and sometimes by thinking that is all too clear.

Amongst what I consider rather cynical uses of the term I have already referred to the Health Promotion Research Trust, supported by money from the tobacco industry. It is also apparent that health promotion has become more popular with politicians, possibly because of its powerful rhetorical value - it is positive and dynamic and vague!

In May this year I heard one of our health ministers discuss health promotion enthusiastically at a meeting in Warrington (where I represented WHO). He identified health promotion as a vital component in the process of developing a healthier Britain - like many others he attributed several of our current health problems to individual lifestyles - and he identified a role for government as a coordinator and funder for programmes of information and education. As he said, "Put before people the facts of life and let them make sensible choices". He did not amplify on other ways in which healthier choices could be made easier!

Several other speakers discussed health promotion exclusively in terms of disease prevention, through illustrating strategies which involved fiscal measures, legislation and community action as well as a contribution from health services. The new Regional Officer for Health Promotion in the Mersey Region suggested that the differences between health education and health promotion were illusory. He went on to discuss health promotion in terms of its methods which included education and information dissemination, but also policy development, community organization and promotion of legislation.

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[2] Ogden, Horace. Report of the 10th International Conference on Health Education. Health Education Council, London, 1980, p. 58.

In his view the health promotion approach involved people from many sectors, operated at the level of national, community and work place as well as individual, and it dealt with factors in the individual's environment, avoiding allocation of all responsibility for health to the individual. The point is I do not have too much problem with this as a description of health promotion, but find it difficult to equate with common practice in health education.

I hope these observations may lead you to believe that the question "health promotion - what is it?" is the wrong one. It might be more productive to ask the subset of questions of the sort we shall address later today: What are the goals or objectives of health promotion? What are the principles of the health promotion approach? What are the methods or strategies employed in health promotion?

In reviewing the literature on health promotion, it is apparent that methods and approaches are often incorporated into definitions of health promotion, and that the relation between health promotion and disease prevention - as separate, complementary or identical objectives - is not often clarified. For example, on the one hand:

> "... preventive medicine comprises prevention of diseases, care, and the promotion and maintenance of health"[3].

And on the other:

> "Health promotion is the effort designed to reduce unhealthy behaviour, improve preventive services, and create a better social and physical environment"[4].

Both terms are employed as "unifying concepts" or umbrella terms - it is hard to say what activities other than acute medical care, cannot be sheltered under the protective umbrella of health promotion; and such an all-embracing formulation may become a recipe for inactivity.

The debate about differences between health promotion and disease prevention is not one I want to go too far into, for several reasons.

> "Exercises in logic drive some people bananas which helps to explain why discussion of whether one is really doing promotion or prevention also drives some people bananas and causes just about everyone to go round in circles"[5].

This overlap often reflects a view of health as absence of disease.

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[3] World Health Organization, Regional Office for Europe, 1978. Health education of the public in cardiovascular diseases. Report of the meeting of a working group. Heidelberg, 7-10 November, 1978.
[4] McAlister, A., Puska, P., Salonen, J.T. et al. 1982. Theory and action for health promotion: illustrations from the North Karelia project. Am. J. Public Health, 72, 42-49.
[5] Low K., 1979. Prevention: narrative I, Action Studies Team. Calgary, Board of Education.

However, an attempt to distinguish between disease prevention and health promotion has been the starting point for several attempts at describing or defining more precisely, and distinctions are increasingly realized. Thus Low himself points out that health promotion has more positive connotations and that it directs our attention away from the specificity of diseases to a broader perspective. These differences, with the emphasis on approach rather than objective have been presented as a series of dichotomies by R. Room, 1981 [6].

Health Promotion	Disease Prevention
optimistic	small-minded
positive	negative
behaviour	microbiology
people	machines
	(Room 1981)
population	risk groups
enhancing health	conserving health
ideal health	status quo
	(Perry and Jessor 1983)

Similarly, Perry and Jessor suggest that although an orientation to disease prevention is not antithetical to health promotion, neither their objectives nor the activities they include can be treated as similar. They (and other authors) argue that the focus of disease prevention is targeted towards people under some specific stress or risk while the focus of health promotion is on the population as a whole. We might take issue here arguing that health promotion is often targeted to those groups with most potential to benefit from the approach: for example, those people currently disadvantaged with fewest opportunities for growth and development.

Further, Perry and Jessor identify differences in the goals of disease prevention and health promotion: the former is intended to eliminate disease or conserve health, while health promotion activities are intended to enhance health, and while disease prevention seeks to maintain the status quo with respect to health, health promotion fosters a departure from the status quo toward an ideal state of health as yet unattained[7].

Inevitably, reference to ideal states of health brings up the difficult subject of positive health - what we might describe as health beyond the absence of disease or the mere adequacy of personal and social functioning. Consideration of positive health clearly transcends the traditional concerns of medicine with preserving or restoring health. It is not a subject which many medical practitioners have explored.

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[6] Room, R., 1981. The case for a problem prevention approach to drug, alcohol, and mental problems. Public health reports 96 (1) 26-31.

[7] Perry C.L. & Jessor R., 1983. The concept of health promotion and the prevention of adolescent drug abuse (mimeo).

I concluded in the 1981 Overview and will again now that few authors who make their definition of health promotion explicit are able to make a break from concern with diseases; and no one has dealt adequately with the concept in a positive sense beyond adaptation and adjustment to liberation of creative energies for the development of a fulfilling and constructive life.

In recent publications the concept of health promotion has been elaborated to be more positive and more broadly inclusive. It is something more than the application of mass media to the reduction of health damaging behaviours of individuals. The widely quoted U.S. definition is illustrative:

- ...any combination of health education and related organisational political and economic intervention designed to facilitate behavioural and environmental adaptations that will improve or protect health".[8]

When I presented this in the 1980 survey, the response was generally quite supportive, especially because it covered a breadth of activities; because it included changes in both the environment and the individual; and because it defined health promotion by intention, not effect - improved health was the specific aim of the intervention. There was debate, however, about whether what individuals do for themselves should be included as health promotion. In the further development of definitions of the meaning of "health promotion" every step forward seems to be accompanied by at least one step back. Often this arises with definitions that remain all-embracing and vague; and often there is a problem with more unclear vocabulary. For example, a recent and broad definition extends the emphasis on positive health and specifies major areas, but it also introduces "wellness","societal health", and "environmental needs".

- "... any effort used to motivate, educate or provide resources that improve individual and societal health by reducing health risks and increasing opportunities to satisfy personal, social and environmental needs. Major areas of health promotion include wellness, risk reduction, self-help, self-care and fitness".

In these definitions health promotion is defined in terms of multiple methods to achieve a (rather vaguely formulated) goal - improved health. I WONDER IF IT MIGHT NOT BE MORE USEFUL TO SEE HEALTH PROMOTION CHARACTERIZED BY MORE GENERAL PRINCIPLES OF APPROACH, e.g. works with people not on them; starts and ends in the local community; directed to underlying, not only immediate, causes; balances concerns for the individual and environment; emphasizes positive dimensions of health; multisectoral.

I wonder if a narrow definition of health is necessary; the main author of a recent book argues that no comprehensive definition of a health promotion programme can be presented at this time (1983) since "the parameters of health promotion programmes are still evolving"[9].

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[8] United States, Office of Health Information, Health Promotion and Physical Fitness and Sports Medicine, 1980. Definitions of Health Education and Health Promotion. Int. J. Health Ed. XXIII/3 p.161.

[9] O'Donell M.P., Ainsworth T.H. eds. Health Promotion in the Workplace. New York, Wiley, 1984.

Possibly for us providing a harder definition would be unhelpful, even counterproductive. We do not want to be accused of WHO imperialism! However, my feeling is that the dangerous and wasteful development of health promotion, as on the one hand a universal panacea, and on the other nothing more than old wine in new bottles demands a considered response.

We want to support people who are interested in developing effective policies and local initiatives for the promotion of health. I hope I have shown that it would be helpful to provide greater clarity for the concept, and to alert people to the potential changes and limits of health promotion as well as promising strategies and opportunities. The question is how best we can do this.

HEALTH - THE ULTIMATE DISEASE

A comment by Lowell Levin

Defining "Health Promotion" has not been my favourite topic for many of the reasons that Robert Anderson has so eloquently put forward at this meeting. I am fond of thinking of it as an exercise in shovelling smoke. You get a little bit on there but you drop more. And you ultimately set down the shovel and think "who put you to this task, anyway." You get very petulant when you discover that your job may demand that you undertake some kind of effort to define these things. In Europe, which I have learned something about over the last decade here, and in the US, where my experience extends several decades, I have seen some things happen that are of interest and I think bear on the issue of definition and development in health promotion.

First, basically I think we are seeing a disappearance of disease. Now that is a statement that upsets a lot of people who know there is plenty of disease around. I grant you that indeed there is plenty of disease, but it is disappearing. The "good" diseases are disappearing, those that we could undertake to do something about with high tech, with institutional care, and with a variety of programmes that would help people back onto the road of good health and restoration and the like. Those diseases, for reasons which we cannot fully explain and have had only modest control, are fading from our grasp. We are seeing a reduction in coronary heart disease mortality, in stroke, and some areas of cancer are beginning to disappear. We cannot explain it, sorry. We have a lot of things happening in the world of disease, the patterns of disease changing in such a way that we now have to begin to look for compensatory opportunities for service.

In my view the next new big disease that we have available to us is health. Health is the new disease, and we can apply to the concept of health precisely the language and style and strategies of operation that we apply to the world of disease. Health is even better than disease (in maintaining the disease care establishment) because everybody wants it. Everybody wants health and we have for the first time the only disease that everybody wants. We will now be able to manage this disease programme without much effort and motivation to get people to undertake advice and counsel and care and technology or whatever is necessary to achieve (or control) it. And, of course, we the experts in public health have a technology and the knowledge to undertake to organize curricula, programmes, institutional care and the like to improve the health status of anybody who is serious about catching this particular disease and holding on to it.

While there are some funny aspects to this construction, it does, I think, help us to understand the potential in maintaining a medical model. That we choose to forget the word medical or social, just use the word power. It is quite convenient and I think fits the situation. With this in mind we can undertake to develop a new approach called health promotion, which converts health to a disease. Now we can organize a system of care and procedures which will ensure that people get what they want, under the advice and counsel of those who know best. Now that is troublesome for me, as you know. Not that I believe for a moment that health is happiness, I do not believe that. I do, however, believe truly that happiness is a higher goal than health and the tragedy will be, of course, when we define happiness, which will be inevitable once we conquer the disease of health.

In a more sober frame, my own personal task is to figure out ways and means of not being too helpful. I believe, that the above scenario is where we are going. It is a real possibility. Look at the United States of Adidas, (I mean of America), which now has a $3.5 billion health promotion industry. I would say that the first job of professional people in health promotion is to find out what is the minimum you can do. What is the minimum undertaking for the health professions, for government, to facilitate the process of people getting indeed what they want. Find what the barriers to achievement are, whether it is in terms of access to social relations or to information appropriate to good quality decision making. So our task, I think, is a minimal task; one which says that we have a very humble but very important role, that is to find what it is that is standing between the public's interest in health and their achieving it and what we can do to ensure that they get there with the least amount of our effort (or control). Now that is nothing that we are going to feel comfortable with because that is not what we are paid for, that is not what we hope our job will be, and we are all very much interested in our own personal security, understandably. I am not saying that that is a terrible thing, I am saying that it is a real thing. Now, how then, the question is, can we stifle ourselves, control our urge to manage what has got to be the most powerful, continuously available health problem, health itself? How can we control ourselves, our urge to fall back, not only on the medical models, but on the power models of a variety of other social institutions?

HEALTH PROMOTION

A discusssion document on the concept and principles

Principles

Health promotion is the process of enabling people to increase control over, and to improve, their health. This perspective is derived from a conception of 'health' as the extent to which an individual or group is able, on the one hand, to realise aspirations and satisfy needs; and, on the other hand, to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living; it is a positive concept emphasising social and personal resources, as well as physical capacities.

1. Health promotion involves the population as a whole in the context of their everyday life, rather than focusing on people at risk for specific diseases. It enables people to take control over, and responsibility for, their health as an important component of everyday life - both as spontaneous and organized action for health. This requires full and continuing access to information about health and how it might be sought for by all the population, using, therefore, all dissemination methods available.

2. Health promotion is directed towards action on the determinants or causes of health. Health promotion, therefore, requires a close cooperation of sectors beyond health services, reflecting the diversity of conditions which influence health. Government, at both local and national levels, has a unique responsibility to act appropriately and in a timely way to ensure that the 'total' environment, which is beyond the control of individuals and groups, is conducive to health.

3. Health promotion combines diverse, but complementary, methods or approaches, including communication, education, legislation, fiscal measures, organizational change, community development and spontaneous local activities against health hazards.

4. Health promotion aims particularly at effective and concrete public participation. This focus requires the further development of problem-defining and decision-making lifeskills both individually and collectively.

5. While health promotion is basically an activity in the health and social fields, and not a medical service, health professionals - particularly in primary health care - have an important role in nurturing and enabling health promotion. Health professionals should work towards developing their special contributions in education and health advocacy.

Subject Areas

Health promotion best enhances health through integrated action at different levels on factors influencing health, economic, environmental, social and personal. Given these basic principles an almost unlimited list of issues for health promotion could be generated: food policy, housing, smoking, coping skills, social networks. The working group sought to frame the general subjects for health promotion in the following areas:

1. The focus of health promotion is access to health: to reduce inequalities in health and to increase opportunities to improve health. This involves changing public and corporate policies to make them conducive to health, and involves reorienting health services to the maintenance and development of health in the population, regardless of current health status.

2. The improvement of health depends upon the development of an environment conducive to health, especially in conditions at work and in the home. Since this environment is dynamic, health promotion involves monitoring and assessment of the technological, cultural and economic state and trends.

3. Health promotion involves the strengthening of social networks and social supports. This is based on the recognition of the importance of social forces and social relationships as determinants of values and behaviour relevant to health, and as significant resources for coping with stress and maintaining health.

4. The predominant way of life in society is central to health promotion, since it fosters personal behaviour patterns that are either beneficial or detrimental to health. The promotion of lifestyles conducive to health involves consideration of personal coping strategies and dispositions as well as beliefs and values relevant to health, all shaped by lifelong experiences and living conditions. Promoting positive health behaviour and appropriate coping strategies is a key aim in health promotion.

5. Information and education provide the informed base for making choices. They are necessary and core components of health promotion, which aims at increasing knowledge and disseminating information related to health. This should include: the public's perceptions and experiences of health and how it might be sought; knowledge from epidemiology, social and other sciences on the patterns of health and disease and factors affecting them; and descriptions of the 'total' environment in which health and health choices are shaped. The mass media and new information technologies are particularly important.

Priorities for the Development of Policies in Health Promotion

Health promotion stands for the collective effort to attain health. Governments, through public policy, have a special responsibility to ensure basic conditions for a healthy life and for making the healthier choices the easier choices. At the same time, supporters of health promotion within governments need to be aware of the role of spontaneous action for health, i.e. the role of social movements, self-help and self-care, and the need for continuous cooperation with the public on all health promotion issues.

1. The concept and meaning of 'health promotion' should be clarified at every level of planning, emphasising a social, economic and ecological, rather than a purely physical and mental perspective on health. Policy development in health promotion can then be related and integrated with policy in other sectors such as work, housing, social services and primary health care.

2. Political commitment to health promotion can be expressed through the establishment of focal points for health promotion at all levels - local, regional and national. These would be organizational mechanisms for intersectoral, coordinated planning in health promotion. They should provide leadership and accountability so that, when action is agreed, progress will be secured. Adequate funding and skilled personnel are essential to allow the development of systematic long-term programmes in health promotion.

3. In the development of health promotion policies, there must be continuous consultation, dialogue and exchange of ideas between individuals and groups, both lay and professional. Policy mechanisms must be established to ensure opportunities for the expression and development of public interest in health.

4. When selecting priority areas for policy development a review should be made of:

   indicators of health and their distribution in the population
   current knowledge, skills and health practices of the population
   current policies in government and other sectors

   Further, an assessment should be made of:

   the expected impact on health of different policies and programmes
   the economic constraints and benefits
   the social and cultural acceptability
   the political feasibility of different options.

5. Research support is essential for policy development and evaluation to provide an understanding of influences on health and their development, as well as an assessment of the impact of different initiatives in health promotion. There is a need to develop methodologies for research and analysis, in particular, to devise more appropriate approaches to evaluation. The results of research should be disseminated widely and comparisons made within and between nations.

Dilemmas

Health related public policy will always be confronted with basic political and moral dilemmas, as it aims to balance public and personal responsibility for health. Those involved in health promotion need to be aware of possible conflicts of interest both at the social and the individual level.

1. There is a possibility with health promotion that health will be viewed as the ultimate goal incorporating all life. This ideology, sometimes called healthism, could lead to others prescribing what individuals should do for themselves and how they should behave, which is contrary to the principles of health promotion.

2. Health promotion programmes may be inappropriately directed at individuals at the expense of tackling economic and social problems. Experience has shown that individuals are often considered by policy makers to be exclusively responsible for their own health. It is often implied that people have the power to completely shape their own lives and those of their families so as to be free from the avoidable burden of disease. Thus, when they are ill, they are blamed for this and discriminated against.

3. Resources, including information, may not be accessible to people in ways which are sensitive to their expectations, beliefs, preferences or skills. This may increase social inequalities. Information alone is inadequate; raising awareness without increasing control or prospects for change may only succeed in generating anxieties and feelings of powerlessness.

4. There is a danger that health promotion will be appropriated by one professional group and made a field of specialization to the exclusion of other professionals and lay people. To increase control over their own health the public require a greater sharing of resources by professionals and government.

Conclusions

The concept of health promotion is positive, dynamic and empowering making it rhetorically useful and politically attractive. By considering the recommended principles, subject areas, policy priorities and dilemmas it is hoped that future activities in the health promotion field can be planned, implemented and evaluated more successfully. Further developmental work is clearly required and this will be an ongoing task of the WHO Regional Office for Europe.

HEALTH PROMOTION

Programme development in the WHO Regional Office for Europe

In January 1984 a new programme "Health Promotion" was started within the context of the Seventh General Programme of Work of the WHO Regional Office for Europe.

Preparatory work had begun in 1980 when a study was commissioned to identify the meaning of this term in Europe on both theory and pratice and to identify the goals, approaches and content of programmes in health promotion[1]. The outcome of this study was discussed by a Working Group on the Concepts and Principles of Health Promotion in November 1981, which advised the Regional Office on the focus it should give the new programme.

At that point in time the conceptual starting point had been a positive and social notion of health. In a basic paper giving the outline and intentions of the health education programme of the WHO Regional Office for Europe, four main conceptual reorientations had been presented to the Regional Committee in 1981 and accepted by Member States:

from health prescription to health promotion;

from individualistic behaviour modification to a systematic public health approach;

from medical orientation to recognition of lay competence;

from authoritarian health education to supportive health education[2].

The paper went on to state:

"if health does not define itself as the absence of disease but as a state of positive wellbeing, then its achievement requires a conscious effort on the part of the individual, the community and the state. Until recently, public health programmes in Europe have been heavily biased in favour of disease/disorder prevention programmes and expansion of the secondary and tertiary care systems. The orientation towards primary health care should be seen as an orientation towards health not disease, towards health promotion rather than cure of already well-advanced problems.

"Whereas a health prescription approach could well be dealt with in one system, i.e. the medical care system, a health promotion approach depends on the coordinated efforts of all units of society".

This basic approach of making health promotion a collective effort, or as has been said "everybody's business" is reflected in the main objectives of the programme that was then outlined and accepted by Member States in 1982:

1. To increase and disseminate knowledge on factors and conditions influencing the development of particular beliefs and behaviour, and on the relationship between lifestyles and positive health[3].

2. To increase awareness of lifestyle choices hazardous to personal health and of how such choices relate to wider social health issues.

3. To promote the development of intersectoral health promotion policies at national and local levels, with special reference to disadvantaged groups.

4. To develop policies and programmes to promote healthy behaviour.

The programme aims at reflecting an enabling approach to health that allows for full public participation and empowerment for health. But it also warned against quick and easy solutions:

"A programme in health promotion should not raise false expectations of a rapid and peaceful transition to healthy living, and must recognize the delicate balance between individual and community responsibility. The achievement can only be measured in the long term, although the programme itself must be sufficiently flexible for it to adapt to changing conditions in the short term. There is neither a single nor a simple solution to good health and there is no "optimal" lifestyle for all people. Culture, income, family life, age, physical ability, traditions and the home and work environments will make certain ways and conditions of living more attractive, feasible and appropriate than others. Since many of the factors that affect health cannot be influenced by individuals, it would be inappropriate to concentrate exclusively on greater personal responsibility for health. Similarly, the assumption of such responsibility may be a problem for people used to being told that they should entrust their health to doctors. An increase in moral judgement is one possible negative consequence of a health promotion programme. Others may result from excessive enthusiasm for certain activities, such as fitness training; from the misplaced prescription or proscription of certain behaviours; from conflicts of interest between different social groups; from the development of a cult of "healthism" and health paternalism; or from the ethical implications of behaviour modification".

The special historical chance for this programme lay in its relevance to overall policy and programme development in the WHO Regional Office for Europe. In 1980 the Regional Committee had accepted the "Regional strategy for attaining Health for All by the Year 2000"[4] and the Regional Office had embarked on a major effort to operationalize this strategy with the help of Regional Targets. One of the three major sections in the Regional Strategy aims at "developing lifestyles conducive to health" and in 1984 the Regional Committee accepted targets for this section in the following five areas, which fully represent a health promotion approach:

- healthy public policy
- social support systems
- knowledge and motivation for healthy behaviour
- promoting positive health behaviour
- reducing health damaging behaviour[5]

The theoretical and philosophical background for this choice of focus was developed in detail in a paper presented to the Regional Committee in 1983 for its technical discusssions on lifestyles conducive to health[6].

It was therefore felt appropriate in 1984 to pull together all these elements of health promotion programme development in the Regional Office and make the notions available in a short and precise document. The result is a discussion document on Concepts and Principles of Health Promotion which outlines principles, subject areas, priorities for policy development and dilemmas[7].

The momentum of the European Health Promotion programme has been taken up by WHO Headquarters in Geneva and in 1985 a WHO study group will be convened to discuss the potential of the health promotion approach for the Health for All strategy at a global level. The Regional Office is acting as secretariat to this study group.

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ANNEX II

WORKING PAPERS AND PUBLICATIONS RELEVANT TO HEALTH PROMOTION PRODUCED BY THE HEALTH EDUCATION UNIT, WHO REGIONAL OFFICE FOR EUROPE

(1) Working group on the Concept and Principles of Health Promotion. Summary report on a Working Group, Copenhagen 1981.

(2) Involvement in Health: a Social Concept of Health Education by Ilona Kickbusch, International Journal of Health Education, Vol XXIV, issue 4, December 1981.

(3) Lifestyles and Their Impact on Health, Copenhagen, WHO Regional Office for Europe, 1983. (unpublished document EUR/RC33/Tech. Disc. 1).

(4) Influence on Health Beliefs on Lifestyles: What Do We know? by Kathryn Dean. Technical paper 1983.

(5) Scenarios for Lifestyles and Health by James Robertson. Technical paper 1983.

(6) Health Promotion and Lifestyle Change in the Workplace by Malcolm S. Weinstein. Technical paper 1983.

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