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Chapter 10: Health Promotion

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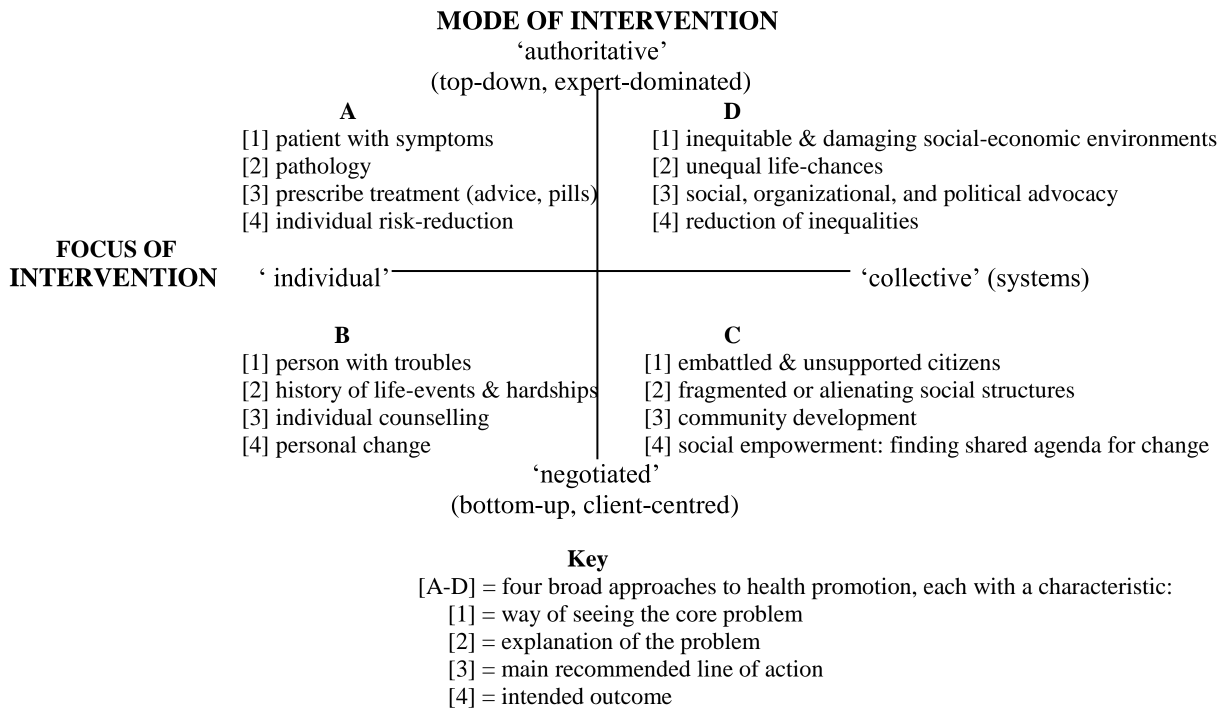
What is health promotion?

Health promotion has become an increasingly prominent item in public policy in the UK and other countries in recent years, and an increasingly important aspect of the work of doctors, nurses and other health professionals, as well as of people in several other sectors beyond the health service. A useful first definition of health promotion is as follows:

'Health promotion is the process of enabling people to increase control over, and to improve, their health'
(World Health Organization, Ottawa Charter for Health Promotion, 1986)

An older approach, often equated with 'health education', has been to give people information in order to enable them to take action to improve their own health. But recent developments have led to the concept of 'health promotion', understood as something that includes not only information-giving, but other ways of strengthening individuals, and also action directed towards changing the social circumstances of people's lives - by enhancing supportive community structures, alleviating detrimental economic conditions, or reducing environmental hazards. A framework that sums up these strategic options in conceptualising and planning health promotion activities is shown below:

[Figure 1] A FOUR-QUADRANT FRAMEWORK FOR REVIEWING HEALTH PROMOTION STRATEGIES



Key
[A-D] = four broad approaches to health promotion, each with a characteristic:
[1] = way of seeing the core problem
[2] = explanation of the problem
[3] = main recommended line of action
[4] = intended outcome

These 4 modes of health promotion (Beattie 1991) can also be summarized in table form (see below)

[Table 1] FOUR MODES OF HEALTH PROMOTION – AIMS, PRACTICES, AND UNDERLYING PHILOSOPHIES

	Mode of health promotion	Aim	Practice	Philosophy
A	Individual risk-reduction	To protect client, to reduce risk of disease	Vaccinate; test; monitor; advise; persuade	conservative-positivist, functionalist
B	Personal counselling	To help client to take control of own life	Listen, clarify, reflect, focus, resolve, support	humanistic, liberal, permissive
C	Community development	To support groups on own agenda of change	Listen, join in, debate, bring together, network	communitarian, radical-humanist
D	Social advocacy	To lobby official agencies to achieve equity	Report, liaise, appeal, persuade, expose	radical-positivist, materialist

This tabulation draws together the principal aims and typical areas of activity that characterise each different mode of health promotion. Practitioners are sometimes attracted to one particular mode because of distinctive personal and social values it is seen to embody – which may be partly a matter of ethical standpoint, partly to do with political views, and for some people perhaps more to do with what kinds of knowledge they deem most trustworthy (eg whether oriented towards the positivist and 'objective', or towards the humanist and 'interpretive'). These positions (termed here 'philosophies') are summarised in the final column of Table 1; though it should be said that many practitioners nowadays try to judge the merits of different modes on strictly pragmatic grounds.

Some insights that arise from scrutinizing this framework (Figure 1 and Table 1) are as follows.

1. Medical education has until recently prepared doctors most obviously for ways of thinking and types of practice that are summarised in quadrant A – what some call 'medical model' health promotion. But successive waves of reform have opened up medical thinking and practice in the directions A → B; A → D, such that doctors are better equipped for working in partnership with clients to improve their health (a shift from top to bottom on the vertical axis), and better able to appreciate the need (often) to take action to change the social institutions that limit the scope for clients to improve their health on their own (a shift from individual to collective on the horizontal axis). Both these axes entail value-shifts that may in different ways challenge not only the academic knowledge-base but even the self-concept of the medical practitioner.

2. The current organization of medical work means that many doctors specialize (for example in hospital-based medicine and surgery) in ways that may encourage a 'mode A' way of seeing the health promotion task. Others may find mode B more convincing as an approach to health improvement, and may move into psychological medicine and psychiatry or may bring this perspective to bear on specialised hospital practice or on general practice. Yet others may find in mode D the most persuasive logic for health improvement, and may move into public health medicine; or may deliberately make time within or beyond their clinical practice for the kinds of advocacy work that this approach entails – perhaps simply as citizens who happen to work in medicine. Those who find social empowerment and community development (mode C) the most compelling ways of going about the health improvement task are unlikely to find a major medical specialism that exclusively or even predominantly uses such an approach, but can bring it to bear significantly in work with lay community groups or voluntary organizations within general practice, psychiatry, public health – or indeed potentially in any area of modern medicine where listening to 'local voices for health' is an important part of the job.

3. The most important train of thought arising from the framework presented in Fig 1 and Table 1 may be that in the future every doctor should be able to understand and to appreciate all 4 of the distinctive ways of seeing and ways of doing, and the values that lie behind them – in all 4 'modes' - and to recognise that all 4 of them may have a part to play in a comprehensive and 'whole-systems' approach to the improvement of health. Even for medical practitioners who choose to work within only one mode, it is becoming vitally important to be able to enter into dialogue with other practitioners and agencies who may be using a different approach to health promotion than themselves; and to be able when occasion demands to contribute to shared tasks within a wider team, or to negotiate a division of labour, or to delegate and support those colleagues whose work in different modes of health promotion may need to come into the picture in a multi-strand programme (or may even need to take the lead for a time in some phases of a complex project).

5 key concepts in the World Health Organization approach to promoting health

A major influence in shaping up-to-date strategies for health promotion has been the World Health Organization [WHO], especially in the work it has undertaken since the 1970s. A series of key concepts were formulated by WHO as part of its work in developing the 'Health for All by the year 2000' framework, and these are being further pursued in the 'Health 21' programmes which are now under way. A classic statement of the WHO approach is in the Ottawa Charter (1986) which identifies - as the basic tools or 'building-blocks' of health promotion – the following 'famous 5' priority areas for action (Nutbeam 1986; 1998):

1. building healthy public policy [HPP]
   This is characterized by an explicit concern for health and equity in all areas of policy, and by accountability for the 'health impact' of all areas of policy. The aim of HPP is to ensure wider social policies that make healthy choices feasible and easier for all citizens.
2. creating supportive environments for health [SEH]
   These are environments that offer people protection from threats to health, and that enable people to expand their capabilities and develop self-reliance in health. SEHs encompass where people live, their homes, their local neighbourhoods, and where they work and play. Action to create SEHs may include direct political action to develop and implement relevant policies and regulations, and economic and social action (for example to foster sustainable environments).
3. strengthening community action for health [CAH]
   This refers to collective efforts by communities that are directed towards improving health by increasing community control over the determinants of health. CAH is one particular kind of social empowerment, wherein local people come together to define their own health needs, then work through the conflicts that emerge in this process of participation, and provide mutual social support for each other in meeting their own agreed needs.
4. developing personal skills for health [PSH]
   These are the skills whereby individuals manage to deal with the demands and challenges of everyday life: they are lifeskills, the means of adapting to and surviving adverse life events and social hardships. PSH are typically seen in people's capacity to live with change, but also to generate change, to control and direct their own lives. They entail both cognitive and emotional capacities - creative as well as critical thinking; decision-making and problem-solving; self-awareness and empathy; skills in communication and interpersonal relations and in managing stress and emotions.
5. reorienting health services [RHS]
   This is characterized by a concern to emphasize explicit health outcomes in the way that health services are planned, funded and managed. RHS seeks a higher profile for health promotion and disease prevention in balance with diagnosis, treatment, care and rehabilitation services; and a better appreciation of the needs of each individual as a whole person, along with the needs of all population groups. It also underlines the importance of the contribution to health outcomes of all the health professions, and of other institutions beyond the health service itself - it therefore entails a call for intersectoral action for health across all government departments.

WHO continues to emphasise that 'multi-track' approaches to health improvement are far more effective than 'single-track'; and that all opportunities must be seized for the implementation of comprehensive combinations of all 5 of the 'building blocks' defined above. This will require new investments in partnership working and in new infrastructures for delivering health promotion.

The WHO's 5 key concepts for health promotion

- 'healthy public policy' is the process of trying to ensure that all areas of policy (not just health services) are favourable to health
- 'supportive environments for health' is where action to improve health is directed at the settings of people's everyday lives - homes, neighbourhoods, workplaces.
- 'community action for health' is where local people come together to share their health concerns, and support each other in improving their own circumstances.
- 'personal skills for health' focuses on what it takes for individuals to deal with the changes and challenges of their lives, to manage stress and emotions in creative and adaptive ways
- 'reorienting health services' is about achieving services that bring practitioners together with a focus on the needs of the whole population and an emphasis on positive health gain.

5 key concepts in recent health improvement strategies in the UK

In the UK, the policies and strategies brought forward by the WHO at global and European level have helped to inform or support a great deal of local activity in health promotion since the early 80s. However, although UK governments have been signatories to the WHO charters, concerted policy development for public health and health promotion at national level was slower in coming, and has sometimes taken a lukewarm and selective approach to the WHO precepts. The 'Health of the Nation' strategy introduced in the 1980s was the first attempt by a UK government to establish a coherent and systematic policy for health promotion, and although this avoided direct reference to the context of social inequalities in health, it did highlight a number of key concepts with origins in the WHO approach. The successor to Health of the Nation brought in by a new government in 1999, named 'Our Healthier Nation', reflects an approach much closer to the WHO and placing a great deal of emphasis on a wide understanding of the 'health field' and of the need for multi-level, 'joined-up' action for health promotion. This – and related research-and-development work in the Health Education Authority – has put firmly on the agenda for planning and action a number of further key concepts that advance the lines of thought seen earlier in WHO policies. Five concepts that seem to offer new 'building blocks' (along similar lines to the WHO's 5 seen above) are:

1. healthy alliances
   One of the key principles of the WHO's strategies for 'Primary Health Care' (1978) and for 'Health for All 2000'(1981, 1986) has been to encourage interagency collaboration, to work to improve health by coordinating activities across different sectors – health, social services, housing, employment, education, environment. And by the end of the 80s many towns and cities in the UK were the sites for considerable efforts to strengthen joint work on public health issues. In 1992, as a way of making its Health of the Nation strategy work, the UK Department of Health encouraged the setting-up at all levels of the service of 'healthy alliances', that is "active partnerships between the many organisations and individuals who can come together to help improve health" (DoH 1992, p5). Each of the 'Key Area Handbooks' for Health of the Nation subsequently published (on HIV/AIDS and sexual health; on coronary heart disease and stroke; on accidents; on cancers; on mental health) incorporated a section on healthy alliances that illustrated local examples and approaches in finding 'likely partners' for multi-agency preventive work in each of these 5 areas. More recently the term has been adjusted to 'health alliances', but the principle of creating new allegiances between the work of separate agencies so as to deliver health improvements at local level remains central to the 1999 'Our Healthier Nation' strategy (DoH 1999). This observes that successful local partnerships will require the development of "a culture in which learning and good practice are shared" across boundaries.

2. healthy settings

   We saw earlier that 'creating supportive environments for health' was a concept brought in by the WHO. This connects in turn to a broader concept of 'settings-based health promotion' and the idea of 'healthy settings' - another area where WHO and UK government policies have increasingly begun to converge. The settings approach tries to make a reality out of the wider, less-compartmentalized, 'ecological' view of health, by taking action within the everyday habitats within which we all 'learn, work, play and love'. 'Health of the Nation' in 1992 advocated action at the level of healthier homes, health-promoting schools, health-promoting hospitals, healthy workplaces, and healthy cities; and subsequent work has pursued this same idea in projects on 'healthy prisons' and 'health-promoting universities'. Ideas like healthy schools and healthy workplaces continue to be an important element in 'Our Healthier Nation'. But 3 new instances of this concept are introduced. *'Healthy Living Centres'* are recommended as places which bring together a new and creative mix of ways of providing help for better health: eg health screening and advice, dietary information, smoking cessation support, exercise, child care and training, employment skills development. All this may be housed in a single building, or it may be a new network of facilities, and it is regarded as vital that local users are fully involved in the planning of such centres. *'Healthy neighbourhoods'* are proposed as a focus for improving health by promoting social cohesion and strengthening social networks: "people relate closely to their neighbourhoods and are likely to be healthier when they live in neighbourhoods where there is a sense of pride and belonging" (DoH 1999 para 4.34-4.35). This is seen as a point at which health improvement must link up with wider 'regeneration' initiatives, such as the 'New Deal for Communities' and 'Single Regeneration Bids' which aim to improve the most deprived Local Authority areas; and 'Local Agenda 21' plans which aim to promote sustainable development through environmental projects such as community gardens, new allotments, city farms, new public transport schemes etc. *'Health action zones'* have been introduced as a way of encouraging local organizations to cooperate in improving health in the most deprived areas of the country. Their 3 broad strategic objectives are to reduce health inequalities in a local area; to increase the efficiency, effectiveness and responsiveness of local services; and to "create alliances for change" that 'add value' by "breaking through current organisational boundaries", by "creating synergy between the work of different agencies" and " by harnessing the dynamism of local people and organisations".

3. healthy citizens

   'Our Healthier Nation' (1999) signals an important development in conceptualizing the way in which health promotion practice addresses the individual. As we saw above it is not new for governments to ask people to take responsibility for their own health, to suggest that there are actions that we can each of us take to improve our own health. However the 1999 policy framework goes some way towards adopting more recent understandings of the extent to which each individual's scope for decision-making and choice is socially-constrained, acknowledging that "better health opportunities and decisions are not easily available to everyone. For example membership of a gym may not be an option for someone in a poor neighbourhood or a single mother" (DoH 1999, para 1.34). Local health improvement programmes are therefore called upon to deliver information and programmes that can enfranchise people in matters of health, can combat 'social exclusion' and can help 'create the right conditions for individuals to make healthy decisions'. This kind of shift in thinking is registered in the idea of 'healthy citizens' and 'expert patients', whereby we are all encouraged to be active agents in helping ourselves and improving our own health, with the support of information from magazines, radio and television programmes, phone-lines, websites and other electronic media resources.

4. ‘contracts for health’
   A key tool of thought in ‘Our Healthier Nation’ (1999) is a series of ‘national contracts’ on each of the major health priorities for which targets are defined in that policy (cancer; heart disease and stroke; accidents; mental health). Each contract enumerates 4 dimensions in which action can be taken to improve a particular aspect of health (services; personal behaviour; social and economic; and environmental); and then enumerates *which* of the various players in the national and local ‘health partnerships’ should be doing *what* in each of these dimensions (individual citizens; ‘local players and communities’; and ‘government and national players’.

A CONTRACT FOR ACTION ON HEALTH IMPROVEMENT

Who does what? / Why?	Front-line medical/ health practitioners can:	Individual citizens can:	Community groups can:	Statutory agencies, local & central government can:
To enhance clinical repair & risk-reduction services	Carry out screening and risk-assessments; offer information/advice run prevention clinics	Make use of screening & advice services; Engage in well-informed active health maintenance	Support complaints about unsatisfactory services; Advertise & protect valued services	Modernise services, ensure efficiency, effectiveness, equity; Monitor & audit standards/frameworks
To strengthen individuals	Offer counselling services; support healthy living centres	Take charge of own life; take opportunities for learning & training	Protect vulnerable members; help them to move on and find their own voice	Offer link and liaison services; Offer protection or respite if necessary
To strengthen communities	Support and enable deprived groups; challenge social exclusion; work with other local agencies	Exchange experience and information with local people; participate in local networks, provide social support	Maintain local networks; provide social support;	Act as statutory enabler Create or maintain supportive infrastructures
To improve wider social economic and cultural environments	Pass on complaints and concerns to statutory agencies; responsible officers; higher authorities [‘blow the whistle’]	Complain about unsatisfactory policies, environments, etc;	Lobby and campaign to transform environments; laws, regulations, policies;	Ensure health-promoting policies, laws, regulations, standards, social norms plans,

   This sort of tabulation (Table 2 above) can be a useful device in planning, consultation and review, and has for example been taken further in a series of ‘National Service Frameworks’ – for example for mental health and for coronary heart disease - which decisively place health promotion at the heart of mainstream health care development and management. Action guides along these lines unmistakably bear the stamp (and show the benefits) of the ‘structures and systems’ thinking outlined above, as a crucial way of keeping in mind the ‘bigger picture’ – the new balance, the ‘third way’, linking individual and institutional action on health.

5. social capital for health
   This receives only a brief mention in ‘Our Healthier Nation’, but it is a concept that is clearly helping to drive much of the new thinking that underlies the commitment to ‘inclusive and integrated, comprehensive and coherent’ ways of tackling poor health. Social capital is a term given to the invisible fabric of social trust at grassroots level, the formal and informal systems for exchanging information, ideas and practical help: the horizontal and ‘egalitarian’ networks of relations, friends, neighbours and mutual aid organizations. Evidence is growing that deaths in infancy and from stroke, heart disease, accidents and suicide are lower (and longevity is higher) in areas with high social capital, and that public health initiatives generally are more likely to succeed in such areas. The basic idea was seen above in connection with ‘healthy settings’: ‘social capital’ is what regeneration schemes are aiming to build or repair or replace,

by increasing social cohesion, strengthening social networks, and reducing social stress and divisions. It is clearly a concept that can have far-reaching implications for the future planning and delivery of health promotion, and it helps to pull together and make sense of several of the other key understandings described in this chapter.

5 key concepts in recent UK government health promotion policies

- 'healthy alliances' is about active partnerships to improve health by coordinating activities across sectors – health, social services, housing, employment, education, environment.
- 'healthy settings' is concerned with taking action to improve health within the major 'institutions' of modern life: schools, hospitals, workplaces, prisons, neighbourhoods, cities.
- 'healthy citizens' involves providing much better information and support to the public, so as to make opportunities and decisions for better health more easily available to everyone.
- 'contracts for health' is a methodical way of setting out the range of actions that may usefully be taken on a particular health problem, and who should be doing what across this range
- 'social capital for health' is a term that refers to the fabric of local life at the grassroots - trust, support, networks of exchange – that makes for cohesion and supports positive health action.

5 worked examples of key concepts applied in clinical practice

Worked example 1: preventing accidental falls among older people

Every year in this country more than 3000 people aged 65 years and over die from falls, and there are many other statistical indicators that flag up the huge toll of injuries and disabilities due to the high incidence of falls in the later years of life (Downton 1993). How best to reduce this burden of illness is a typical challenge in orchestrating several different and parallel strategies for health promotion (Oakley 1996):

1. There is often a great deal of clinical work that can usefully be done: for older people who have already fallen at least once and have received treatment, an in-depth assessment of risk factors can be made before they return home. Older people newly entering hospital or nursing homes (etc) can be assessed in terms of 'falls risk scores', and case management policies (or care plans) can be written accordingly. Older people living at home can be assessed and fitted (if appropriate) with body-worn alarms, backed up by staff training and regular checks. Careful guidance can be given on the risks of unsteadiness and falls associated with certain drugs, especially 'poly-pharmacy'. Specialist falls clinics can be set up to give guidance on this.
2. Older people living at home can be provided with education/information/advice on how to reduce the risk of falls, what to do in the event of fall, how to get up after a fall, etc. They can be encouraged to attend sessions of dance and other forms of exercise that are known to enhance the balance, strength and mobility of older people (as well as yielding benefits for psychological wellbeing, alertness, self-confidence and social interaction).
3. Older people's own homes can be checked for accident risks and hazards, and modified as appropriate (by negotiation!); where necessary aids and adaptations can be put in place, and other socio-physical and socio-economic elements of domiciliary care and support. Similar reviews can be conducted in hospital wards and day units and in nursing homes, and the ideas associated with 'healthy settings' can be brought bear, to prompt a broader managerial effort to clarify and monitor operational policies and practice protocols, and to involve and update all relevant staff and encourage teamwork and liaison (across agencies where necessary).

4. Local groups (such as Age Concern, Help the Aged, tea dance groups etc) can be used as forums to run discussions and debates with older people on concerns about risk and safety, and about achieving a balance between 'protection and independence' in older people's lifestyles. In local schools or adult education institutions or community centres, 'learning and outreach' networks can be set up for older people (and other sections of the community), to engage in discussion around the meaning of 'safety as a community value', 'the competent community', etc. These could draw on techniques of community development and empowerment education to explore the possibilities for local citizen action on 'safe community projects' etc.

Worked example 2: action on stress and emotional disorders

At any one time around 1 in 6 adults of working age are experiencing mental health problems, for example anxiety or depression; 1 in 250 adults will experience a psychotic illness such as manic depression or schizophrenia (NSF 1999). Mental health problems result in the greatest burden of premature death and years of reduced quality of life. But dealing with mental health problems is well-known to be a controversial field: different viewpoints and schools of thought coexist, they recommend what sometimes appear to be starkly different guidelines for practice, and they are frequently the focus of intense dispute and conflict (Clare 1976; Tudor 1996). These different approaches may sometimes indeed be in conflict and incompatible; but increasingly they can be used to complement one another as successive phases in an unfolding programme of mental health development work, or as alternative emphases within a comprehensive strategy for mental health, running as parallel strands - one or another of them given particular attention from time to time as appropriate. It is another challenge in orchestrating multiple strategies for health promotion:

1. One of the more striking developments in mental health promotion has been the increasing recognition that service users – current or former psychiatric patients or 'survivors' – can bring crucial insights to the planning and delivery of services. Moreover, mutual aid groups formed by survivors can have a beneficial impact on people with or at risk of mental health problems. They give clients the chance to share their experiences (sadness, frustration or anger prompted by their social circumstances) with others who have 'been there', and they can thereby find - with the support of the peer group - a common agenda and possibilities for empowerment and action to change their lives. For clinicians, liaison with other appropriate agencies may offer an essential entry-point to such support networks – often a local community development worker, or a local voluntary group or agency.
2. For some clients, some of the time, prescribing psychoactive medicines may be best practice, to cope with an immediate crisis, or to alleviate troubling acute symptoms. There are many cases of long-term psychiatric patients who welcome regular or occasional medication that helps to keep crises at bay, to maintain their independence and autonomy, and to continue to work to resolve underlying problems. Often however, this focus on the illness or the symptoms can lead to neglect of broader opportunities for promoting mental health.
3. Some clients can best be helped by in-depth counselling that explores feelings and the origins and meanings of symptoms, and can thereby be helped towards a greater sense of control and ownership of their lives; in such cases, referral to other practitioners may be essential. In other cases, it may be appropriate to refer a client to adult education or similar 'tailored' education services, where lifeskills and coping strategies can be learned (or re-learned), and new horizons of personal capability and social interaction can often open up. In such cases, relaxation, stress management and exercise seem to be beneficial. In addition creative and performing arts projects (in hospital or community settings) can give access to individual and group activities that enhance self-esteem and self-confidence, as well as offering new personal insights.

4. Recent policy directives have encouraged clinicians to make themselves aware of the wider socio-economic and socio-cultural contexts that contribute to the burden of mental health problems: for example, long-term hardship or abuse (notably of women) or discrimination (notably against black & minority ethnic people). Such awareness can guide action of the sorts already mentioned here, but can also suggest other interventions, for instance professional or citizen advocacy to improve local and national policies on inequity in mental health. Another example of a broader agenda to which health professionals can contribute significantly is that of challenging the negative stereotypes of mental illness in the media, fighting discrimination against people with mental health problems and promoting their social inclusion (NSF 1999)

Worked example 3: action on coronary heart disease and cardiovascular health

Coronary heart disease [CHD] is the single commonest causes of premature and avoidable death in the UK. In England every year over 1000,000 people die from heart disease, 3 times that number are victims of heart attacks, and nearly 5 times as many again suffer from angina. The risk of CHD is closely associated with social disadvantage: unskilled men are 3 times more likely to die from CHD than professional men (and their wives 2 times more). There is much that can be done to turn this situation round (NSF 2000) but it will take action at many levels simultaneously (Calnan1991)

1. Clinical interventions are one vital starting point for action: primary care staff can ensure that coronary risk factors are brought into the conversation (when appropriate) during individual consultations (eg smoking, body-mass index, eating patterns, exercise). It is important to raise these topics in a personalised way and to link them to individualised care planning. A team approach to monitoring and advising on these risk factors needs to be agreed.
2. Cardiac health promotion needs to go beyond a narrow focus on behaviour change related to the major coronary 'lifestyle risk factors', and to encourage a 'whole person' approach. This can include support through personal counselling re problems with relationships, with alcohol and substance abuse, with stress or lack of control in the workplace etc. Recommendations for personal change (eg taking up opportunities for exercise and physical activity at local facilities) can be made more vivid and memorable by linking to current themes in the media - whether news items or incidents in popular soap operas.
3. Practice nurses and other primary health care team members can organize to ensure a higher profile is given to issues around personal and workplace stress and lifestyles among the practice population; and this can be supported and followed up through primary health care facilitators. This in turn can be linked to the provision of advice, information and advocacy on occupational lifestyles and health, including liaison between workplaces and GP surgeries etc around financial and benefits advice. Primary care teams can work with other local agencies to install coronary prevention programmes in workplaces, to include both individual attention (clinical checks and advice, personal counselling) and where appropriate, directives to redesign the physical and psychosocial aspects of the work environment and working regimes. In this way health can be established as a key dimension in organizational learning, human resource management and corporate development – if necessary across consortia of firms or businesses. It may also be helpful to contribute to local campaigns to improve cycling facilities and to use other opportunities to encourage more ‘activity-friendly’ policies and environments.
4. Many local community education and community development programmes encourage ‘look after yourself’-type programmes, such as ‘shop smart for your heart’, food co-ops, and other community nutrition schemes; and it may be helpful to support and work with such schemes. The same applies also to other self-help groups linked to active lifestyle or community sport

initiatives, eg local ‘quit-smoking’ action groups or local ‘heart beat’ support groups, who can benefit from liaison and networking with health professionals – eg in a healthy living centre.

Worked example 4: action on teenage pregnancies and sexual health

There are increasing rates of unintended teenage pregnancy in many countries, and the UK has the highest rate in Europe; the reported incidence of sexually transmitted diseases is also increasing among young people. There is a strong link between teenage pregnancy and STD rates and social disadvantage, and young people growing up in the poorer parts of Britain are exposed to some startling risks to sexual health. Strategies in this area of health promotion need to be multilevel and multi-agency, but also to be imaginative, flexible and responsive (Allen 1991; HEA 1993).

1. There is a strong case for supporting the development of young persons' drop-in facilities, that can offer advice (and probably a freephone helpline) on contraception and sexual health This should guarantee confidentiality - the single most important factor in designing services for young people, who often have little faith in confidentiality in their dealings with professionals and official agencies. Similar access points to contraceptive advice and counselling services can be provided at key sites in priority neighbourhoods. It is helpful to extend sexual health promotion services 'vertically' beyond schools and youth agencies, to ensure that sex education and contraceptive advice reach the older male partners of sexually active teenage girls
2. Encouragement needs to be given to every school, college and youth centre to develop structured, well-informed - and published - sex education policies. Sex education programmes should start early, and build up a stage-wise and sustained progression of learning, to allow open discussion of sexual matters and to enhance self-awareness, personal-social skills, and the widening of 'life options'. All this can be linked to a planned 'health promoting school/college' policy. Rolling programmes of training (on sex education policies and methodologies) need to be provided for school and college teaching staff, and for governors, and for parents. These should provide participants with access to appropriate information and materials, and with opportunities to review and discuss, and to address the possibility of ‘lack of confidence’ as a barrier to effective communication. Schools should be helped to maintain sex education books and other resources that can be borrowed by parents, to support discussion at home.
3. New local alliances and coalitions at neighbourhood level can be established so as to improve liaison and coordination around sex education between clinics, youth clubs, schools, and between the staff who work in them (eg school nurses, health visitors). Frontline clinicians (eg GPs) can be trained for better common understanding of what makes for 'approachability' and 'trust' in 1:1 work with young people. In schools, colleges and youth clubs, projects can be set up that focus on messages about sexuality and pregnancy in the popular media (TV, films, newspapers and magazines, pop/rock music and dance, etc) and that use creative methods to examine, expose - and where appropriate challenge - the images of love, romance, desire and fantasy portrayed in these sources. The settings that are most popular with and accessible to teenagers themselves (discos, night clubs, raves, music stores, and other local 'events') should be targeted with specially-created publicity and outreach projects that highlight positive health messages, eg 'I'm a condom carrier'; 'safer sex' etc.
4. There should be investment in ‘peer-led’ teaching and learning initiatives around teenage pregnancy and sexual health, and other efforts should be made to listen to the voices of young people themselves on matters of sexual health. Local 'community forums' can be developed through schools, through youth services, through adult education etc, as vehicles for discussion of issues around 'aims and values' in preventing teenage pregnancy - to encourage debate and to share ideas, especially around the dilemmas posed by religious and cultural pluralism.

Worked example 5: action on health in relation to homelessness and housing poverty

The numbers of people sleeping rough ('roofless') in Britain has been growing alarmingly for over 20 years, as has been obvious in city centre shop doorways, multi-centre car parks, cardboard city etc. But the traditional stereotype of the destitute 'down-and-out' is misleading, and needs to be replaced by a broader and more fluid concept of homelessness. Young adults and families with children make up an increasing proportion of this population; and beyond street-level homeless people there are many others who drift through a sequence of short-term accommodation: bed-&-breakfast hotels, overcrowded flats in houses in multiple occupation, or living 'care of'. Sleeping rough is one stage in a continuum of housing poverty. Such people are highly vulnerable: many have a previous history of mental health difficulties, they are at risk of violence and harassment, and their nutritional status, their sexual health, and their self-esteem are often poor. Effective action on these issues requires energetic coordination between disciplines (Fisher & Collins 1993)

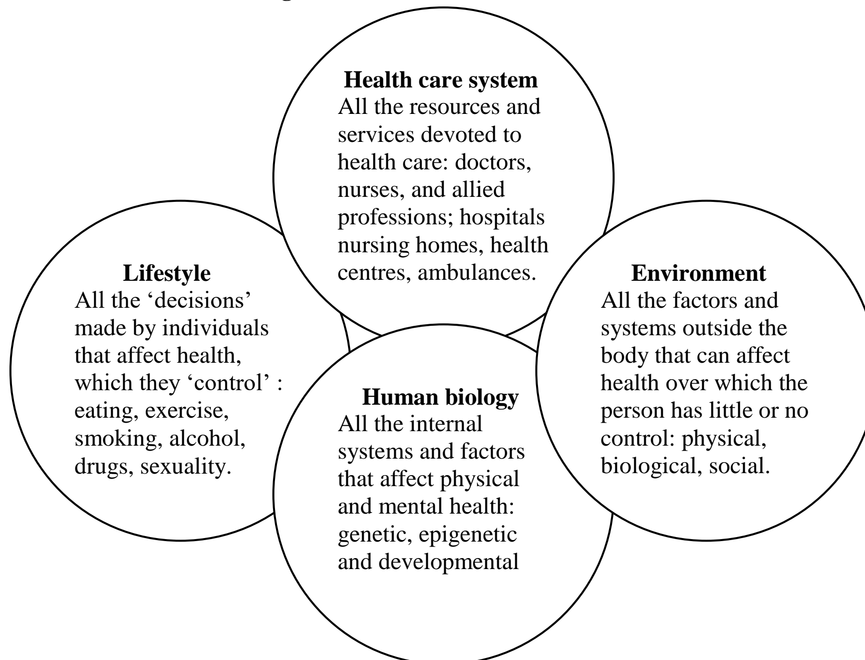
1. Health agencies and health professionals need to ensure that local populations of 'the new homeless' have adequate access to primary care. Some services may need to be provided on a more flexible or outreach basis. Difficulties in getting registered and/or in retrieving records need to be tackled. Partnership working can be encouraged between primary health care staff and other community teams: eg mental health; rehabilitation; child health and welfare.
2. Special programmes of health education can be established for homeless people, going beyond 'information-giving' on narrowly-defined illness topics: giving access to learning opportunities encouraging the development of broader social and life skills, and restoring self-esteem.
3. It is helpful to set up a post of 'health advocate for the homeless', intended to provide specialist help and advice for the local homeless population, and also to go beyond crisis working and be pro-active in achieving more accessible and better coordinated services. That post-holder may find it vital to network with local multi-agency resource centres based in the voluntary sector to ensure that clients' inter-connected problems of health, of housing, and of deprivation are dealt with in a joined-up way.
4. Health professionals and their employing agencies should work in alliance with local authority housing and other departments to champion and deliver healthier housing policies: to improve the stock of local housing and the ways in which it is allocated. It may be important to take the lead in linking health and homelessness activities to wider 'anti-poverty' strategies and to joint planning for environmental renewal and social regeneration.

Reflecting critically on a seminal text: the Lalonde Report

The publication 'A New Perspective on the Health of Canadians', usually known as 'the Lalonde Report' appeared in 1974, just on the threshold of the last quarter of the 20th century. It was an official report of the Federal Department of National Health and Welfare in Ottawa, Canada (it is named after the Marc Lalonde, then Minister of National Health and Welfare). The report is the first example of a national government committing itself to a major investment in developing a policy that gave a central place to disease prevention and health promotion. It led to the setting up of the world's first 'Health Promotion Directorate' (in the Canadian Department of National Health and Welfare in 1978), and much of the work that emerged subsequently from that agency has been a shaping influence in the development of WHO 'Health for All 2000' and 'Healthy Cities' policies and guidelines, and in the testing and formalization of key concepts like 'healthy public policy' and 'supportive environments for health'. The sustained body of practice that has been built up in Canada since the Lalonde report has in itself proved highly impressive.

However, the seminal influence of this Report probably derived most of all from the new theoretical model that it introduced, which continues to have many resonances for all those who occupy themselves with policy and practice in public health and health promotion. This new model was 'the health field concept', which argues that access to medical care systems is not the only, or even the most important determinant of health, and that there are 3 other determinants: human biology, lifestyles, and environment. A diagrammatic formulation of this concept is seen at Fig 2:

[Figure 2] THE HEALTH FIELD CONCEPT



The Report uses the health field concept to draw attention to the urgent need in contemporary developed societies to expand our official and professional discourse on health decisively beyond the narrow scope of medical services or the health care system. It argues that 'future improvements in levels of health (will) lie mainly in improving the environment, moderating self-imposed risks, and adding to our knowledge of human biology – rather than in the availability of physicians and hospitals'. An understanding of the pathways through which health and illness are produced in the interplay between biology and environment had been available for some time, and more recently a similar understanding had become available for the interplay between lifestyle 'risks' and medical interventions. But the health field concept pulls these insights together, juxtaposes them in a vivid phrase and a memorable picture, and provides a salutary stimulus to new thought - beyond the study, out in the worlds of policy and practice. In some respects it can be seen as an early example of the 'whole systems' thinking in health that has come to prominence very recently: it underlines the significance of individual lifestyles as a major source of risks and as a focus for practical action in working for improved health, yet at the same time it firmly introduces a socio-ecological view of health to set alongside the individual model. Indeed it prefigures one of the main themes in recent policies for health promotion, in proposing that the 'health field concept' offers a tool for inquiry and action in several 'domains' or 'sectors' simultaneously, and indeed that it is only by getting going in several parts of the field at one and the same time (at both the individual level and the systems level) that really effective progress will be made in improving health. It may be said to offer a key new metaphor, that helps us more clearly to see health as a landscape - stretching away in several directions - rather than as a finished object or a finite commodity: as a complex open system rather than a closed container, moving rather than static.

Most commentators acknowledge that, in the event, after the Lalonde Report came out, for the first decade or so national governments in Canada, then in the USA and the UK all drew from it selectively and chose to give priority to action on lifestyles as the new direction for developing health promotion. This is in part an example of the way in which the values that lie behind different approaches to health promotion appeal to particular stakeholders: it is often far more congenial to governments to try to bring about change at the individual level - in people's lifestyles - than to embark on change at the level of wider social systems, structures and environments. It may also be partly a limitation in the health field concept, inasmuch as it separates the lifestyles domain from the environment domain, and implies that individuals have freedom of choice, rather than considering lifestyles as closely intertwined with the physical, socio-economic and socio-cultural environments in which people live and work. It is only since the late 1980s that this dimension of interplay has come to be better understood and taken more fully into account in planning health promotion programmes.

But the Lalonde Report showed how a fundamental recognition of the 'systems and structures' that determine health (and of which medical care is only one part) can lead to new insights and to new approaches to planning. The WHO's key principles enshrined in the 1986 Ottawa Charter and seen in action the Primary Health Care approach in less developed countries, in Healthy Cities projects, and in Health for All 2000 and Health 21, all exemplify the idea that health is best promoted by intervening at several levels (in several parts of the 'field') at the same time. Public health policies in the UK – first 'Health of the Nation', then especially 'Our Healthier Nation', and successive reports on inequalities in health, likewise illustrate the 'multi-level' approach to health promotion. Many theoretical frameworks for reviewing and planning health promotion (an example of which is given in Fig 1 and Table 1) also inherit and take forward the legacy of the Lalonde Report and the health field concept: it is this way of working with a 'whole systems', open-ended model of health and its determinants, and with a flexible and creative (multi-facetted, multi-level, 'joined-up') approach to intervention, that holds the best promise for improving individual and community health in the future.

3 discussion points

1. With the recent rise in health promotion of concern to pay attention to 'lay perspectives', to listen to 'local voices', and to encourage the involvement of local communities in their own health, is the power of decision over prevention and health matters shifting from doctors (or other health professionals) to clients? How similar or different is this to other recent trends in the health world such as patients who 'shop smart' for their health – around complementary therapies, on the internet, etc; or patients who insist on full explanations and evidence for medical advice before they comply with it? What new challenges does this pose for the professional practitioner? On balance are you in favour of such developments?
2. Contemporary theories and policies for the delivery of preventive medicine and health promotion emphasise the importance of 'teamwork' and 'interagency collaboration'. What are the benefits of 'working with others' in this context? How well are doctors prepared for working to promote health alongside colleagues from other professions and other agencies? What implications do such ways of working have for the boundaries between medicine and other health professions? What are the difficulties or dangers of these lines of development in health promotion? On balance how enthusiastic are you about moves in this direction?

3. Increasingly, the basis for planning and implementing health promotion programmes both for the general public and for the individual patient is the assessment of 'risks to health'. What dilemmas arise in defining 'risk' in different areas and aspects of health today? How well do you think most health professionals and/or health agencies carry out the job of 'communicating about risk' to the public? What could usefully be done to ensure a balance between protection of the public interest (or the public purse) and infringements of individual freedom?

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