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LEEDS METROPOLITAN UNIVERSITY

Values, Health Promotion and Public Health

Report compiled by

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February 2003

Values, Health Promotion and Public Health

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Commissioned by the Health Development Agency

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INTRODUCTION

Values issues have been integral to health promotion and public health and at all times there have been differing ideological positions on values. Such issues have frequently been implicit, rather than made fully explicit, and when explicit may have been asserted, rather than fully argued. For dynamic activities such as health promotion, undertaken in the context of a specialist role, or as part of other professional roles, contradictory positions on values are to be expected. Similarly public health which has changed over time, and where there are currently debates over what it entails, is also likely to throw up values issues. At the same time it might be expected that some degree of consensus would emerge over time in relation to the respective values of each of these activities and their shared values. The series of documents issued by the World Health Organisation have provided one important record of the development of thinking about values concerns, beginning with the 1978 Alma Ata Declaration (WHO, 1978) and the statements on Health For All. At the same time a growing emphasis on evidence based practice across most areas of health and social care appears to be informed by a rather different set of values.

There are a number of values issues which have been addressed during the recent history of health promotion including: the status of particular values and the justifications for emphasising some values rather than others; the extent to which health promotion is an activity driven by values; the importance to be given to respect for individual values etc. Arguably there has been somewhat less explicit discussion of these questions in public health. The presence of differing values positions in contexts of practice throws up issues which have to be negotiated.

This study was commissioned by the Health Development Agency in England with the following broad aims:

- To clarify the ways that values have been defined in health promotion and public health and to consider the relationships between values and related concepts.
- To map health promotion and public health values from the 1970s onwards with special reference to WHO documentation, selected policy documents and key commentaries.
- To identify and discuss consensus and contradiction in values in health promotion and public health.
- To consider the implications for training arising from the review, with particular reference to the UK.

The report is divided into five sections. Section 1 provides a general discussion of values and related concepts before considering values in public health and health promotion. The second section offers some historical background on the development of health promotion and public health prior to the 1970s order to throw light on current debates. This is followed by a more detailed discussion of the last three decades. Section 3 analyses the series of WHO documents beginning with Alma Ata with particular reference to values. Section 4 describes the views of key informants in the UK who have written on the subject of health promotion and public health, or are actively involved in practice. These views were derived from a short open ended questionnaire sent to selected key informants. The final section provides a synoptic

discussion and offers some recommendations. The intention of the document is to stimulate further discussion.

SECTION ONE: PROMOTING PUBLIC HEALTH: THE VALUES BASE

Introduction

The term 'value' is widely used in every day discourse. It is, additionally, particularly relevant to health promotion in the following ways:

- *health* itself may be conceived as a highly important value – and one that is contested;
- the strategies and activities involved in *promoting* health are themselves value - laden – and again open to debate and subject to disagreement;
- values play a significant part in determining whether or not *individuals* respond to health promoting strategies and methods.

Moreover, values are involved in professional practices associated with the promotion of health. It is, therefore, important to subject the concept and its various manifestations to critical consideration.

The early conception of the term values in social scientific literature was as objects with some social meaning (Thomas and Znaniecki, 1918; Allport, 1954). Later the term was used to refer to an individual's concepts of what is desirable rather than to the desired objects themselves. In distinguishing beliefs from values the former describes what people think to be true, while values describe what people want to be true. In the case of beliefs it is not implied that an individual will feel a need to behave in any particular way towards the object of the belief. By contrast, values involve some behavioural tendencies, whether the value is defined as a desirable object (e.g. money), or as a concept of the desirable. A number of behaviours can be associated with the pursuit of any specific value. If we know something about the values of an individual or group we can have some sense of how they may act in specific circumstances, and how behaviours will be modified in order to fit in with values.

Values range from the highly abstract, such as truth and justice to the concrete. Values are also related to form systems which can include a number of end state values and other values which are instrumental to achieving end states. A value can be an end state within one system and instrumental within another. For example, health can be a terminal value within one value system and instrumental within another.

Values can be of different orders – some, described as foundational, guide all aspects of life. They can be brought together in systems associated with religions and act as moral precepts in guiding actions. Many people do not aspire to a religious code and their morality is secular. The same values which are part of a religious code can also be part of a secular code, but their status in relation to individual action is different. Values are developed in the course of socialisation but the extent to which these are passively, in contrast to actively, acquired is conceived according to theories of the individual and of the process of socialisation.

In functionalist sociology – particularly as described by Parsons (1971)– values are ascribed a pivotal role in creating social order. Order depends on the existence of general shared values which are regarded as legitimate and binding and act as the

standard by means of which the ends of action are selected. These values are internalised through the process of socialisation. Parsons categorised values in relation to the four main functional imperatives of social systems: adaptation to the environment; goal attainment; pattern maintenance and tension management; and integration. While this conceptualisation of values continues to underpin much day to day discourse, it nonetheless has weaknesses in relation to contemporary society. Societies hold together when there are considerable disagreements over values and such value differences may even be celebrated. Most Western societies are pluralist-characterised by differing value systems over and above commitment to a small number of foundational values. For example, most people will ascribe to the value of justice but differing value systems may inform the means to achieve justice. Socialisation in such contexts becomes not so much an induction into one agreed set of values but an introduction to the complexity of values and the achievement of individual value positions.

For a long time, and still in many societies, it is systems of values associated with particular religions that guide a great deal of social action. With a decline in conformity to religious values in Western societies concerns arose about the loss of 'education for morality' which had accompanied religious socialisation and accordingly, in the 1960s, moral education as a curriculum subject in schools was one societal response to these concerns. Generally there has been a shift in thinking about the nature of the individual – influenced by the Kantian tradition with its emphasis on autonomy and the recognition of the uniqueness of human beings and their consequential right to make their own decisions and determine their own 'essence'. Such an active model of the individual is in conflict with the idea of the individual as passively inducted into a given set of values and associated practices.

The Nature of Values

Despite the common sense discourse on values, there is a lack of agreement and, often a lack of clarity, in their definition – and in providing technical analyses. This lack of agreement frequently centres on the relationship between values per se and other psychological constructs - for instance in the context of discussion of the psychological, social and environmental determinants of decision-making and action.

Although values are most commonly considered to be affective dimensions of personality, it is not unusual for confusion to exist with cognitive components – more particularly with beliefs. This probably reflects earlier, omnibus definitions of attitude as having cognitive, affective and 'conative' aspects (i.e. in addition to the affective core of attitude, associated beliefs and actions). As will be apparent later in this chapter, this conflation of affective and cognitive can also be seen in discussions of ideology which refer not only to the central value dimension but also to the essentially cognitive notion of 'doctrine'.

The definition of values in this report derives from the clear and deliberate separation of cognitive and affective featuring in the work of Fishbein and Ajzen (1975) who wisely differentiate 'belief' (a 'subjective probability' calculation) from 'attitude' which refers to pure affect in terms of its evaluative function. Interestingly Fishbein and Ajzen do not include value in their theoretical and research formulations – presumably

following the Law of Ockam's Razor in considering that the concept of attitude is quite sufficient!

Locke's (1983) dictionary entry emphasises the affective dimension and also provides an indication of how values are 'caught' rather than 'taught' through the process of socialisation.

What individuals consider good or beneficial to their wellbeing ... acquired through experience ... often by 'osmosis' ... Values exist on different levels with moral values being most fundamental; at a more concrete level values may involve tastes in food, clothing and music etc. People are not necessarily aware of all of their values; some may be held subconsciously and may even conflict with conscious values. (p651)

Mouly (1960), writing as an educational psychologist, not only emphasises the affective but also notes the relationship between the two affective constructs values and attitudes.

Attitudes tend to be definite and specific from the standpoint of the object or the value to which they are attached. They differ therefore from ideals, which tend to be more generalized and abstract and to represent a higher level of conceptual organization. Thus, tolerance toward a minority group is an attitude whereas tolerance as an abstraction is an ideal. Attitudes can be differentiated from values in that values have reference to social and moral worth; they are also more stable and more general and, of course, of greater significance to society. Whereas values are related to broad goals residing within the individual, attitudes have more specific (external) objects of reference and are more closely related to narrow channels into which activity can be directed. (p452-3)

Mouly not only makes the important hierarchical connection between values and attitudes but also reminds us that values are at the very core of the way people evaluate their entire self concept.

Attitudes permeate our very existence. The self-concept, for example, is best viewed as the complex system of attitudes and values which the individual has developed concerning himself (sic!) in relation to the external world with which he has psychological contact... (p453)

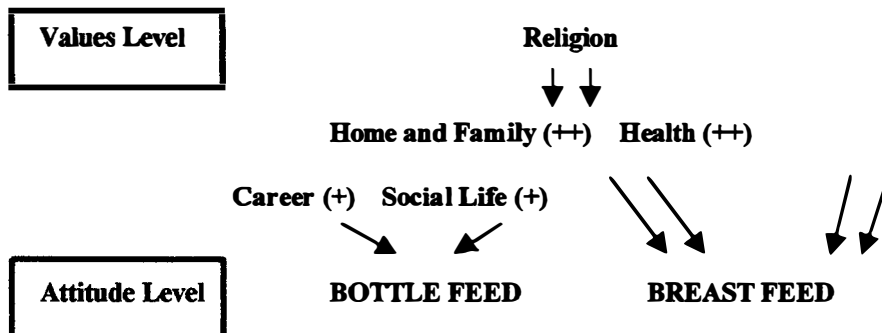
It would, however, be more accurate to describe the self concept as a conceptual construct – being the entire collection of understandings and beliefs about one self. A more appropriate term for the sum total of feelings about self is the term *self esteem* (or, to use preferred terminology of the distinguished psychometrician and personality theorist, Raymond B. Cattell's - the *self sentiment*).

Rather strangely, Cattell seems to conflate value and attitude:

By values we mean the social, artistic, moral, and other standards which the individual would like others and himself to follow. Most value attitudes (sic) are found embedded in the self sentiment and the super-ego structures. (Our underlining). (Cattell, 1965 p264)

The relationship between values and attitudes is illustrated in Figure 1 which demonstrates how values such as religion, home and family etc. generate a number of attitudes, which might contribute to decisions to either breast or bottle feed.

Figure 1: Relationship between Values and Attitudes



(Tones and Tilford, 2001)

Cribb's (2001) use of the term 'values', in the context of discussing professional ethics is consistent with the approach adopted here – note for instance his discussion of the professional role of pharmacists:

Pharmacists have a unique contribution to make to debates about medicines, values and society.....we are using the word 'values' in a very broad sense to refer to all those aspects of pharmacy that are not purely factual or technical. It encompasses a very wide range of things which are valued by individuals, groups and institutions – for example these valued things include 'goals' (e.g. happiness or welfare), or certain types of behaviour (e.g. keeping promises, treating people with respect), or certain qualities of character (e.g. generosity, loyalty). Ethical values can be drawn from a wide set of arenas, e.g. religious values, commercial values, academic values etc.(Cribb, 2002, personal communication)

Cribb also uses the term 'value literacy' to refer to the extent to which individual professional lives may be governed by an enlightened understanding of, and commitment to, values:

Value literacy ... a cluster of things (which) include an awareness of, interest in, and capability in identifying, discussing and 'handling' value and ethical issues in pharmacy ... the focus ... overlaps with, and complements, the widespread concern for professional standards and professional ethics. (Cribb, 2002, personal communication).

(The rather indiscriminate use of the term 'literacy' to describe constructs other than reading and writing competences has been challenged. For further discussion see Tones (2002)).

Values: Levels and Typologies

A number of theoreticians and researchers have sought to identify lists and taxonomies of key values. For instance Spranger (1922) identified six ideal types of value:

- theoretical;
- economic;

- aesthetic;
- social;
- political;
- religious.

Each has its own associated ‘ethic’: e.g. economic – utilitarianism; aesthetic – harmony.

Rokeach’s Formulation

In psychology, arguably Milton Rokeach has been the doyen of research into values. He made five assertions about the nature of human values:

- the total number of values is relatively small;
- everyone possesses the same values to different degrees;
- values are organised into value systems;
- values are created and influenced by culture, society and its institutions and personality;
- values play a part in ‘virtually all phenomena’ investigated by the social sciences – psychology, sociology, anthropology, psychiatry, political science, education, economics and history. (Rokeach, 1973 p3)

In relation to other psychological and social constructs – all of which are of importance in explaining health and illness related decisions – values have a transcendental quality insofar as they energise attitudes and underpin behaviours. In Rokeach’s words:

... values are guides and determinants of social attitudes and ideologies on the one hand and of social behavior on the other. (p24)

He defines the key characteristics of values in terms of beliefs, modes of conduct, a conception of, something *that is personally or socially preferable*.

Rokeach also related the affective dimension of values to associated beliefs. The belief aspect is conceptualised as follows:

Three types of beliefs have previously been distinguished (Rokeach, 1968): descriptive or existential beliefs, those capable of being true or false; evaluative beliefs, wherein the object of belief is judged to be good or bad; and prescriptive or proscriptive beliefs, wherein some means or end of action is judged to be desirable or undesirable. A value is a belief of the third kind – a prescriptive or proscriptive belief. (Rokeach, 1973 p6-7)

Rokeach subscribed to Allport’s (1961) oft-cited definition, *a value is a belief upon which a man (sic) acts by preference*.

Rokeach thus follows ‘traditional’ formulations of ‘attitude’ insofar as he considers that values have cognitive, affective and behavioural components. However, it is the affective dimension that is more commonly considered to be at the definitional core of values. Hence, the second and third of the characteristics mentioned above are of most relevance to our present concerns in considering the values underpinning public health promotion – although it is quite clear that people do have conceptions about what is desirable or morally appropriate without this conception necessarily influencing their feelings and behaviours. Indeed. Rokeach acknowledges the motivational functions of values:

... the immediate functions of values and value systems are to guide human action in daily situations (and) their more long-range functions are to give expression to basic human needs. (p14)

Rokeach usefully distinguishes terminal values from instrumental values:

Terminal values are motivating because they represent the supergoals beyond immediate, biologically urgent goals. Unlike the more immediate goals, these supergoals do not seem ... to satiate – we seem to be forever doomed to strive for these ultimate goals without quite ever reaching them... .. there is another reason why values can be said to be motivating. They are in the final analysis the conceptual tools and weapons that we all employ in order to maintain and enhance self-esteem. They are in the service of what McDougall (1926) has called the master sentiment – sentiment of self-regard. (p14)¹

Rokeach also acknowledges the existence of higher and lower order values (a fact implicit in the notion of terminal and instrumental values). Moreover, he identifies two varieties of terminal value: interpersonal or intrapersonal, self-centred or society-centred. For instance, end-states such as ‘salvation’/unity with God are intrapersonal whereas ‘world peace and brotherhood’ are inter-personal. There are also two kinds of instrumental values: moral values and competence values. Both kinds of instrumental value can play a central part in health related actions at individual and social level. For instance, the moral value, concern for the welfare of other people, is a sine qua non for community action.

A prime example of an intrapersonal ‘competence value’ that figures prominently in Rokeach’s discussion has to do with ‘self-actualisation’. He cites Maslow’s (1954) contention that there is a major, over-riding, higher-order value:

... it looks as if there were a single ultimate value for mankind, a far goal toward which all men strive. This is called variously by different authors self-actualization, self-realization, integration, psychological health, individuation, autonomy, creativity, productivity, but they all agree that this amounts to realizing the potentialities of the person, that is to say, becoming fully human, everything that the person can become.’ (p123)

Perhaps Rokeach’s greatest achievement has been the construction and validation of empirical measures of values. He identified a list of 18 terminal values and a similar number of instrumental values. These are at Appendix I.

From our present concerns with discussing the values underpinning health – at both individuals and ‘public’ levels – it is interesting to note that health per se does not figure in the 36 major values listed. Three possibilities exist:

1. health is considered to be such an ambiguous notion that it is not possible to operationalise it, or
2. one or more of the values listed may themselves be defined as health or components of health (for instance, health is frequently seen as synonymous with happiness and inner harmony, or

¹ The definition of self esteem as a major value has clear relevance given its prominence in health education/promotion in general and, more particularly, in empowerment and models such as HAM.

3. some of the values may be seen as determinants of health (for instance, self esteem, a world at peace).

As noted above, although Rokeach emphasised the importance of self-actualisation as a key *instrumental* value, it is worthy of note that self-actualisation is quite frequently used as a central aspect of or even identical with a ‘terminal’ health outcome.²

A Map of Values and Their Relationship to Health

The very nature of health, its determinants and the methods and strategies of achieving it are value-loaded. Health is by definition a major value or cluster of values that is considered worth pursuing by most people and governments. In common with other values, the definition of health has both cognitive and affective components. On the one hand it reflects personal perceptions and social constructions; on the other hand it generates commitment and motivates action in pursuit of both the achievement and promotion of health status. Like many values its nature and desirability is essentially contested.

We can usefully identify four values dimensions in relation to health promotion:

1. a dimension having to do with defining the nature of health and its pursuit;
2. a dimension relating to the determinants of health (however it is defined);
3. value judgements related to the actions and activities considered appropriate (and ethical) in addressing the determinants of health and achieving satisfactory health status at a personal or public level; and
4. the ways in which the values of stakeholders – both as individuals and institutions affect the first three dimensions listed above.

Figure 2 represents these dimensions diagrammatically.

Constructions of Personal Health

The main focus of this paper is on public health/the health of the public/community health. However, in order to emphasise the multifarious effects of values on definitions of health and the impact of doctrine and ideology on practice, it is enlightening to give some brief consideration to the multiple, different and often competing constructions of personal health. In other words the argument and debate over what is involved in individuals being healthy.

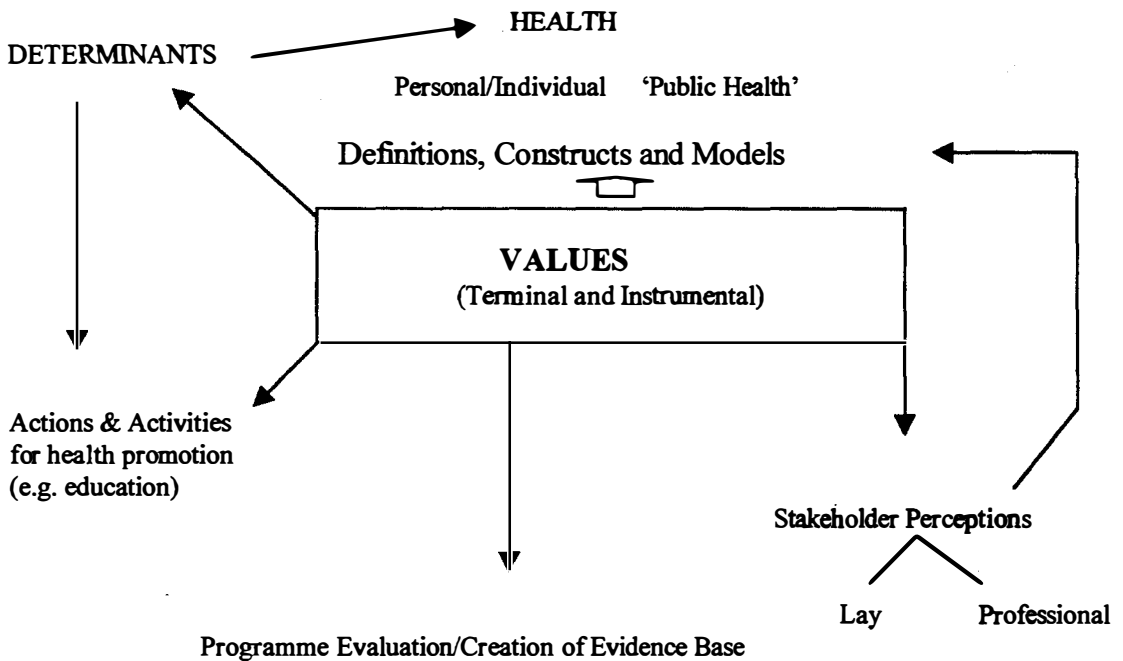
Needless to say, there is a plethora of definitions of health and often-fierce contention over the reality and validity of different interpretations and constructions. A flavour of the variety of definition is provided by Blaxter’s (1990) review of health and lifestyles. This invited lay views on individuals’ own health and the health of ‘others’.

Conceptions of Health

- Health as a ‘normal’ state: ill health as deviation from normality;
- Health as ‘not ill’ (an especially common view among those who *were* ill);

² And even in the context of preventive medicine – see for instance Scottish Health Education Unit’s ‘Be All You Can Be’ brand image.

Figure 2: Health - Four Values Dimensions



- Health as absence of disease;
- Health *despite* illness;
- Health as reserve (e.g. rapid recovery; inborn reserve);
- Health as 'healthy lifestyle' (almost equivalent to 'virtuous behaviour?');
- Health as physical fitness (especially prevalent among younger people);
- Health as 'outward appearance' (especially prevalent among women);
- Health as social relationship (especially among women);
- Health as 'energy and vitality';
- Health as 'function' ... ability to work;
- Health as psycho-social wellbeing.

It is interesting to note that, while acknowledging more holistic/ 'positive' aspects of health, these lay views frequently draw on a more medical construction of health – unlike philosophers!

Rijke (1993), drawing on earlier work on health and healing by 14 authors – including his own previous publications – identified the following nine key characteristics of health:

- Autonomy;
- Will to live;
- Experience of meaning and purpose in life;
- High quality of relationships;
- Creative expression of meaning;
- Body awareness;
- Consciousness of inner development;
- Individuality: the experience of being a unique part of a greater whole;
- Vitality, energy.

Two things will be apparent from both lists: first a suggestion of the equivalence of both terminal and instrumental values and second, the fact that the majority of the features considered to be characteristic of health have a positive dimension (indeed, might just as well be viewed as features of ‘the good life’! The contrast between these various positive dimensions and a more medical view of health is central to much past and present debate and has figured quite prominently in Greek philosophy.

The Myths of Hygeia and Asclepius: Wellbeing and the Medical Model

Perhaps the most obvious dichotomy in discussions of personal health is the often Manichaean distinction between health as (relative) absence of disease and illness and some more holistic and arguably more ‘positive’ construction. This dichotomy was encapsulated in the classical Greek cults of the gods Hygeia and Asclepius. As Dubos (1979) noted, Hygeia symbolised ‘living well’, or, rather, the ‘good life’.

The myths of Hygeia and Asclepius symbolize the never-ending oscillation between two different points of view ... For the worshippers of Hygeia, health is the natural order of things, a positive attribute to which men are entitled if they govern their lives wisely. According to them the most important function of medicine is to discover and teach the natural laws which will ensure to man a healthy mind in a healthy body. More skeptical or wiser in the ways of the world, the followers of Asclepius believe that the chief role of the physician is to treat disease, to restore health by correcting any imperfection caused by the accidents of birth or of life. (p130)

The disease focus is, of course, associated with the hegemony of the ‘medical model’ – i.e. the construction of health that derives from the doctrine of specific aetiology and in which health results from a return to normality by treating disorders at the micro level or in preventing the disorder at primary, secondary or tertiary levels (Vuori, 1980). This medical perspective – and, latterly, the whole process of medicalization – has been notably challenged by WHO. The emblematic and influential declaration enshrined in its constitution (WHO, 1946) maintained that health was not merely the absence of disease. Instead it proposed a more holistic and positive alternative. In brief, it involved an interaction of not just physical but mental and social aspects (and ‘mental’ was not to be considered in relation to mental *illness*); moreover, successful outcomes of health promoting activities should be assessed in terms of ‘wellbeing’.

Rijke (1993) discussing the characteristics of health, commented on the results of Sheehy’s (1981) research into 60,000 people’s conceptualisations of health using a ‘wellbeing test’. She demonstrated that ‘high-scoring’ individuals differed from the rest in respect of the following characteristics:

- Courage;
- Faith;
- Creativity;
- Flexibility;
- Ability to love;
- Being a model for people in crisis;
- Having true friends;
- Conviction that life has meaning;

- Humour;
- Energy.

While this affirmation of wellbeing is welcomed by those who object to the narrower medical definition of health, others have rejected such a vague and unworkable definition. For instance, Smith (1977), in a thoughtful - and in many ways a radical - article, expressed his doubts about WHO's formulation in the following words:

In any discussion of how health may be promoted it would seem useful to be clear about what is meant by health. Such clarity is not always evident. Indeed, the definition of health presents a number of difficult problems. The World Health Organization adopts a definition – more of a slogan – which asserts that health is not merely the absence of disease. However, those who believe, as does the present author, that disease can only reasonably be defined as the absence of health, feel compelled to accept the consequent proposition that health is indeed the absence of disease. (Smith, 1977 p135)

Smith, offers an alternative approach,

I should like to propose, as a working definition, that an individual is healthy when his level of function does not impede or determinably threaten to impede the performance of an acceptable social role. (Smith, 1977 p135-6)

Needless to say many people would treat this conceptualisation with as much, or more hostility than Smith directs at the WHO definition!

We should perhaps note before continuing this exploration of meanings that WHO modified its original view of health. It treated health not so much as an ultimate outcome but rather as a means to an end. Health had an instrumental purpose and should be considered to contribute to 'a socially and economically productive life'. Whatever the challenge to notions such as wellbeing, the rejection of a disease-related focus is central to many conceptualisations of health. We should, however, be wary of equating wellbeing with 'wellness' – and even 'high-level wellness' - terms which at a superficial glance seem quite 'positive' but which have been used to describe goals of super physical and mental fitness. They have, accordingly, been denigrated as examples of 'healthism' since they emphasise individualism and ignore the social and environmental determinants of wellbeing.

Holos and Eudaemonia

The Greeks really did have a word for it! One of the most influential formulations of health and, above all the wellbeing dimension is due to Aristotle. This Greek philosopher discriminated between 'health' ('holos') and well being ('eudaemonia'). This latter notion was deemed by Aristotle as the ultimate good and has been variously translated as 'flourishing', 'blessedness', 'prosperity' or even just 'happiness'; in short the pursuit of eudaemonia is the pursuit of the 'good life'. Buchanan (2000) provides a useful review having particular relevance to health promotion. He comments that:

The good life is the life spent seeking clearer understandings of values we think important to realize and striving to live our lives more closely attuned to those values. The end of health promotion is, accordingly, the life of integrity. (p107)

The Holistic Dimension

WHO's emphasis, as noted above, has a holistic dimension in its reference to mental, physical and social health. The Eudaemonic construction of health – discussed above – is also associated with a broader, holistic approach (although paradoxically, as noted above, the word is derived from 'holos' which is associated with a narrower, biological conception of health). Holistic health may take a number of forms - discussion of which are beyond the scope of this paper. They range from Hippocratic notions of balance between elements to a more ecological concern with achieving equilibrium with nature.

A Salutogenic Approach

Seedhouse (1995a) questioned the value of ever using the term wellbeing in health promotion. His critique centres on its vagueness and asserts that its use actually obscures attempts to clarify and operationalise the philosophy and practice of health promotions. He concludes that,

... either the term 'well-being' should be given clear and substantial content, or it should be discarded by health promoters. The latter option is favoured.
(p61)

However, given the widespread commitment to identifying and endorsing a positive perspective on health and health promotion, it is clearly important to categorise and, above all, operationalise these positive perspectives - despite Seedhouse's criticism. One of the more valuable – and potentially operationalisable - models of health is the 'salutogenic' approach of the late Aaron Antonovsky (1979, 1987, 1993). A full discussion is inappropriate here but the author convincingly demonstrates the importance of looking for alternatives to a medical model of health. Central to his formulation is the 'sense of coherence'. A healthy state is a 'negentropic' state involving both individuals' beliefs in their capacity not only to manage and impose meaning on their lives but also to achieve a sense of meaningfulness and commitment. In one of his last articles (Antonovsky, 1996), he commends the relevance of his approach to health promotion; in this he was supported by Kickbusch (1996) who notes that,

... much of the literature and practice that carries health promotion in its title is just disease prevention in another guise. (p5)

The notion of salutogenesis is particularly relevant to the ideology of public health promotion in its relationship with the key concept of empowerment – which will be explored later.

Health as Self Actualisation

The last construction of personal health to be mentioned here is derived from Maslow (to whom reference was made in our earlier consideration of Rokeach's values). It has two inter-related characteristics of concern to health promotion. Firstly, there is an empirical element that demonstrates that human motivation can be represented as a kind of pyramid. At the base of the pyramid are certain pressing human needs and associated drives, such as those associated with satisfying hunger, thirst and achieving safety and security. The top segment of the pyramid represents self-actualisation, i.e. the process of achieving and maximising individual potential. The self actualised state could – in a eudaemonic sense – be viewed as the pinnacle of health. However, it will only be achieved once a substantial proportion of earlier, lower order concerns and goals have been satisfied. Moreover, it is highly likely that, like demands for health

services, it is by definition unachievable as each new achievement generates a restless demand for further actualisation of newly developing needs and capabilities. Health is, therefore, in part the achievement of the unachievable and in part the process of trying to achieve it. Following Dubos' (1965, 1979) writings, it involves pursuing the mirage. As mentioned in an earlier footnote, the self actualising principle was adopted in an attempt to provide a more positive 'spin' on health education under the guise of the slogan *Be All You Can Be!* It has, however, greater relevance to the pursuit of empowerment.

Notions of Healthy and Unhealthy Communities

Although it is possible to conceptualise a healthy community as a collective of healthy individuals, it is often assumed that communities – like 'societies' can be healthy or unhealthy in their own right. A healthy community may be a desirable terminal state or fulfil an instrumental function in fostering the health of its members – or both.

An unhealthy community might be viewed as suffering from social malaise, i.e.:

- its values and normative characteristics may be inconsistent with some philosophical or ideological goals – e.g. goals characterising some religious, spiritual or political system;
- it may fail to offer appropriate support for its members and their health needs;
- it may be unhealthy in respect of anomie and, therefore, be approaching its 'death throes' in its proximity to collapse and disintegration.

A healthy community on the other hand might be viewed as the opposite of an unhealthy community or have certain *sui generis* healthy characteristics. These might include one or more of the following:

- a sense of community that contributes to a sense of coherence and contributes to 'negentropy';
- a community that is empowered in the sense encapsulated in WHO's notion of an 'active participating community' which is assumed, *inter alia*, to challenge inequity and achieve the various goals associated, again, with WHO's formulation of overriding values;
- a community having a high level of 'social capital'.

Citizenship Education and the Health Promoting School

The formulation of ideas of social/ community health in the health sector has clear parallels in the world of education. Given the present political climate and the emphasis on inter sectoral working (and even 'joined up government'), it is worth noting the quite explicit values inherent in the recent Crick Report on citizenship education (1998). Since these values are congruent with WHO and related values, it is probably worth drawing attention to the coherence of these values within the context of 'healthy school' initiatives which are the concern of the health sector and of the Health Development Agency in particular.

The report states,

Citizenship education (should) be a statutory entitlement in the curriculum.
(p22)

The statutory entitlement should include the,

knowledge, skills and values relevant to the nature and practices of participative democracy; the duties, responsibilities, rights and development of pupils into citizens; and the value to individuals, schools and society of involvement in the local and wider community. (p22) (our emphasis).

The relationship to the health promoting school notion is doubtless quite clear. For instance, reference is made to the importance of,

... whole school issues including school ethos, organization and structures (p23).

Reference is made specifically to the,

... development of pupils into active citizens. (p36) (our emphasis).

The 'Key Concepts' are

... democracy and autocracy; cooperation and conflict; equality and diversity; fairness, justice, the rule of law, rules, law and human rights; freedom and order; individual and community; power and authority and rights and responsibilities'. (p44) (our emphasis).

'Values and Dispositions' are explicitly identified:

- concern for the common good;
- belief in human dignity and equality;
- concern to resolve conflicts;
- disposition to work with and for others with sympathetic understanding;
- proclivity to act responsibly: that is care for others and oneself;
- premeditation and calculation about the effect actions are likely to have on others;
- acceptance of responsibility for unforeseen or unfortunate consequences;
- practice of tolerance;
- judging and acting by a moral code;
- courage to defend a point of view;
- willingness to be open to changing one's opinions and attitudes in the light of discussion and evidence;
- individual initiative and effort;
- civility and respect for the rule of law;
- determination to act justly;
- commitment to equal opportunities and gender equality;
- commitment to active citizenship;
- commitment to voluntary service;
- concern for human rights;
- concern for the environment'. (p44)

Apart from re-playing the moral education initiatives of the 1960s and 1970s, the values inherent in the Crick Report are entirely consonant – and sometimes identical – with the terminal or instrumental values of public health/ health promotion/ health development.

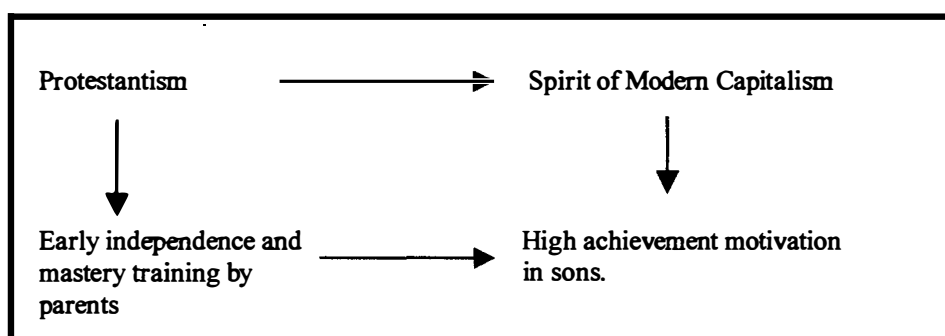
Values, Doctrine and Ideology

It is not possible to discuss the values underpinning personal and public health without giving some serious thought to the nature and meaning of ideology. Although ideologies are value-laden and it is not unusual for the term to be used synonymously

with values or even a values system, ideology is more than this. It consists of a coherent corpus of inter-related ideas and values, i.e. both cognitive and objective constructs, and is thus similar to Rokeach's definition of values system. However, as we will note later, the concept of ideology is wider than this – for instance its particular mix of cognitive and affective factors is often construed as intrinsically misleading and/or distorted.

Brown's discussion of 'Achievement Motivation' (N.Ach.) – a well established psychological concept (McClelland, 1961) – is interesting since N.Ach. is probably better conceptualised as a value. Brown considers that McClelland has suggested a '*mediating social-psychological mechanism*' in his formulation of N.Ach. Of especial interest is the link that Brown makes – almost incidentally – between ideology and values. He refers to Weber's view of large scale social movements. His version of Weber's analysis is at Figure 3 below: (our emphasis)

Figure 3: Achievement Motivation – ideology and socialisation



This analysis is clearly relevant to the notion of socialisation and health career – and, insofar as N.Ach. can usefully be defined as a value, is consistent with the notion of socialisation as a process of transmitting cultural values, norms, beliefs etc.

DeKadt (1982), in discussing WHO's major initiative, *Health for All by the Year 2000* (HFA, 2000), deliberately uses the term 'doctrine' rather than ideology. Again, having recourse to a standard dictionary definition, a 'doctrine' is viewed as,

... a body of teaching relating typically to religious or philosophical groups (which is) ... presented for acceptance. (Collins English Dictionary, 1979)

Etymologically speaking the reference to teaching or instruction is highly appropriate, however, the intention would be that those who had been thus instructed would actually believe the doctrine presented – a fact also included in the dictionary definition's reference to a 'credo'. The notion of doctrine is thus not far removed from the notion of 'dogma' (from 'dokein' - to seem good. The purpose of indoctrination is therefore to present a body of ideas in an (intellectually?) appealing way such that the ideas are accepted. The distinction between indoctrination and 'education' is therefore fundamental and will be explored later in this chapter. For the present, we can note that the term doctrine is similar to the term ideology in the coherence of its blend of values and beliefs and its intention to influence. However, the term ideology typically emphasises disparity in status and power that is incorporated in the concept of 'hegemony'. The effect of power in privileging certain ideas and their associated values is, of course, central to pronouncements of Marx and Engels (1955) and encapsulated

in their assertions that, *the ruling ideas of each age have ever been the ideas of its ruling class.*

We should not, however, assume that the partiality and over-simplifications characterising doctrine necessarily indicate the presence of ideology. Indeed, theory in general and, certainly, models of all kinds routinely oversimplify in order to emphasise the essential components of sets of ideas. Many theoreticians would resent the accusation that they were being other than 'scientifically' neutral!

There are, then, a number of possible interpretations of the meaning of ideology. Eagleton (1991) suggests that the opposite of ideology would be an 'empirical' or 'pragmatic' approach to discussing issues. On the other hand, ideology-speak would involve a partial and biased view of the world characterised by,

... some rigid framework of preconceived ideas which distorts their understanding. I view things as they really are; you squint at them through a tunnel vision imposed by some extraneous system of doctrine. There is usually a suggestion that this involves an oversimplifying view of the world – that to speak or judge 'ideologically' is to do so schematically, stereotypically, and perhaps with the faintest hint of fanaticism. (p3)

Eagleton cites Shils (1968) view of ideologies as,

... explicit, closed, resistant to innovation, promulgated with a great deal of affectivity and require total adherence from their devotees. (p4)

He lists 'more or less at random' some 16 definitions in current use. They range from, *... the indispensable medium in which individuals live out their relations to a social structure and the process whereby social life is converted to a natural reality to socially necessary illusion and false ideas which help to legitimate a dominant political power. (p1-2)*

It is the last of these four examples, which probably most nearly approximates to the interpretation of ideology used in political discourse – and in recent discussions of public health and health promotion strategies. Indeed, De Kadt (1982) in discussing the problems of overcoming barriers to implementing HFA 2000 in third world countries, makes a further reference to a Marxist analysis of ideologies,

... as weapons in the class struggle whereby, for example, hegemonic groups portray reality in such a way as to make those dominated conform to their fate, which may then give rise to 'false consciousness' on the part of the latter.' (p742)

Again, Eagleton (1991) cites Thompson (1980) in his analysis of the legitimating power of a dominant social group or class:

To study ideology is to study the ways in which meaning (or signification) serves to sustain relations of domination. (p5)

According to Eagleton,

A dominant power may legitimate itself by promoting beliefs and values congenial to it; naturalizing and universalizing such beliefs so as to render them self-evident and apparently inevitable; denigrating ideas which might challenge it; excluding rival forms of thought, perhaps by some unspoken but systematic logic; and obscuring social reality in ways convenient to itself.(p5)

In short then – and in Fairclough's (1995) laconic phrase, ideology is

... meaning in the service of power. (p5)

We will give some further thought to the relevance and utility of these interpretations of ideology in relation to clarifying the values underpinning public health, health promotion and various strategies involved in translating its principles into action and in evaluating it.

Determinants of Health and Illness: Ideological Perspectives

At first glance, analysis, description and explanation of the manifold factors influencing health and illness would seem to be a technical and empirical matter. However, it is a fact that some explanations have omitted key influences (and in many cases the most important influences); this 'blindness' is a sure sign of ideology at work. It could, for example, be argued that the construction of health as absence of disease is the imposition of the values of a powerful medical profession and therefore ideological. On the other hand it could be argued that, as we noted earlier, the concept of well being and 'positive health' is a morass of vague and overlapping notions and unworkable in practice – and its omission from serious policy formation more a pragmatic matter than ideological blindness. No such explanation is possible for the failure to pay proper attention to the contribution of broader social and structural factors to the explanation of health or illness – and its absence from health policy.

The 'Health Field Concept' (Lalonde, 1974) is now justly renowned for its critique of the failure to take account of social, economic and environmental influences on health. The model identified four main 'inputs' to health: genetic factors, health services, individual behaviour and lifestyle and those macro level influences encapsulated in the term environment. It is now generally accepted that health services make the least contribution to the public's health while social, economic and cultural circumstances have the most substantial effect. Despite this reality, rhetoric and policy have tended to concentrate on individual behaviour and lifestyle. Only recently is there evidence that attempts are being made to rectify this imbalance between evidence and action. The ideological basis of what many commentators have construed as years of misdirected effort is nowhere more apparent than in the social and political construction of inequality.

It is now virtually a truism to observe that socio-economic inequalities are mirrored in disease prevalence and experience. Of particular importance is the gap between rich and poor: the healthiest nations in terms of mortality and morbidity are those in which inter-class differences are minimal. Despite these realities, the continued emphasis on lifestyle change has with justification been described as victim blaming.

The Ideology of Victim Blaming

The term victim blaming was coined by William Ryan (Ryan, 1976). It is a process operating, not only in respect of health and illness, but is at the heart of many social phenomena – such as crime, poverty and racism. Ryan made it clear that victim blaming is an ideological process which serves to justify inequalities and inequity in western capitalist society. He provides a revealing image of ideology in action in his description of John D Rockefeller preaching inequality and the virtues of capitalism in Sunday School:

The growth of a large business is merely a survival of the fittest ... The American Beauty rose can be produced in the splendor and fragrance which

brings cheer to its beholder only by sacrificing the early buds which grow up around it. This is not an evil tendency in business. It is merely the working out of a law of nature and a law of God. (p21)

Ryan does not actually use the term ‘victim blaming’ as a synonym for the crude Social Darwinism demonstrated by Rockefeller; rather he uses it to refer to the misguided sentiments of many liberals who, while sympathising with the plight of the have-nots, still insist on focussing on the victims of the social circumstances that created their plight. The solution is to be found in their psychological make-up rather than their socio-economic context. The solution is still being offered – in a rather more sophisticated and less brutal guise – in certain technically inept and misguided versions of empowerment! An example, perhaps of false consciousness?

For Ryan, the solution was clear and embodied in the title of one of his book chapters: *‘In Praise of Loot and Clout!’* Power and financial resources rather than lifeskills!

Thoughts on the Notion of Underclass

It is becoming increasingly politically incorrect to crudely assert that the poor could and should by employing moral fibre pull themselves up by their bootstraps (although some poor people have in the past been successful in overcoming their social circumstances - the personal trait of ‘hardiness’ demonstrates - it would certainly be ill-advised to bank on this happening!). However, a new version of victim blaming has emerged which at first glance seems to acknowledge the reality of inequality and deprivation on health status and social malaise. Nonetheless, the moral tone embodied in the pronouncements of its advocates reveals the powerful presence of ideology. Because of its contemporary importance and its capacity to mislead, it is worth spending a little time here elaborating on this notion.³

The Problematic Notion of ‘Underclass’

The notion of ‘underclass’ is highly contentious. It gives rise to heated debate and angry exchanges – rooted in conflicting political ideologies. Although, at first glance, its demonstration of major inequalities would appear to be consistent with concerns about inequalities, the explanation it offers for those inequalities attracts considerable opprobrium. In fact, Townsend and Davidson (1992) caution against the pitfall of concentrating on the *‘dangerous notion of an “underclass”’*. They cite an editorial in the Lancet (1990):

The emotion of the well-heeled towards underclasses is fear, often voiced as blame and articulated in exhortation to uphold the family, obey the law, be industrious, and make use of the opportunities of the market. More appropriate emotions might be shame and indignation. Once cannot walk about London - an exercise eschewed by Prime Ministers – without a strong measure of both. (p26)

The invention of the term ‘underclass’ has been attributed to Ken Auletta, an American journalist writing in the 1980s. However, the most notorious advocate of the concept is Charles Murray who made a messianic visit to Britain in 1989 at the invitation of the

³ What follows is derived from Chapter 1 of Tones and Tilford (2001), *Health Promotion: Effectiveness, Efficiency and Equity* (3rd edn.), Nelson Thornes: London.

Sunday Times and made a second visit in 1994 to ascertain whether his apocalyptic forecast that Britain would shortly be in the same unfortunate predicament as the USA was becoming reality. His Sunday Times articles were subsequently published by the Institute of Economic Affairs (Lister, 1996).

In short, Murray distinguished between the deserving and undeserving poor. As Green noted in his foreword to the conclusions Murray drew from his first visit and published under the title of 'The Emerging British Underclass' (Lister, 1996), .

the term 'underclass' was applied only to those poor [who were] ... distinguished by their undesirable behaviour, including drug-taking, crime, illegitimacy, failure to hold down a job, truancy from school and casual violence. (p19)

In the publication resulting from his second visit - and tellingly entitled 'Underclass: the Crisis Deepens' (Lister, 1996). Murray indicated his intention to focus on three 'symptoms': crime, illegitimacy and economic inactivity among working-aged men. In reality his major concern was with illegitimacy. Within this latter context, he compared unfavourably the 'New Rabble' of the 'underclass' with the 'New Victorians'. His solution to the problem was to substantially abandon welfare funding and emphasise 'authentic self government'. He was, incidentally, reticent about the meaning of 'authentic' and the means for achieving this.

The Underclass: Explanations and Definitions

Inevitably, Murray's analysis created a furore. Some opponents challenged the very existence of an 'underclass' and the associated notion of a 'culture of dependency'. For example, Lister cites Kempson's (1996) conclusions from a review of 31 research studies supported by the Joseph Rowntree Foundation:

... people who live on low incomes are not an underclass. They have aspirations just like others in society: they want a job; a decent home; and an income that is enough to pay the bills with a little to spare. But social and economic changes that have benefited the majority of the population, increasing their incomes and their standard of living, have made life more difficult for a growing minority, whose fairly modest aspirations are often beyond their reach. (p163)

Others, however, accept the existence of an 'underclass' – or something like it. Willetts (1992), for example, identifies three problematic groups: the long-term unemployed, unskilled workers in erratic employment and younger single mothers. Of greater importance, however, is the nature of the disagreements about explanations and causes between those who accept the existence of a problematic socio-economic group or sub culture but cannot accept Murray's diagnosis nor his proposed remedies. The crux of the debate about explanations centres on the distinction between those who view the problem as 'structural' oppression and those who consider that it arises from individual ineptitude. Wilson (1987) seemed to subscribe to both in his definition of 'underclass' as:

... that heterogeneous grouping of families and individuals who are outside the mainstream of the American occupational system. Included ... are individuals who lack training and skills and either experience long-term unemployment or are not members of the labor force, individuals who are

engaged in street crime and other forms of aberrant behaviour, and families that experience long-term spells of poverty and/or welfare dependency. (p8)

Field (1996), too, is prepared to use the term 'underclass' for the current situation in Britain.

... I accept that Britain does now have a group of poor people who are so distinguished from others on low income that it is appropriate to use the term 'underclass' to describe their position in the social hierarchy. (p57)

Field, however, distinguishes the British from the American context by asserting that, unlike the US experience, there is no racial basis to Britain's underclass. He also emphasises its structural causes and identifies three major constituent groups:

the very frail, elderly pensioner, the single parent with no chance of escaping welfare under the existing rules and with prevailing attitudes, and the long-term unemployed. (p57)

Again, it is possible to agree with some of the problems identified by Murray without subscribing to an individualistic explanation. Phillips (1996) - while likening Murray to 'a bit of chewing gum that gets stuck to the sole of your shoe' (there's ideology for you!) - nonetheless believes that,

... the progressive collapse of the intact family is bringing about a set of social changes which is taking us into uncharted and terrifying waters.

Additionally, she recognises that,

... there are now whole communities, framed by structural unemployment, in which fatherlessness has become the norm. These communities are truly alarming because children are being brought up with dysfunctional and often antisocial attitudes as a direct result of the fragmentation and emotional chaos of households in which sexual libertarianism provides a stream of transient and unattached men servicing their mothers. (p156-7)

The Individual Dimension

Despite the popularity of the structural explanation among social scientists and many health care workers, it would be unwise to completely exclude the possibilities of individual capacities and responsibilities. Buckingham (1996, in Lister, (1996) provides a 'statistical update' and, not without a degree of courage, directly addresses the question, 'Are the Underclass Workshy?' While he emphasises the primacy of structure he does provide some evidence that there may well be - for some people - alternative explanations. He utilised the invaluable 1958 cohort originally recruited for the National Child Development Survey (Davie et al., 1972) and compared the responses of a sample of working class men with 'underclass' men to the following two statements:

*I would pack in a job I didn't like even if there was no job to go to.
Almost any job is better than none.*

There was a statistically significant difference between both samples. Some 39% of the underclass group agreed with the former statement compared with 16% of the working class group. Furthermore 47% of the underclass considered that 'any job was better than none' compared with 59% of the working class sample.

Buckingham also chose to challenge the dictates of political correctness by addressing the question of cognitive ability and asserted that, 'Even when compared with the below average scoring working class, the underclass are significantly less intelligent.' (A full standard deviation below the mean male score). 'Underclass

women', for instance, whose child was illegitimate scored 30.6 (out of 80) on a standardised score of general ability whereas the mothers of children born within marriage scored 41.2.

Lister's (1996) thoughtful review of the 'underclass' issue also observes that an emphasis on structural explanations needs to be balanced by an acknowledgement that individuals can, in certain circumstances, make a difference. As Lister puts it, *...there is ample evidence of the ways in which, both individually and collectively, people in poverty (and especially women) struggle to gain greater control over their own lives and to improve their situation and that of the communities in which they live.* (p12)

This observation will find a strong echo in our later discussion of health promotion's empowerment imperative. In the meantime, it will be useful to conclude this discussion of inequalities and the social determinants of health by referring to Galbraith's valuable contribution to the critique of the concept of 'underclass'.

Challenging the 'Culture of Contentment'

Galbraith (1992) acknowledged what he termed the '*present and devastated position of the socially assisted underclass*'. However, he vigorously attacked Murray's formulation and its associated 'trickle down' theory which proclaims the benefits of enriching those who already have power and wealth. He disapprovingly quoted one of the Reagan administration's metaphors that,

... if one feeds the horse enough oats, some will pass through to the road for the sparrows. (p168)

Galbraith's (1992) wholehearted espousal of structural-economic solutions is made explicit:

Life in the great cities in general could be improved, and only will be improved, by public action – by better schools with better-paid teachers, by strong, well-financed welfare services, by counseling on drug addiction, by employment training, by public investment in the housing that in no industrial country is provided for the poor by private enterprise, by adequately supported health care, recreational facilities, libraries and police. (p180)

In the light of contemporary attempts to deal with 'underclass' problems within existing fiscal and economic strategies, his final observation is especially relevant:

The question once again, much accommodating rhetoric to the contrary, is not what can be done but what will be paid. (p181)

Promoting the Public Health: Ideological Dimensions

Reflections on the Meaning of the New Public Health

It is possible to conceptualise public health as the mere aggregate of the health of individuals within a given geographic or socio-cultural entity – a kind of gestalt or collective incorporating the sum total of individual health statuses. Such an analysis would thus involve identifying the factors contributing to individual health and taking actions to ameliorate individual health status by various means ranging from face-to-face 'counselling' to the use of mass media. However, such a view would be idiosyncratic to say the least and, rather like the relationship between individual

empowerment and community empowerment, it would be more accurate to consider the macro as more than the sum of the parts of the micro level.

Probably due to uncertainties about the nature of wellbeing and its omnipretentiousness, health workers have been reluctant to pursue the mirage. This has doubtless resulted - by default - in public health being defined in medical terms, i.e. as a concern with macro level distribution of disease as defined by the science of epidemiology, and the development of measures to manage and prevent these various disorders. The 'medical' endeavour has been described variously over time as preventive medicine leading on to 'community medicine' - with a brief dalliance with 'social medicine' (that perhaps narrowly missed the opportunity to become a 'new public health') - until, at present, it is entitled public health medicine.

McKeown and Lowe (1974), noted that social medicine was concerned with subjects (more particularly, epidemiology and the study of medical care) that were a relatively late development in medicine and defined the discipline 'in the broad sense', as follows:

... an expression of the humanitarian tradition in medicine (and) ... people frequently read into it any interpretation consistent with their own aspirations and interests. Thus it may be identified with humane care of patients, prevention of disease, administration of medical services; indeed with almost any subject in the extensive field of health and welfare. (p vii)

Detels and Breslow (2001), comment on the 'Current scope and concerns in public health' in an introduction to the 3rd edition of the *Oxford Textbook of Public Health*. Interestingly, the editors had serious doubts about the existence of a New Public Health arguing that public health was public health - only the concerns and problems differed over time. The authors defined public health as,

... the process of mobilizing local, state, national, and international resources to ensure the conditions in which people can be healthy. (p3)

Having commented on public health's main concerns in the 19th and early 20th centuries with,

... faecal contamination of water supplies and widespread undernutrition, crowding, and exhaustion associated with early industrialization, they state that, ... at the end of the 20th century, another set of health problems, [including new infectious diseases and major non-communicable diseases] that confront major industrialized nations.... (p3)

Detels and Breslow acknowledge the importance of basic economic and social conditions on health and the importance of

'strong economic forces expressed in agriculture, manufacturing, commerce, and politics'. (p3)

The example they give, however, of the impact of these forces is concerned with, swaying,

people to use tobacco and thus injure their health. (p3)

Although the authors emphasise the continuity of 'old' and 'new' public health, it is probable that much of what passes as new public health may merely involve the identification of new diseases and new determinants of those diseases. Nutbeam's (1986) Health Promotion Glossary defines the new public health as follows:

Professional and public concern with the effect of the total environment on health. ... The term builds on the old (especially 19th century) public health which struggled to tackle health hazards in the physical environment (for example, by building sewers). It now includes the socio-economic environment (for example, high unemployment). 'Public health' has sometimes been used to include publicly provided personal health services, such as maternal and child care. The term new public health tends to be restricted to environmental concerns and to exclude personal health services, even preventive ones such as immunisation or birth control. (p122)

On the other hand, many health promotion writers, researchers and workers in general have sought to switch the emphasis away from disease and victim-blaming intervention strategies. Some have re-asserted the 'wellbeing principle'. Indeed Mahler (1986) linked the new public health with the HFA 2000 movement:

... public health is reinstating itself as a collective effort, drawing together a wide range of actors, institutions and sectors within society towards a goal of a "socially and economically productive life".

Kickbusch (1989) reiterates the point:

Public health is the science and art of promoting health. It does so based on the understanding that health is a process engaging social, mental, spiritual and physical well-being. It bases its actions on the knowledge that health is a fundamental resource to the individual, the community and to society as a whole and must be supported through sound investments into conditions of living that create, maintain and protect health. (p267)

So how new is the New Public Health? Perhaps it is new in the sense that it has involved a re-discovery of the 'old' public health after a lengthy period of medical model hegemony during which the main focus has been on individuals, their microbiology and their lifestyle. Certainly, like the old public health, public health re-discovered is concerned with environment rather than individual. At first glance, the nature of environmental concern with the older model was more material and physical (e.g. the emblematic significance of John Snow's action with the Broad Street pump) whereas the current version is primarily concerned with social and socio-economic matters in general and poverty, inequality and inequity in particular. However, consider Rudolf Virchow's report into the typhus epidemic in the winter of 1847 in Upper Silesia (a Prussian province with a suppressed Polish minority).

The epidemic, Virchow argued ... was due not to any simple aetiological factor but a socio-political nexus ... epidemics were symptoms of a general malaise; they mainly affected oppressed groups. The answer was thus not medicine, but "political medicine" (my emphasis): education, freedom and prosperity. "The improvement of medicine would eventually prolong human life." he proclaimed, "but improvement of social conditions could now achieve this result more rapidly and more successfully." Dispossessed and exploited, the Silesian Poles were sitting targets for sickness. Only democracy, he claimed, would prevent future epidemics. The physician's responsibility was to serve as an "attorney for the poor" (our emphasis). (Porter, 1997 p415)

Virchow's socio-political analysis and prescription for action would sit very well with many current new public health concerns. As Porter reveals, the Prussian authorities

were not at all pleased with the report and recommendations and chose to ignore it. Plus ça change!

It would, of course, be wrong to deny significant ideological differences between old and new public health - and thus the values underpinning action. While in Britain the devastating effects of squalor and poverty were well recognised, there was great reluctance to challenge the capitalist establishment and its victim-blaming morality. Accordingly distinctions were made between deserving and un-deserving poor and workhouses were deliberately designed to ensure only the most desperate chose to enter and remain in them.

The Times report that voiced opposition by vested interests and a general devotion to individualism is now a classic:

We prefer to take our chance with cholera and the rest rather than be bullied into health. As Porter (1997) records, *The Times* also declared in 1848 that, *the Cholera is the best of all sanitary reformers!*

Before considering the action dimension of public health promotion, it is interesting to note how Petersen and Lupton (1996) cast an expertly jaundiced eye in their critique of the New Public Health. They suggest that,

... the new public health is at its core a moral enterprise that involves prescriptions about how we should live our lives and conduct our bodies, both individually and collectively. (p174)

They acknowledge that many new public health supporters are concerned about inequalities in health:

lack of access to health care services, the constraints of bureaucracy, professional dominance, the limits of biomedicine, and "healthier", "more sustainable" society and ecosystem. (and, of course, the espousal of empowerment).

These words give a fair indication of the agenda of the New Public Health. But Peterson and Lupton urge caution:

The arguments and evidence presented in this book indicate the need for a more critical appraisal of the new public health, whose agenda has been largely set by professional experts and is closely aligned with official objectives. New public health knowledges (sic) and related practices have implications that may not be in accordance with what its supporters envisage. (p175)

Promoting the Public Health: Action Dimensions

Analysing the nature and meaning of public health and its underlying values is only part of the whole story. If public health is anything it must be action-oriented. At one time it was possible to argue that Health Promotion was a kind of militant wing of public health. More recently, a degree of confusion surrounds a number of concepts that have been previously used quite extensively and in the reasonable certainty of what they actually meant. For instance, note the recent observations by the Secretary of State for Health (Milburn, 2000) who asserted:

... the time has come to take public health out of the ghetto. For too long the overarching label "public health" has served to bundle together functions and occupations in a way that actually marginalises them from the NHS and other

health partners. Let me explain what I mean. "Public health" understood as the epidemiological analysis of the patterns and causes of population health and ill-health gets confused with "public health" understood as population-level health promotion and prevention, which in turn is best delivered – or at least overseen and managed – by medical consultants in public health. The time has come to abandon this lazy thinking and occupational protectionism.
(p5)

As a government minister delivered these observations, the statement cannot be regarded as anything other than at least having political overtones. We might note that the first definition of public health as an analysis of population health signals the importance of including 'health' as opposed to 'ill-health' within the overall conceptualisation. It is linguistically somewhat problematic to use a noun signifying a state as an action intervention (i.e. health promotion) but it is interesting to see the acknowledgement of a wide constituency of other stakeholders in the public health promotion strategy (i.e. what in Health Promotion 'proper' has been consistently fostered in terms of the desirability of 'inter sectoral collaboration'). Perhaps the most powerful political point is the apparent marginalisation of public health medicine accompanied by the undesirability of 'occupational protectionism'. It is doubtless true that there has been a good deal of 'lazy thinking' but the confusion over particular terminology also involves some ideological dissent as well as multiple meanings of certain discourses.

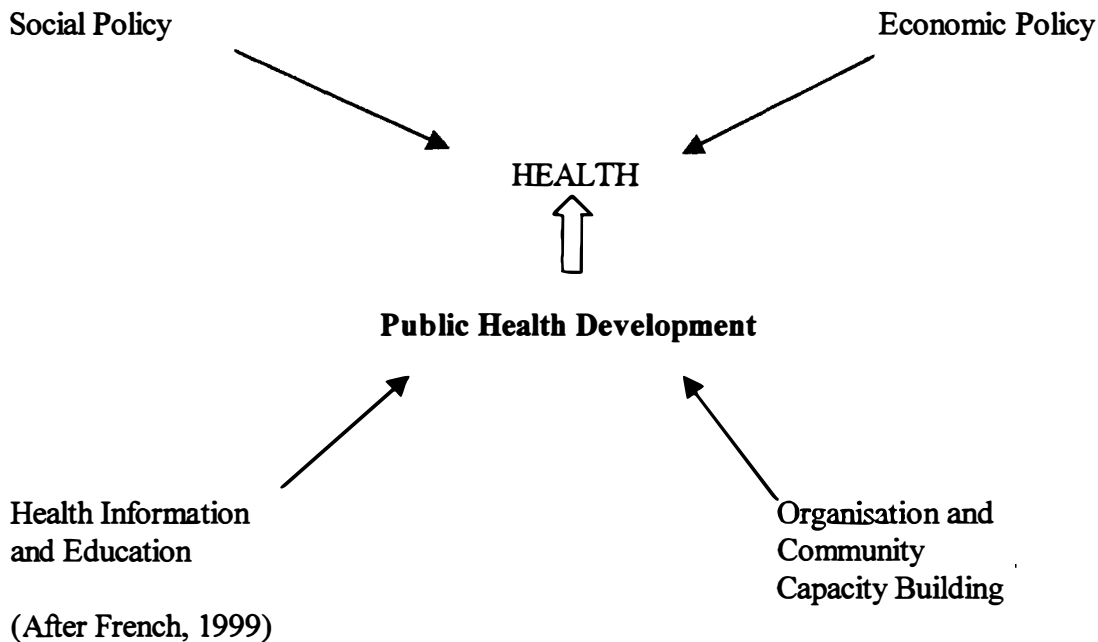
It is interesting to note that the term Health Promotion seems to have been partially displaced by 'public health' (something which is certainly far from being a logical formulation) and, rather more logically, by the term Health Development. It is always rather worrying when terminology is discarded especially when individuals or occupational groups have, more or less happily, been identified with the discarded term. It certainly makes sense to talk about public health promotion but we should ask whether this implies that promoting the health of individuals is not a valid activity – and, if it is, who should undertake it. It is not especially clear why Health Development has made its appearance (although the term is certainly not widely used at the time of writing) unless it refers to approaches to health promotion that emphasise the importance of ensuring a continuing and sustainable effect. Indeed, in an updated version of the Health Promotion Glossary (Nutbeam, 1998), health development is defined in such a way, i.e.,

... the process of continuing progressive improvement of the health status of individuals and groups in a population.

It should be added that the rationale, philosophy and ideology of health promotion as defined, debated and extensively reiterated in a number of key reports by WHO is relatively unambiguous – certainly more substantial than such notions as health development.

French (1999), writing as a Director of Health Development, seeks to clarify the concept of Health Development. The formulation that emerges is summarised in Figure 4 overleaf.

Figure 4: The Nature of Health Development



An analysis such as the above could well replace ‘health development’ by the term ‘health promotion’ without doing serious injury to either concept!

The Ideology of Health Promotion and Health Education

With due deference to the various debates over correct nomenclature, two terms have been retained for the following discussion about the values base of public health/ health development/ (public) health promotion. They are health promotion and health education. Health promotion is viewed as the over-arching strategy which encapsulates the two key functions of health education and what has frequently been described by WHO as ‘healthy public policy’. The model and its working is described more completely elsewhere (Tones, 2001; Tones and Tilford, 2001). Emphasis will be placed here on the major ideological dimension of this model – and some comment will be made about Health Education.

The Resurrection of a (?New) Health Education

If there is confusion about the various terms used so far in this paper, there should be no confusion about the term health education. The following definition is derived from Tones and Tilford (2001):

Health education is any intentional activity that is designed to achieve health or illness related learning, i.e. some relatively permanent change in an individual's capability or disposition. Effective health education may, thus, produce changes in knowledge and understanding or ways of thinking; it may influence or clarify values; it may bring about some shift in belief or attitude; it may facilitate the acquisition of skills; it may even effect changes in behaviour or lifestyle. (p30)

The ideological base of health education is, inevitably, more contentious. In short, the reason that health education figures so marginally in discussions about health

development, health promotion, public health and the like reflects one of the main ideological shifts discussed at some length earlier in this paper namely that, health education was – almost indelibly – contaminated by association with (1) a medical model and (2) the blinkered individualistic focus associated with ‘victim-blaming’. In fact, ‘education’ per se has an ideological background that is much more respectable. For an approach to merit the appellation ‘education’ it must be voluntaristic: its purpose is essentially to provide understandings in as nearly objective mode as possible and requires the individual in receipt of the education to make his or her own free choice. Furthermore, educational interventions must be intrinsically worthwhile (admittedly a somewhat question-begging criterion but one that would be eminently acceptable for most of the democratic and humanistic views associated with the ‘new’ public health). Additionally, the methodology used in education must be morally acceptable, e.g. those at the receiving end of the educational process should fully understand the process – and educationalists, by definition, must eschew dubious techniques such as fear appeal and similar ‘persuasive’ devices.

If education is to be criticised at all, it should be because of its naivete: mainly its assumption that people are genuinely free to choose and merely need information, understanding and, perhaps, cognitive skills in decision-making. In other words, a traditional educational strategy must be re-framed in terms of empowerment.

The Empowerment Imperative

One of the most consistent formulations for an ethical and ideological approach to public health promotion centres on the importance of empowerment. Appendix II indicates the two major strands of the empowerment imperative: personal or self empowerment to facilitate individual choice and community or public empowerment to maximise the chance of attaining health promoting policies that ‘make the healthy choice the easy choice’ and contribute to the removal of physical, cultural and socio-economic barriers to choice. As Appendix II shows, the educational task is complemented by lobbying, advocacy and coalitions of the great and good – and the powerful – whose influence should be brought to bear on the development and implementation of social, economic and health policies. A full discussion of the ideology and technology of empowerment of individuals and communities is examined elsewhere (Tones and Tilford, 2001). One of the key educational strategies having a peculiarly prominent ideological base is described by DeKadt (1982).

Critical Theory, Ideology and Values

It is virtually axiomatic that health promotion is an essentially political activity. Its orientation is radical and therefore frequently problematic; for these reasons its principles, practice and dilemmas are best appreciated in the context of critical theory. It should, in short, be viewed as a critical social science (*and emancipatory action research a prime strategy for assessing its effectiveness*). In a discussion of environmental health education, Fien (2000) summarises this approach in terms of *explanation* of the social world, *critical* analysis of the explanation and the concepts derived and the *empowerment* of individuals and groups to challenge and change the world. In short, in the context of environmental education, the process involves:

- a knowledge of *concepts* – e.g. about sustainability;
- a set of *valuing processes* that generate a wider commitment to community well-being and a desire to act upon this knowledge and these values;

- the *action competencies* of environmental citizenship. (our emphasis). (p61)

Four themes would emerge for the development of critical environmental curricula (e.g. in schools).

- *Crisis*: scope, root causes and historical development of the environmental crisis;
- *False consciousness*: review of the ways in which the environment is socially constructed; an ‘ideology critique’; provision of a vision of an alternative world view;
- *Curricula for enlightenment*: theory of environmental education and teaching practices for enlightenment;
- *Transformative action*: strategies for social and environmental change in which members of society can become agents of self and social transformation.

Conscientisation: Converting Radical Ideology into Action

DeKadt discusses the relevance of ‘dominant’ ideologies in the context of health promotion. He identifies for particular discussion the dominant, and arguably related, ideologies of medicine and capitalism. ‘Radical ideologies’ are those which seek to overturn dominant ideology. He describes the conscientisation (critical consciousness raising) approach associated with Paolo Freire (1972) as based on such an ideology. In his words:

... presenting such an alternative meaning system has also been called conscientisacion: educational and political activities undertaken among people who have always lived “surrounded” by the dominant ideology. Those involved want to help the subordinate groups improve their lot, which they usually try to achieve through specific development activities rather than by means of general political organization. Such activities may be in the productive field or they may relate to non-formal education. They may also use health-related projects as entry points into development, in order to create a wider critical awareness of the underlying causes of health problems. (p743)

A discussion of the limitations and potential for critical consciousness raising is beyond the scope of this paper. It is the intention, though, to note the empowering quality of an educational method. The increasing use of media advocacy also represents a radical and empowering method for fostering policy change and thus promoting public health. We should also note that the specific methods employed as part of public health promotion are themselves firmly rooted in various values. For instance, certain kinds of face-to-face health counselling are grounded in principles of voluntarism and empowerment; community development has a well recognised radical agenda to empower communities and achieve a more equitable society by achieving a fairer distribution of resources. Again, community development will frequently be used as a stock-in-trade of strategies designed to create ‘social capital’ - itself a valued social goal which operates both as a terminal and instrumental value.

Evidence and Evaluation: Ideological Dimensions

The final element in the 'ideological overview' provided by Figure 2 is concerned with the current concern for efficient evaluation of public health projects as part of the development of evidence bases that will, in principle, facilitate the best use of limited resources. The very fact that it is considered worthwhile to establish an evidence base is itself based on values: it is better to spend money wisely rather than adopt a cavalier approach to programme development. Again, it is unethical to subject the public to unproven interventions - especially those that raise expectations or/ and create anxieties, discomfort or loss of gratification to no avail. Moreover, what is apparently a technical operation is in fact deeply saturated by ideological issues. A more complete discussion of such issues is available elsewhere (Tones and Tilford, 2001). However, we might note Green and Tones (2000) emphasis on the following major points:

- At an epistemological level, certain evaluation methodologies which derive from public health medicine, do not generate full insights into the programmes investigated. The results of the inappropriate use of such methodologies can leave managers with insufficient evidence on which to base cost effective and ethical planning.
- If participation and empowerment are core values of health promotion and new public health it is inconsistent to carry out research *on* people rather than *with* people. Individuals and communities should be full partners in the evaluation exercise.
- The concern of public health promotion is with action not with academic research. Action research requires community participation and, quite frequently, an interpretivist mode of investigation. Moreover, critical evaluation theory requires that research should be a tool for social and political change (e.g. Connelly, 2001). Appropriate methodology is therefore essential.

Summary

This first Section has provided a context for the remainder of the report. It began with a consideration of the meaning of values and related concepts. A distinction was made between instrumental and terminal values which will be applied in Section 4. This was followed by a detailed discussion of the concept of health and health as a value. Four values dimensions related to health promotion were presented: values associated with defining the nature of health, the determinants of health, the actions and activities appropriate to achieving health and the ways that the values of stakeholders affect the first three dimensions. Each of these dimensions was examined in detail. A particular emphasis was on a general discussion of ideology and values followed by a consideration of ideological perspectives on the determinants of health and illness and on promoting the public health. The final part of this section focused on a critical examination of key terms to be considered throughout this report: public health, new public health, health education, health promotion and health development, - and their interrelationships. In particular, the importance of health education informed by critical theory in the context of wider public health was noted.

APPENDIX I

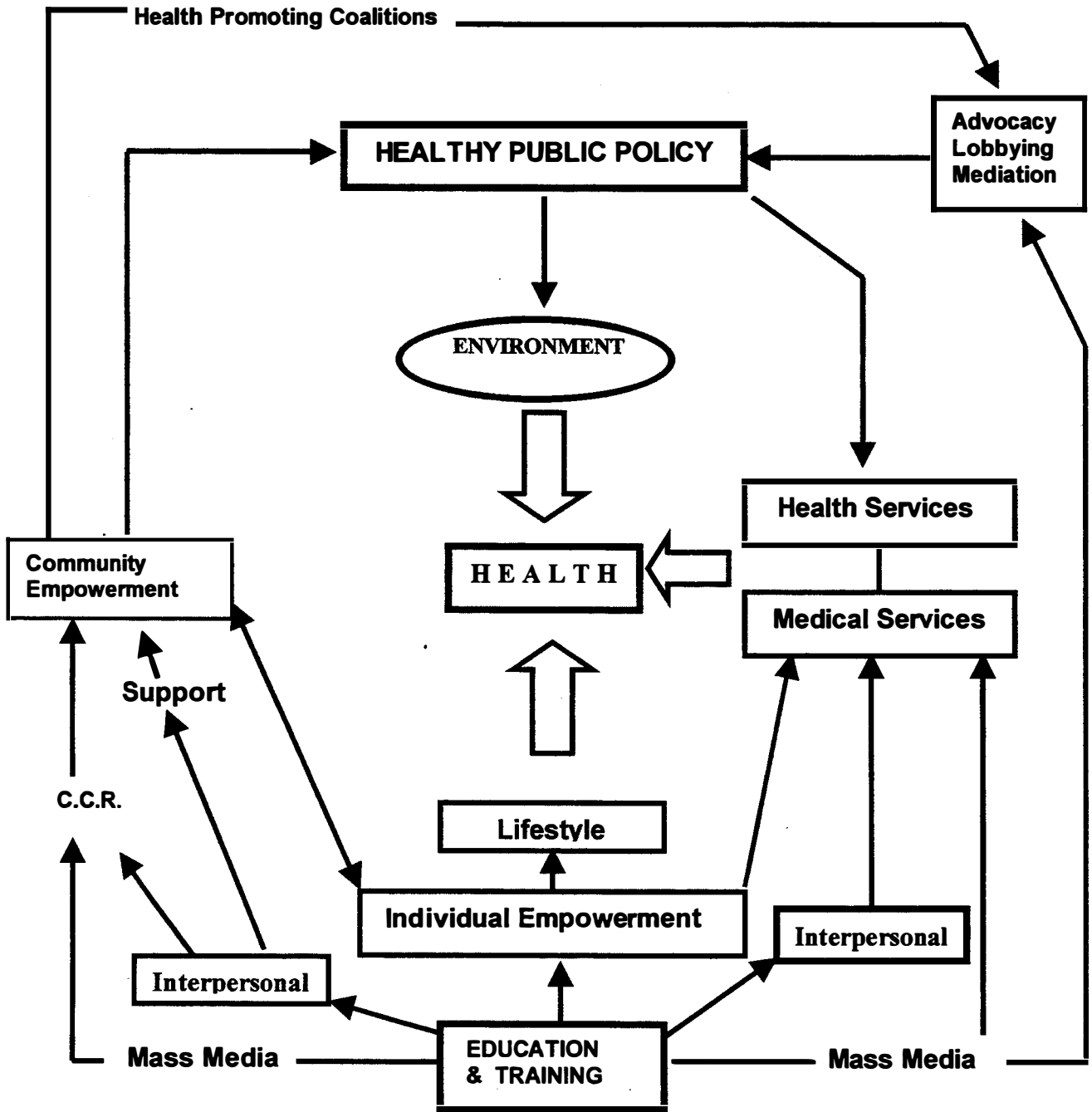
Rokeach Taxonomy of Values

Terminal Values	Instrumental Values
1. A comfortable/prosperous life	Ambitious/hardworking/aspiring
2. An exciting/stimulating/active life	Broadminded/open-minded
3. A sense of accomplishment	Capable/competent/effective
4. A world at peace	Cheerful/joyful
5. A world of beauty (nature and arts)	Clean/neat/tidy
6. Equality/brotherhood/equal opportunities for all	Courageous/standing up for beliefs
7. Family security/taking care of loved ones	Forgiving
8. Freedom/independence/free choice	Helpful/working for welfare of others
9. Happiness/contentedness	Honest/sincere/truthful
10. Inner harmony/freedom from inner conflict	Imaginative/daring/creative
11. Mature love/sexual & spiritual intimacy	Independent/self-reliant/self-sufficient
12. National security/protection from attack	Intellectual/intelligent/reflective
13. Pleasure/enjoyable, leisurely life	Logical/consistent/rational
14. Salvation/saved/eternal life	Loving/affectionate/tender
15. Self respect/self esteem	Obedient/dutiful/respectful
16. Social recognition/respect/admiration	Polite/courteous, well-mannered
17. True friendship/close companionship	Responsible/dependable/reliable
18. Wisdom/mature understanding of life	Self-controlled/restrained/self-disciplined

Rokeach (1973)

APPENDIX II

An Empowerment Model



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SECTION TWO: THE HISTORICAL PERSPECTIVE

Introduction

Writing and reading history, reliving the past, is the best way to learn how to build the future: although today little value is placed on Vico's recurrences, there is no doubt that the best lessons are learned from life and experiences. Unfortunately this custom is disappearing, and the latest generations tend to keep starting over from scratch. Spending a great amount of energy, but above all without the wealth of the past and an awareness of the mistakes to be avoided. (Briziarelli, 2001 p12)

The above quotation offers a succinct justification for inclusion of the historical perspective within this report. With reference to the particular content of this study Martin and McQueen (1989) have stated that:

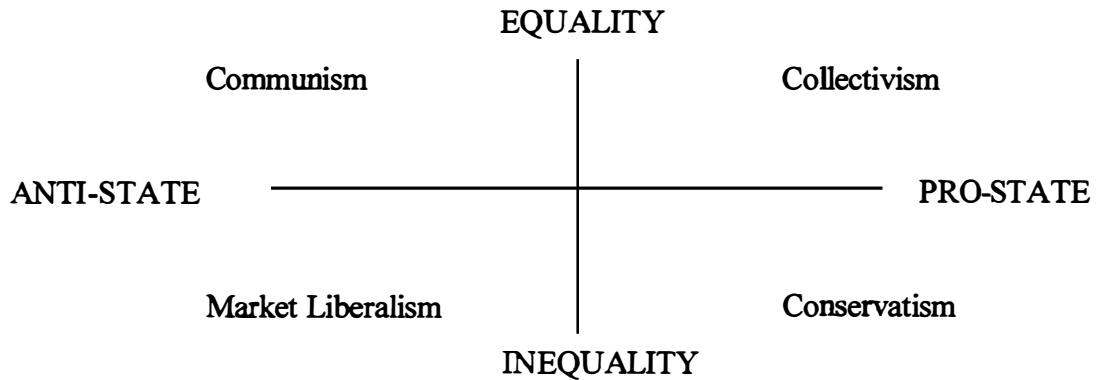
the efforts to establish a 'new public health' should be seen in the context of the public health in general. In Anglo Saxon cultures public health has a rich and varied history although it is necessary to distinguish the public health movement from the development, establishment and growth of public health institutions. (p1)

The period from the late 1960s onwards was selected as the main focus for this historical review. Any starting date is to an extent arbitrary but the one selected marks a point from which there was a significant expansion of health education as a specialist activity in the UK. Other events also took place which contributed to the later development of health promotion and public health, notably the Alma Ata Conference (WHO, 1978). The last 30 years cannot, however, be understood fully unless there is some reference to the preceding period in both the UK and the European context. A brief background account of the developments of public health and health education and promotion prior to the 1960s will be provided as a context within which to discuss the subsequent decades more fully.

Developments in Public Health, Health Promotion and Health Education prior to 1970

When examining developments in thinking and practice about public health in Europe it is conventional in many texts to take the 19th century as the starting point. This is to ignore developments beginning in ancient times. This early history is beyond the scope of this report but is addressed in brief in Baggott (2000). During the 18th and 19th centuries the thinking about the nature of public health and its associated activities differed between countries reflecting political systems and prevailing ideologies. There were alternative positions on the authority of the state, the freedom of the individual, and the balance between individual and collective responsibilities in securing population health. For the greater part of the period under discussion there was, according to Baggott (2000), an interplay between two broad ideological perspectives - liberal individualist and collectivist/socialist. In the later 20th century environmental and green ideology has emerged quite strongly as a third ideological perspective. A more differentiated model of ideological positions is offered by George and Wilding (1976) and is useful to note because of its use of a 2 x 2 structure (Figure 2.1) also used by Beattie (1991) in conceptualising health education/promotion.

Figure 2.1: Ideologies of Welfare



Developments in England had their own distinctiveness - partly a response to European changes but largely a response to endogenous factors. Running through the period were developments in scientific thinking which influenced the type of actions taken to protect and promote health. There was also the early professionalisation of medicine and developments in state medicine.

Rosen's analysis of the developments in public health in Europe (1979) is one of the best known. He examined public health in the old Prussian Empire, in France and in England and revealed how the lead in thinking moved between countries. It is in some of these early developments that we can see evidence of ideas which were later to be important in health promotion and the new public health. Rosen took as his starting point the 18th century which he identified as one where the basic elements of a concept of 'social medicine' had been established with the following elements:

- the need to study the relationship between the health of a given population and the living conditions determined by social conditions;
- the noxious factors that act in a particular way, or with special intensity, on those in a given social position;
- the elements that deleteriously affect health and impede improvements of general well being.

Social medicine emerged in the context of a set of ideas about social and political life and the role of the state known as mercantilism - a scheme of policy or organisation with the main aim of '*placing social and economic life in the service of the power politics of the state*' (Rosen, 1979 p23). The theory and practice of public administration associated with mercantilism - described as '*police science*' - gave rise to the concept of 'medical police' which, according to Rosen, increased interest in health as a matter of public policy. Frank, a major writer on medical police, specified the measures to be taken by governments for the protection of individual and group health. His 6 volume document, although containing much broad thinking, was primarily designed to guide officials '*who were supposed to regulate and supervise all aspects of human activity, for the benefits of society*' (Rosen, 1979 p24). His ideas were particularly influential in the German states and those adjacent countries with which there were close links. Although a great deal of the broader thinking contained within Frank's work was not put into effect within the German states Rosen presents the concept of medical police as a pioneer attempt at the systematic analysis of the health problems of community life. The political and social conditions in Britain and France at the time were different from Germany and Frank's ideas were not directly

appropriate or transferable to situations lacking similar administrative structures. Their main influence was probably on the control of communicable disease and sanitation.

The further development of thinking about social medicine took place in France in the context of the revolution and the post revolutionary period of the late 18th and early 19th centuries, a period also associated with the industrial revolution. Some limited legislation to address the health problems arising from industrialisation in France had begun in the 1840s. At the same time there was the development of surveys and statistical studies documenting the lives of urban workers and the impacts on health of social circumstances. A key figure was Villerme whose studies documented the links between social class and mortality rates, between poverty and disease, the influence of housing on growth etc. The term social medicine was the preferred term in France - about which Guerin said:

We have already had occasion to indicate the numerous relations that exist between medicine and public affairs. Instead of those half-hearted and uncoordinated approaches which we have tended to include under such rubrics as medical police, public health, and forensic medicine the time has come to collect these separate parts into an organised whole and to raise them to their highest potential under the designation of social medicine. (Rosen, 1979 p28)

Social medicine had four parts:

1. Social physiology - study of the relations between physical and mental conditions of a population and its laws and other social institutions.
2. Social pathology- the study of social problems in relation to health and disease.
3. Social hygiene - the determination of measures for health promotion and disease prevention, and
4. Social therapy - provision of medical and other measures to deal with social disintegration and other conditions that societies may experience.

The ideas of social medicine were developed against a background of early professionalisation of medicine and the role of medicine was clearly stated in Guerin's description of social medicine as:

...the key to the most important issues of our period of regeneration and the medical profession as the most appropriate group to use this tool. (Rosen, 1979 p28)

In the mid 19th century there were also important developments in German states in thinking about medicine and social science encapsulated in the well known observation by Virchow (Taylor and Rieger, 1984) that:

Medicine is a social science and politics nothing but medicine on a grand scale.

Further that:

If medicine is really to accomplish its great task it must intervene in political and social life. It must point out the hindrances that impede the normal functioning of vital processes, and effect their removal. (p210)

A statement by Neuman is also interesting in the light of 20th century concerns about the shortcomings of social science in community medicine training:

Medical science is intrinsically and essentially a social science and as long as this is not recognised in practice we shall not be able to enjoy its benefits and shall have to be satisfied with an empty shell and a sham. (Rosen, 1979 p29)

He stated three principles of social medicine:

1. A people's health is a society's direct concern and obligation.
2. Social and economic conditions have an important - often crucial- impact on health and disease, and these relations must be subjected to scientific investigation.
3. Steps taken to promote health and combat disease must be social as well as medical.

A public health action programme based on these principles was presented to the Berlin Society of Physicians and Surgeons. The objectives for public health were stated as:

- the healthy mental and physical development of citizens;
- the prevention of all dangers to health;
- the control of disease.

This document stated that:

Public health must care for society as a whole by considering those conditions that may adversely affect health and must consider each individual by considering those conditions that prevent him from caring for his health. (Rosen, 1979 p30)

The conditions were divided into two categories:

- conditions, such as poverty, where the individual has the right to request assistance from the state;
- conditions, such as transmissible disease, where the state has the right and obligation to interfere with the individual's personal liberty.

Public health could fulfil its duties by supplying sufficient well trained medical personnel and adequate organisational structures. It should be noted that the terminology of this period included the interchangeable use of social medicine, public health and social hygiene.

The broad thinking about social aspects of health and disease in Germany and France and the identification - if not always the implementation of relevant actions, did not emerge as early in England. As argued by Rosen, the climate of strong economic liberalism in England was less conducive to such developments than the climates in France and the German states at that time. Nonetheless there were studies in England examining the relationships between aspects of the environment and health and some actions taken in response. It was from the end of the 18th century that a number of specific developments occurred: early action on communicable disease following the development of smallpox vaccinations and some improvements in civic environments, although towns and cities lacked any coherent systems of public health. Concerns for health also emerged from the prison reform movement.

While the consequences for health of industrialisation were fully apparent in the 19th century, the specification and implementation of remedial actions occurred slowly in the prevailing political climate. Actions taken were partly in response to the levels of infectious diseases associated with poor environments, partly to the health consequences of industrial working conditions and to a lesser extent to concerns about 'lifestyle' problems associated with alcohol use. It has been noted that the occurrence

of disease outbreaks - most particularly cholera - when all sections of the community were affected - acted as triggers to a greater acceptance of the need for national and local actions.

The English public health developments from the mid 19th century have typically been divided into two periods - the sanitary reform period when improvements in health were sought through better physical environments - and the later personal services period when the emphasis was on personal health and hygiene through specific health and welfare services.

The Sanitary Reform period.

Rosen (1979) observed that there was relatively little systematic theoretical basis for early public health action programmes in England, with the notable exception of Rumsey's formulation of public health and medical care within a framework of social organisation and action. Rumsey emphasised that promotion of health and prevention of disease were matters of social concern and required governmental action, pointing out that various diseases were caused by factors in the social environment. He put stress on health education and urged that district medical officers be appointed to carry out the proposed programmes. In England, as in France, the key role of medically trained officers in public health was established.

From the early 19th century, but particularly from the mid century onwards, there was growth in state intervention with a series of acts addressing public health including specific Public Health Acts and also the Factory Acts. Achieving public health reform was in opposition to the ideological climate of economic laissez faire and local self government. At the same time utilitarian philosophy, used to support economic liberalism, could also be used by proponents of state intervention to support those actions designed to promote health for the maximisation of public benefit. There were multiple influences on public health developments - some in support and others in opposition and including:

Support for reform

- local authorities who changed to become supporters of public health developments in the context of emerging ideas of civic pride;
- the Health of Towns Association;
- the Social Science Association;
- the British Medical Association;
- Royal Sanitary Commission in 1869 whose recommendations led the way to the major Public Health Acts of 1872 and 1875;
- specific individuals including the well known Edwin Chadwick Sir John Simon, and Southwood Smith;
- the influence of philanthropy.

Opposition to reform:

- politicians;
- various interest groups - industrial and water companies, and civil liberties groups;
- the press;
- the medical colleges.

The specific role of the medical profession in public health developments

As noted earlier the 19th century was the period during which there were developments of medicine as a profession and the institution of specific medical roles in public health. The labelling of the public health role, its activities, and the organisational context in which it is delivered has changed over time with the original title being 'medical officer of health'. It was not compulsory to appoint medical officers of health until 1875, although many local authorities did actually do so before this. Posts were often precarious in the early stages. The growing influence of the medical profession on public health was partly related to its developing professional status, but also to the developments of scientific epidemiological knowledge and knowledge of bacteriology which doctors were seen to possess. Early public health reforms had taken place in advance of scientific understanding of cause and effect but as such knowledge emerged it was given priority in the planning of interventions. Baggott (2000) says the following about the implications which followed from the acceptance of germ theory during this period:

In future public health would be the province of scientifically trained professionals. By implication scientific knowledge would carry greater weight than other competing forms of knowledge. This favoured laboratory studies over and above circumstantial evidence and qualitative studies. It also emphasised the importance of medical intervention, which could be easily measured and quantified, over social intervention, which was more difficult to evaluate. (p35)

Personal services period

What has been defined as the second phase of public health development and preventive medicine replaced the sanitary idea as the dominant philosophy of public health and provided a context for the development of the activity of health education. Doctors became even more important in this second phase, described as one where there was the 'medicalisation of public health', with some shift from a population focus towards subgroups of individuals (Baggott, 2000). Various state medical services were developed from the 1860s - the public health services of the local authorities and the medical services for destitute people run by the Poor Law Guardians. While the concern to address social and environmental causes of health did continue this was obscured in the general moves to develop specific health and social services for defined groups, such as mothers and young children and school children. By the end of the 19th century improvements in population health had occurred. A key analysis of the determinants of improvements was provided by McKeown and Lowe (1974). They argued that in the sanitary reform period actions on water and sanitation played the major role but from 1875 onwards improvements in nutritional status were the major determinant. Nonetheless, by the turn of the century infant mortality rates were still very high and there was public concern about this. Surveys on social conditions in London and York reinforced knowledge about the impact of poverty on health although appropriate actions to redress poverty were not secured. Further evidence of poor health came from the inspection of recruits to the Boer War. At the turn of the century the only free medical services available to people outside hospitals were provided under the Poor Law through low paid general practitioners. A need for change was recognised and there were alternative proposals. What emerged was a system of preventive personal services through local authorities, overseen by Medical

Officers of Health, and medical treatment through private doctors. The School Medical Service was set up in 1907 and a Maternity and Child Welfare Act in 1918 led to the provision of maternity and child welfare services. It was in 1911 that the first National Health Insurance Scheme provided for treatment services but only for employed and insured workers. The first Ministry of Health was set up in 1919 with a statutory duty to:

Take all steps as may be desirable to secure the preparation, effective carrying out and coordination of measures conducive to the health of the people. (Baggott, 2000 p44)

There have been differing judgements on public health at this time - some describing it as a golden age but others seeing it as one where preoccupation with a service delivery role obscured the development of a philosophy of public health (Baggott, 2000 p41). In the period leading up to the formation of the NHS there was continuing growth of local authority health and social services and in 1927 the setting up of the Health Education Council with a role to support preventive actions. A particularly interesting initiative of this period was the Peckham Experiment (Pearse, 1979) which encapsulated some of the philosophy of primary care contained within the imaginative Dawson Report (Ministry of Health, 1920). The Peckham Centre focused on positive health, adopted a holistic approach and was concerned to observe how health was generated through social interaction. Although there are reservations about some of the thinking and practice in the Centre it has exerted an influence on current ideas about Healthy Living Centres.

With the setting up of the NHS in 1948 a tripartite system of hospital, general practice and community health services led to a changing role for medical officers of health and some reductions in their sphere of influence. They no longer had responsibility for municipal hospital services. Although there was further growth of local health and special services there were moves to develop separate social services and, at the same time the clinical work of public health doctors was increasingly taken over by GPs.

We have examined this early period because of its importance in relation to the later developments of health promotion and the new public health. During this time we can see evidence of all the issues which informed later discussions:

- recognition of the complexity of determinants of health and illness and the selection of points of intervention in accordance with differing ideologies;
- the acknowledgement of the promotion of positive health as well as the prevention of disease although the latter governed the majority of interventions;
- references to health promotion - many remarkably in tune with contemporary thinking - and also to health education;
- the identification of social disadvantage and poverty as key determinants of health status but varying degrees of reluctance to address the root causes;
- the growth of modern medicine and unrealistic expectations about its contribution to health;
- the importance of biological science and the medical model;
- the continuing interplay between individualistic and collectivist ideologies in relation to the production of health and prevention of ill health;
- the notion of shared responsibilities for health between the individual and the state;

- the shifting emphasis in public health from action on environmental determinants of health to provision of preventive services and education to support the development of general health behaviours and the utilisation of services;
- the role of the public health specialist - a defined medical professional role but one with a high degree of protection from dismissal from local authorities thus giving freedom for action on health issues;
- the notion of 'rights' to health and health care.

1970s - The Decade of Community Medicine and Health Education

The two 'strands' of public health and health education/promotion will be discussed separately. While this may be seen as somewhat artificial it acknowledges the fact that the traditions have had varying degrees of separate development during the last 30 years. The discussion will focus mainly on the UK.

Community Medicine

Community medicine, rather than public health, was the term commonly used in this decade. It had been adopted in 1968 following the recommendations of the Royal Commission on Medical Education. The long established title of Medical Officer of Health (MOH) was lost in the 1974 National Health Service (NHS) reorganisation which placed community health services in new health authorities and created specialists in community medicine with the role of integrating health and related services. They were appointed to the three tiers of organisation at the time - regional, area and district management teams. Community physicians advised local authorities on health and environmental matters. They also managed the specialist health education services which were transferred from local to health authorities as a result of the 1974 reorganisation. These changes have been seen as particularly significant in relation to the protected role of the MOH in the local authorities. Even if the opportunities to challenge and advocate on public health issues, integral to the position, had not always been maximised the loss of the watchdog role and the possibilities for action were quite soon regretted. More generally there was seen to be a decline in public health as specialist function.

A Faculty of Community Medicine had been established in 1972 to arrest the decline of public health. Revised training procedures which would make it like other clinical, medical specialisms were put in place. Community medicine was defined as:

That branch of knowledge which deals with populations or groups rather than individual patients... It requires special knowledge of the principles of epidemiology, of the organisation and evaluation of medical care systems, of the medical aspects of administration of health services and of the techniques of health education and rehabilitation which are comprised within the field of social and preventive medicine. (Unit for the Study of Health Policy, 1979 p20)

The developments of the Faculty led to what Acton described later (1984) as a schism between the new Faculty and the old Society of Community Medicine. Many people joined the former and there were moves to disband the Society about which Acton (1984) said:

It is difficult to comprehend the magnitude of this disengagement from their reformist, interventionist traditions. (p16)

The period following this change has been seen as one where public health roles and functions became unclear, status was lost, and recruitment became difficult. Critiques began to emerge and the ground laid for the emergence of what later came to be called the 'New Public Health'. The Unit for the Study of Health Policy which produced a series of influential publications in the 1970s and 1980s delivered an early report which contributed to New Public Health thinking (1979). Entitled 'Rethinking Community Medicine' the report offered a critique of the 1970s community medicine developments - noting positive developments as well as negative ones. The preface to this report stated that it was written partly in response to the confusion among community physicians about their objectives and tasks and the preoccupation with administration which had resulted in poor recruitment. The authors were of the view that in discussions about the community medicine function, the public health component was usually forgotten if public health was taken to be:

The maintenance of health through attention to the social, economic, political and environmental conditions that are hazardous to it, and more positively, the encouragement of conditions that promote health, (Unit for the Study of Health Policy, 1979 p7)

Proposals for a contemporary public health movement were offered together with an assessment of the contribution of community medicine to such a movement.

The main points that were made in this report are of interest in the light of later developments in public health and health promotion:

- The need to encourage the wider debate of, and action on public health issues.
- Currently no 'public watchdog' comparable to the Medical Officer of Health existed whose *raison d'être* was the prevention of illness and the promotion of health.
- It was quite unrealistic to think of the 'medical officers' of the 1980s as isolated individuals. Inter-disciplinary groups were needed to provide the intellectual resources to tackle the health implications of social and economic policies at local, national and international levels. A viable and effective public health contribution required a broader disciplinary base than medicine.
- An interdisciplinary group would have the capacity to challenge specialists like economists and planners, in their own terms.
- Health promotion teams, comprising a range of basic disciplines, would have significantly better resources to observe, investigate and analyse contemporary hazards to health and communicate effectively with a wide range of people and interests. The teams could form the nucleus of a public health movement in the 1980s.
- At the national level health promotion teams could take the form of a series of bodies looking into and acting as pressure groups within specific policy areas relating to health. Public health activity would also be required at local and at international levels.

A number of examples of how teams at different levels would operate in relation to specific issues were outlined. The principles of public health were also stated:

- The public health presence would again be concerned with stimulating change towards a healthier social and economic environment - with politics understood in its widest sense.
- There should be no relapsing into the current complacent neglect of wider environmental health issues.
- An effective public health voice requires a guarantee of organisational independence sufficient to challenge establishment thinking when necessary. It also required a degree of invulnerability, visibility, autonomy and standing to tackle the policies of both local and national government and other institutions. Health promotion therefore needs a form of accountability which renders it immune from attacks from vested interests, attacks which are inevitable even if it is moderately successful. On the other hand it should be accountable to the public.
- The familiar vicious circle described in the Seeborn report must be faced. *Only when the imperative demands made by the casualties are diminished can prevention become possible; but the number of casualties can only be reduced by preventive action.* (Unit for the Study of Health Policy, 1979 p86)
- A public health base that can be adapted to different circumstances is required. The public health force should not be permanently committed to a cause that may become redundant.

There was some interchangeable use of the terms public health and health promotion in this document. The future organisation of public health was actually discussed under the heading 'health promotion'. Locations for health promotion within local authorities and health authorities were considered. Interestingly the developments of health promotion at local levels were discussed in some detail before there was any mention of the existing health education services which, as part of the 1974 changes, had moved from local to health authorities. The assumptions about those services are clear:

Another possibility within the NHS is that the existing preventive and health promoting work in the community carried out by Health Education Officers, Health Visitors and others could be built on. Some of these professionals would like to be more involved in activities other than teaching or exhorting individuals to behave healthily. (Unit for the Study of Health Policy, 1979 p94)

Suggestions were offered for a new type of training which would provide a more systematic basis on which to provide education about health and those factors in the wider environment which are potentially harmful to health. Preparation for public health and prevention work needed to be different from the current community medicine training. The development of non medically trained community health advisors, in parallel with medically qualified community physicians was also suggested. After examining various locations for training they suggested developments on the lines of American Schools of Public Health. It is interesting to note that the writers, in making their recommendations, did not betray any obvious awareness of the specialist health education training that was in place by 1979.

Health Education

The discourse during this period used the term health education, seen to be needed if the health of individuals and communities was to be promoted. The term health promotion was in use but in a general sense and not closely tied to the meanings which

emerged later. The 1970s was the decade of the Lalonde Report (1974), of Alma Ata (WHO, 1978) and, in the UK, of the Prevention and Health (DHSS, 1976, 1977) documents. The latter emphasised clearly and strongly the importance of individual responsibility for health, and the adoption of lifestyles conducive to the achievement of health.

Health education was defined during this period in various ways reflecting overlapping, and to some degree, distinctive values positions. Health education was a recognised activity within a number of professional roles and, in the UK, a specialist function in Local Authorities, and then, post 1974, in Health Authorities. Specialists could be involved in face to face health education although the extent of this was, and continued to be debated. More importantly their activities focused on strategic planning of health education and catalysing and facilitating the health education activities of others such as teachers, nurses, community workers etc. The differing ideas about health education informed what were often described as *approaches* to health education, and subsequently to health promotion. (Tones, 1981; Beattie, 1979). Initially the clearest distinction was made between preventive and educational approaches. The former focused on the adoption, through appropriate means, of knowledge attitudes and behaviours linked to the prevention of ill health. The latter focused on providing knowledge and understanding and the skills to make informed choices. The inherent tension between the values positions of the preventive and the educational approach was noted by Sutherland (1979) in an early historical review of the development of health education:

There is much potential for prevention in health education aimed at altering people's attitudes towards such things as tobacco, alcohol and exercise – persuading them in effect to invest in their own health --- but the onus on making the decisions in order to safeguard health must necessarily rest on the individual. (p16)

Both approaches were focused on individuals and both have been criticised equally as 'victim blaming' although the educational approach, if implemented in accordance with its underlying philosophy, is less vulnerable to such criticism. It was informed by ideas which came to be central to health promotion - autonomy, participation, empowerment, self esteem and so on. In reality much that took place in the name of education fell short of incorporating such ideas and Tones later distinguished an educational from an empowerment approach to signal this. He also specified a radical approach which was directly linked to later health promotion - making available knowledge on the root causes of health and campaigning for actions on root causes in order that making healthy choices became possible. The radical approach - while focused on the underlying determinants of health and avoiding victim blaming - was also associated with ethical concerns. The methods to secure action might have the same shortcomings as those associated with the preventive model and individual freedoms could be compromised in securing policy and environmental change (Tones, 1981). Radical action in the 1970s was most clearly seen in the community development projects. The impetus to the community development tradition had come in the 1960s with a series of Home Office projects. Community development for health projects were developed in the 1970s (Tones and Tilford, 2001). In the transition to health promotion some of the plurality of approaches to 'health education' has been, if not forgotten, sidelined. This has had consequences for the health education component of health promotion to which we will return later.

Health Education in Schools

In the context of the values focus of this report a brief diversion into school education of the time may be of some interest. Developments in general education, as well as health education, have relevance. In schools beginning from the late 1960s and continuing into the 1970s, there were values focused innovations. These had some influence on thinking about health education at the time and can logically be linked with processes later defined as integral to health promotion. The best known projects were Lifeline on moral education (Schools Council, 1972), and the Humanities Curriculum Project (HCP) (Schools Council, 1970). The HCP was built around group discussion of issues facilitated by a teacher acting as a neutral chair. The pedagogical aim of the project was to develop an understanding of social situations and human acts and the controversial values issues that they raised. Interestingly Stenhouse (1975), who initiated the HCP, reflected in retrospect that it would have been better to delete the term 'values' since the aim could imply that the only controversial issues are values ones and that values issues are necessarily controversial. While the project materials did not focus specifically on health issues, the intention was that teachers would build on existing materials to address other values areas, such as health related ones, using the project methodology. There is no evidence that this took place to any significant degree. Evaluation of this project was innovative at the time in challenging the dominant scientific approaches and in adopting action research approaches and qualitative methods. Discussions of evaluation issues foreshadowed many similar debates in health promotion of the 1990s. The concept of the teacher as researcher valued both the autonomy of the teacher and the autonomy of students as learners. One particular value much discussed in health education, that of self esteem - was evaluated positively from this project - increases in self esteem were identified after 5 months of using the project where the teachers had applied the project with fidelity.

Looking back, the 1970s (and the 1980s - for most of the decade) were an exciting time - and, arguably, the high point in developments of school health education. It can be argued that this was largely because of the support from the Schools Council and the Health Education Council. In line with much curriculum development at the time there was a focus in the health education developments on specific projects which has subsequently been critiqued. The most influential of the projects were, arguably, the Schools Health Education Projects 5-13 and 13-18 (Schools Council/HEC, 1977, 1982) and the My Body project (HEC, 1983). The developmental thinking underpinning these projects took place towards the end of the 1970s and the early 1980s, with the adoption in schools happening mainly in the 1980s. The attention to values in these projects was interesting. Essentially they were informed by an educational model which supported the idea of young people as autonomous and rational decision makers. Clarification of values was an important element of the decision making process. There were curbs on autonomy since there was also the promotion of the 'considerate way of life', and the latter was implicitly given greater weight than the former. There was, therefore, some tension between some of the surface values such as autonomy, and the underlying commitment to a stated set of values. Another issue of discussion at the time was the extent to which the values of these projects were undermined in the classroom situation where the teacher's commitment was to an alternative model of health education This was nicely identified

in the evaluation of a decision making model approach to drugs education (Dorn 1976).

It is interesting to note that the period of curriculum development of health education in schools began when progressive ideology - whether implemented in a strong or a weak form - was under attack following the 1976 speech by James Callaghan in which he called for a return to basics, and the subsequent election in 1978 of the Conservative Government which heralded a sustained attack on progressivism in education and a challenge to pluralism. It was still possible at that time for schools at the local level to continue to work with relatively little national interference. In schools during this period health education was informed by the values associated with both preventive and educational models but there was relatively little, if any, adoption of the ideas associated with the radical model as discussed below.

Although very much a decade of community medicine and health education it was at the end of this decade that the publication of the Alma Ata document and targets for Health For All 2000, discussed in the next chapter, laid the foundations for the growth of health promotion in the 1980s.

1980s -The Development of Health Promotion and the New Public Health

The early literature assessing the achievements following the Alma Ata Conference (WHO, 1978) focused predominantly on the ways that the ideas in the document had been adopted. In particular, there were analyses of the extent to which the responses to Alma Ata were *comprehensive* - addressing the underlying determinants of health as well as developing appropriate systems of health care - or were *selective* and focused on vertical programmes addressing prevention of key diseases and limited primary health care. (Walsh and Warren, 1979; Gish, 1982; Heggenhougen, 1984). The lack of attention to the central ideas in Alma Ata in the *North* was noted although there was a useful contribution from Green (1987). Taken up widely, although mainly in Europe at the start, was the notion of Health For All following the World Health Assembly in 1977, and the specification of Health For All targets for 2000. What ensued was the development of thinking and the dissemination of ideas about Health Promotion. Putting health promotion on the agenda took place in the UK in a number of ways - a key one being a series of road shows facilitated by Professor John Catford.

An ongoing concern during the early part of the decade was the definition of health promotion and exploration of its relationship to health education. While the activity of health education was contained within many conceptions of health promotion there were differences in the relative importance that it was granted in comparison with other constituent elements. In the early 1980s there was a degree of resistance to what was sometimes seen as a health promotion bandwagon from those in health education who were most aware of the plurality of ideas contained within health education and saw this concept as having the potential to accommodate the Health For All ideas. Throughout this decade, under the rubric of health promotion, some writers continued to refine models of health education. Tones distinguished more fully an educational from an empowerment model and increasingly promoted the latter (Tones, 1990).

We have mentioned earlier the specification by Tones of a radical model. Similar ideas were contained within the social model of health education from French and Adams (1986). Beattie's 2 x 2 model, originally applied to health education and later to health promotion, mapped the differing approaches to activities, distinguishing clearly between focus and level of activity and ideological positions (Beattie, 1991). In health promotion practice radical ideas were seen in the support for community development projects, even though official support was much reduced from the late 1970s. As the decade went on there was growing emphasis on the healthy public policy component of health promotion alongside health education.

We noted earlier the relatively limited adoption of social models in school health education practice and this continued. The Schools Council Health Education projects (1977, 1982) did expect in their training activities that teachers would reflect on the whole set of influences on health and give consideration to these in drawing up health education curricula. These projects also introduced the holistic notion of the health promoting schools and included activities designed to encourage the development of such schools. There was plentiful evidence from training workshops at the time that the idea that school health education might address the social causes of health was not seen as relevant. The emphasis was overwhelmingly on the education of the individual with the particular value positions being adopted by teachers not always clearly articulated. There was one project at the time - Health Careers - which was different and took on fully the idea of social determinants of health. (Dorn and Nortoft, 1982). Not surprisingly there was little evidence of wide use because its approach lay outside the mainstream values informing health education in schools - although there was some limited adoption in the somewhat different context of Further Education.

The series of documents published by WHO, beginning from 1984, were important influences on developments in thinking about health promotion and these are analysed fully in the next section of the report. It was the Ottawa Charter (WHO, 1984) that can now be identified as the key influential document during this decade in the conceptualisation of health promotion and the values associated with it.

Public Health

From the onset of the changes to community medicine which took place in 1974 there was dissatisfaction, as noted earlier. This was increasingly voiced and the ideas for the rejuvenation of public health, labelled as the New Public Health, gradually came together. Essentially the New Public Health was a return to the broader conceptualisation of the nature and role of public health in the 19th century. There were various influences on this development: These included:

- individuals and groups - radical community medicine specialists, practitioners and academics;
- the ideas associated with the WHO health promotion developments in Europe. Writers on public health have reflected on the seminal influence of the Ottawa Charter;
- renewed awareness of health inequalities and a determination to address them following the Black report;
- dissatisfaction with the New Right thinking of the UK Government elected in 1978.

Initially the contributory strands in the New Public Health development were relatively distinct, although interaction increased during the decade. We have already noted the publication from the Unit for the Study of Health Policy and the influence of this group was also noted by Scott Samuel (1989). The activities of the Unemployment and Health Study Group, formed in the early 1980s and involving community medicine specialists, practitioners and academics, provided a good example of a sustained and comprehensive analysis of a public health issue combined with advocacy, in the spirit of the old public health, of a broad set of preventive and ameliorative actions. The influential journal 'Radical Community Medicine', initiated by Alex Scott Samuel addressed health issues from a broader perspective than institutional community medicine. A specific issue in 1984 - entitled Public Health - provided a number of critiques from both practitioners and academics of the post 1974 situation in community medicine. Dunlop, writing in this issue as a District Medical Officer in Hull, argued strongly that community medicine had led to neglect of key environmental health issues, the loss of legal powers in relation to health under the local authority, the loss of clear and distinct duties, and the loss of protection by law from being sacked that had allowed medical officers of health to give advice on public health matters which was against local interests. With hindsight he concluded:

...the 1974 reorganisation was in many ways a disaster. Community physicians have not been accepted by the rest of the profession and we ourselves have lost our way.... Come back MOH - all is forgiven. (p10)

Dissatisfaction with the state of community medicine led to a committee of inquiry chaired by the Chief Medical Officer to:

...consider the future development of the public health function, including the control of communicable diseases and the speciality of community medicine.

The resulting report (DoH, 1988) provided a definition for public health which is widely used:

The science and art of preventing disease, prolonging life and promoting health through the organised efforts of society. (p63)

This definition was said to signal a broadening out from a narrow focus on sanitary hygiene and disease control. The report acknowledged the thinking about health promotion of the WHO, and the intersectoral nature of actions which was required for promotion of the health of the public. The terms community medicine and community physician were seen to have caused confusion and the recommendation, which was adopted, was to use as alternatives, public health medicine and public health consultants. In this report health education and health promotion were defined as a part of the public health function.

It was also in 1988 that Ashton and Seymour published 'The New Public Health'. While this book did not say anything that was particularly new it did summarise in an accessible way current thinking and developments. The particular strength of the book was the bringing together in one volume of the traditions of community medicine and specialist health promotion practice with the two writers coming from each. Throughout the book there is much interchangeable use of the terms health promotion and New Public Health although there is a definition of health promotion as:

...an activity whose basis resides in gaining change, change to promote health. The methods of change are its subject. (p41)

Health promotion was distinguished from health education and community medicine. It is worth quoting the comments in full:

First, it recognises the proposition that health is bigger than the prevention of disease, illness and disability. It is, therefore, inclusive and its rhetoric includes ideas of participation, multisectorality, populism etc. It is interested in big systems, the body politic, in education (not just health education, but general education throughout life which is probably a better indicator of health and well-being than investment in medical care) and in a thriving economy.

Second: while recognising the important contribution that individuals can make to their own health it concentrates on mass effects and the creation of environments which encourage healthy choices. (p41)

The fact that much health education already had a focus on positive health appears not to have been recognised. It had also been commonplace in health education to point out the important contribution of education in a general sense to the achievement of health.

In taking forward new public health ideas in the Mersey Region a multidisciplinary Regional Health Promotion Team was set up within the Health Authority along the lines suggested by the Unit of the Study of Health Policy and working to principles which bear similarities to those in the report:

1. Action on health promotion and disease prevention should be carried out at the most decentralised level that is compatible with effective action.
2. There should be a team approach.
3. Participation by the community should be an overriding principle.
4. Health promotion teams should have security of employment and independence of action.
5. A strategic plan for the promotion of health should be produced at the regional level which is informed by the priorities and objectives decided at the periphery.
6. Health promotion teams should produce annual reports based on the development of appropriate indicators than can be used to assess progress and revise objectives.

In describing the actions undertaken in Mersey it would appear that these demanded the combined skills of specialist health promotion and of public health medicine in developing the New Public Health.

Also at the end of the 1980s Martin and McQueen offered a 'Framework for a New Public Health'. They observed that the departments of community medicine were founded in social ideology but were largely without a social science basis and said:

The growing awareness of the discrepancy between the received ideology about what constitutes public health and the current practice and institutionalisation of public health has led to a movement to create a 'new public health' that is concerned with both the public and with health. (p2)

They suggested that the new public health had a divided legacy - the public health ideology or mythology of the nineteenth century fused with the rapid changes of the two decades from 1970. They were of the view that the movement crystallised in the Ottawa Charter.

1990s - The Eclipse of Health Education, the Review of the Public Health Function and the Consolidation of the New Public Health

Health Promotion

Although the early health promotion documents appeared during the 1980s it was not until this decade that the widespread adoption of the terminology and ideas of health promotion became fully established. The early 1990s were also a period of terminological confusion. Some professional groups rebadged health education as health promotion but continued to offer health education as before, while in the specialist services there was a change to become health promotion departments with varying degrees of emphasis on the full range of activities described in the Ottawa Charter. The activities of the Society for Health Promotion Specialists and the development of occupational standards contributed to the clarification of the nature of health promotion tasks and skills.

The National Occupational Standards documents (Care Sector Consortium, 1997) provided insights into values in health promotion and other areas of health and social care. The programme of work to develop standards took place between 1995 and 1997 and addressed three groups of workers - one of which was health promotion. An inclusive approach was taken to defining health promoters:

- *health promoters* - those with a specialist role, those for whom it is a part of their role - such as doctors, nurses, health visitors, professions allied to medicine etc - and those who work in public health, environmental health and occupational health.

The occupational standards were linked to other developments and trends at the time:

1. An increase in joint working - both on a multi-disciplinary and multi-agency basis - to optimise health and social well being.
2. The promotion of health as 'enabling individuals and communities to increase their control over the determinants of health and thereby improve their health'.
3. Concerns over the efficacy of traditional western medicine with a corresponding increase in the use of complementary and sustainable approaches to promote health and social well-being.
4. An increased interest in evaluating the effectiveness of interventions and using the evidence to guide practice.
5. The need for those who work in the sector to evaluate and review their practice constantly and to develop new knowledge and understanding and related changes in education, training and development.
6. A focus on improving the quality provided to people and hence placing work with individuals, families, groups, communities and organisations at the heart of standards.
7. The national focus of the development work across all four of the UK countries as people should have the right to expect the same quality of services wherever they live. (p9)

Occupational standards were linked to professional ones and comments were made about values. Professional standards were described as providing broad principles designed to guide how an individual practitioner acts. National occupational standards would nearly always be consistent with, and supportive of professional standards. Professional standards from a number of bodies were analysed to identify the values

and principles on which the national standards should be based and the values identified were - *respect for*:

- the human condition and its complexity;
- our essential humanity;
- the wealth of human experience;
- the holistic nature of health and social well being;
- diversity. (p11)

Principles of good practice which had informed the standards for professional activity were also laid out. The first six are particularly relevant to the focus of this report:

1. Balancing people's rights with their responsibilities to others and to wider society and challenging those who affect the rights of others.
2. Promoting the values of equality and diversity, acknowledging the personal beliefs and preferences of others and promoting anti-discriminatory practice.
3. Maintaining the confidentiality of information provided that this does not place others at risk.
4. Recognising the effect of the wider social, political and economic context on health and social well-being and on people's development.
5. Enabling people to develop to their own potential, to be as autonomous and self managing as possible and to have a voice and to be heard.
6. Recognising and promoting health and social well-being as a positive concept.
7. Balancing the needs of people who use services with the resources available and exercising financial probity.
8. Developing and maintaining effective relationships with people and maintaining the integrity of these relationships through setting appropriate role boundaries.
9. Developing oneself and one's own practice to improve the quality of services offered.
10. Working within statutory and organisational frameworks. (p12)

Three broad areas of occupational standards were identified: foundations of professional activity, context of professional activity and range of professional activities. Issues of principles and values were addressed in various ways. For example in the foundations of professional activity they form the specific focus of Key Role 0 which is concerned with the principles and values on which practice is based:

Promote and value the rights, responsibilities and diversity of people'.

Key role 1 was:

To develop own and others' knowledge and practice to optimise the health and social well being of people. (p18)

It included reflection on, and evaluation of one's own *values*, priorities, interests and effectiveness. The necessity for this focus was said to be because of the existence of areas of practice with potentially conflicting values and priorities. The principles and values included in the standards bore similarity to those identified in the wider health promotion literature.

This decade was also significant for the health education component of health promotion. There was growing recourse to the description 'traditional health education' which was associated with a particular set of values associated with a medical model and often commented on dismissively. There was rather little reference to the fact that there was a 'traditional' health education informed by a differing set of

ideas - education and empowerment. The concepts and processes associated with the empowerment model of health education tended to become subsumed within the core concepts of health promotion and dissociated from the concept of health education. At one level this may not matter but what seems to have been happening is a reluctance to acknowledge that the development of individual and community empowerment does involve a whole range of educational activities. Whether or not these are still seen to be part of contemporary health promotion is one question posed by this particular project.

Public Health

The decade was notable for the institution of the first Minister for Public Health and for a series of documents focused on public health policy and action. The Health of the Nation (DoH, 1992) as the first coherent strategy of its kind was initially welcomed. It managed to acknowledge the range of determinants of health but dissociated itself from a responsibility to address root causes and in no way addressed health inequalities. There was a recognition that other sectors in addition to the health sector had contributions to make to public health, and some emphasis was given to the development of health promoting settings. The targets set were disappointing in that they were narrowly focused on the prevention of key diseases. The evaluation of The Health of the Nation (Hunter, 1999) concluded that although it had played an important symbolic role in putting health on the agenda, it failed over the 5 years before the change of Government to realise its potential. A key problem identified was the failure to achieve cross sectoral ownership - especially by local authorities. A survey of local authorities views on the Health of the Nation (Moran, 1996) identified four main issues:

1. The health strategy was too narrowly focused on disease models and failed to promote a positive view of health;
2. Health of the Nation neglected key socio-economic and environmental determinants of health;
3. The strategy failed to appreciate the potential local authority contributions to a national health strategy;
4. No new resources were forthcoming to progress the strategy.

General concerns were noted by Hunter (1999) about the:

...preoccupation of Health of the Nation with the NHS and DoH which seemed to confuse public health with the NHS, and while the latter had a key contribution to make to public health, to give it the lead role seemed curious to many. (p15)

The most significant documents of the decade were the Green Paper, Our Healthier Nation (DoH, 1998b) - the consultative document which built on The Health of the Nation (DoH, 1992), and the White Paper, Saving Lives: Our Healthier Nation (DoH, 1999). The particularly interesting feature of the Green Paper was the proposed change in the relationship between the individual and the state. Described as 'the third way - it proposed a 'new contract' between government, local communities and the individual. The document redressed the shortcomings of the Health of the Nation in giving full recognition to the socio-economic and environmental determinants of health and brought action on inequalities firmly on to the agenda proposing the idea of Health Action Zones as initiatives to focus on inequalities. The report of the Independent Inquiry into Inequalities in Health (Acheson Report, 1998), provided a wealth of

evidence and recommendations which could inform this renewed focus on health inequalities. The focus on settings within the earlier DoH policy was continued into Our Healthier Nation. As with the earlier document what were essentially mortality/morbidity targets were presented - partly revised in the White Paper - but no specific targets in relation to health inequalities. These did, however, emerge independently from the Independent Inquiry into Inequalities in Health. As far as public health was concerned the coordination of policy across government departments was a role for the new Minister of Public Health and a cross departmental Cabinet Committee was set up. The Health Education Authority was also replaced by the Health Development Agency. Saving Lives also made recommendations in relation to the people who were to have an enhanced public health role and training requirements for this role were described. Of particular importance was the creation of Public Health Specialists who did not necessarily need to have had medical training. As widely noted the attention to the specialist health promoter role was conspicuous by its absence. An open letter from SHEPS to the Secretary of Health in 1998 explained the specialist health promotion role and pointed out that it was one of the few whole time resources dedicated to the broad public health function and had a key role to play in health improvement programmes.

The public health function

Against the background of the public health policies in the 1990s there were initiatives to examine the development of the public health function as a whole, in contrast to public health medicine. The Kings Fund had researched the multidisciplinary contribution to public health in advance of the Green and White papers. The aim of its project was to provide the NHS with knowledge on good practice in multidisciplinary public health and to help to further good practice. Although they had a working definition of multidisciplinary public health from the NHS Executive they came up against a variety of definitions in practice. The project selected eleven case study sites. Different forms of multidisciplinary working were found and various benefits were drawn from the case studies:

- it brings a wider range of perspectives and possible solutions to complex problems;
- change is more likely because of wider ownership of problems and solutions;
- a multidisciplinary approach brings in user and community perspectives and is necessary for this to occur;
- it opens the health authority's purchasing to a wider range of professional groups;
- it leads to better value for money;
- it can facilitate non health care interventions for health gain;
- it can facilitate a considered response to political imperatives.

The research project pursued the issue of whether the public health function could be led by a non medical professional and identified a range of positive and negative views. The perceptions of differential status and power between public health workers were identified as a barrier to multidisciplinary working. (Levenson, Joule and Russell, 1999)

The Interim Report of the Chief Medical Officer (DoH, 1998) reported on strengthening the public health function in order to deliver the public health agenda described in Government policy. It introduced three categories of public health workers:

- Professionals, including managers in the NHS, local authorities and elsewhere, who would benefit from a better understanding of public health.
- A smaller group of hands on public health practitioners who spend a substantial part of their working time furthering health by working with communities and groups, including public health nurses, health promotion specialists, health visitors, community development workers and environmental health officers.
- A still smaller group of public health specialists from a variety of professional backgrounds, including social sciences, statistics, environmental health, nursing, health promotion and dental public health. Their knowledge and skills and experience include the ability to manage strategic change in organisations, to work in management teams and leadership of public health initiatives as well as more technical areas.

Evidence based practice

A further feature of the 1990s scene was the attention to matters of effectiveness and pressures to implement evidence based practice. In many contexts the evidence demanded and the methods by which it should be acquired reflected values with which many people in health promotion and the new public health were unhappy. In some cases there was wholehearted rejection of these values and strong assertions of alternatives but in situations of practice a pragmatic consensus between the two positions was developed. For a crude distinction between the two positions see Box 2.1.

BOX 2.1: VALUES

Evidence based medicine	Alternative view
Positivist inquiry	Non positivist
Quantitative	Qualitative
Objectivity	Subjectivity
Priority to RCTs	Opposition to RCTs
Professionally driven inquiry	Participative and collaborative inquiry
Value free	Value laden
Theory testing	Theory building
Cost effectiveness	Meeting identified needs
Modern	Post modern

Stevens and Milne (1997) have discussed the relevance of the evidence based health movement for public health although their analysis is rather more focused on public health medicine than it is on health promotion and the new public health. They pointed out that the Acheson definition of public health (DoH, 1988), if taken as its mission statement, cannot be achieved without a focus on what is, or is not, effective. They also reminded us that it was within public health that some of the early reflections on effectiveness occurred (McKeown and Lowe, 1974) and that such questions have been part of the public health tradition. Resources for public health are bounded and considerations of effectiveness have to be one - but not the only - criterion in making decisions about use of resources. The organisational location of public health medicine also meant that issues of evidence and effectiveness were everyday concerns in the context of the internal market and the pressure to commission effective activities. Finally they suggested that effectiveness considerations may have an intrinsic interest.

They are a way of going beyond the balancing of costs towards a focus on ways for securing the greatest health gains for the population.

2000 Onwards - The Demise of Health Promotion and Unity Under the Banner of Public Health?

This new decade in the UK is characterised, in some contexts, by concern with the appropriateness of health promotion as a useful term around which to organise activities and the nature of the health promotion/public health relationship. More generally the focus is on clarifying the nature of the public health function and identifying the relative contributions of different groups to promoting the health of the public. As far as health promotion is concerned the implications of the Chief Medical Officer's Report (DoH, 1998) for this workforce were analysed in 2000 by SHEPS (Learmonth and MacDonald, 2000). They mapped a number of existing public health/health promotion workers against the three categories of workers identified in the Report and concluded that:

- The three CMO categories are not watertight and it was better to think of a spectrum of expertise rather than a restrictive categorisation of different sorts of experts;
- It is not job title that dictates position along the spectrum but the actual nature of work undertaken;
- Hence the analysis should be more about what workers do, not what they are called - more about specialisms than specialists;
- It is not that different specialisms need totally different sets of competencies but that all specialisms with a public health/ health promotion focus or aspect to their work need a range of skills which are common to all, except in terms of the level at which they are developed, assimilated or utilised.

The position paper proposed that the debate about specialists in public health medicine had diverted attention from key features of the public health/health promotion situation. The issues they identified will be discussed in the final section of the report.

Summary

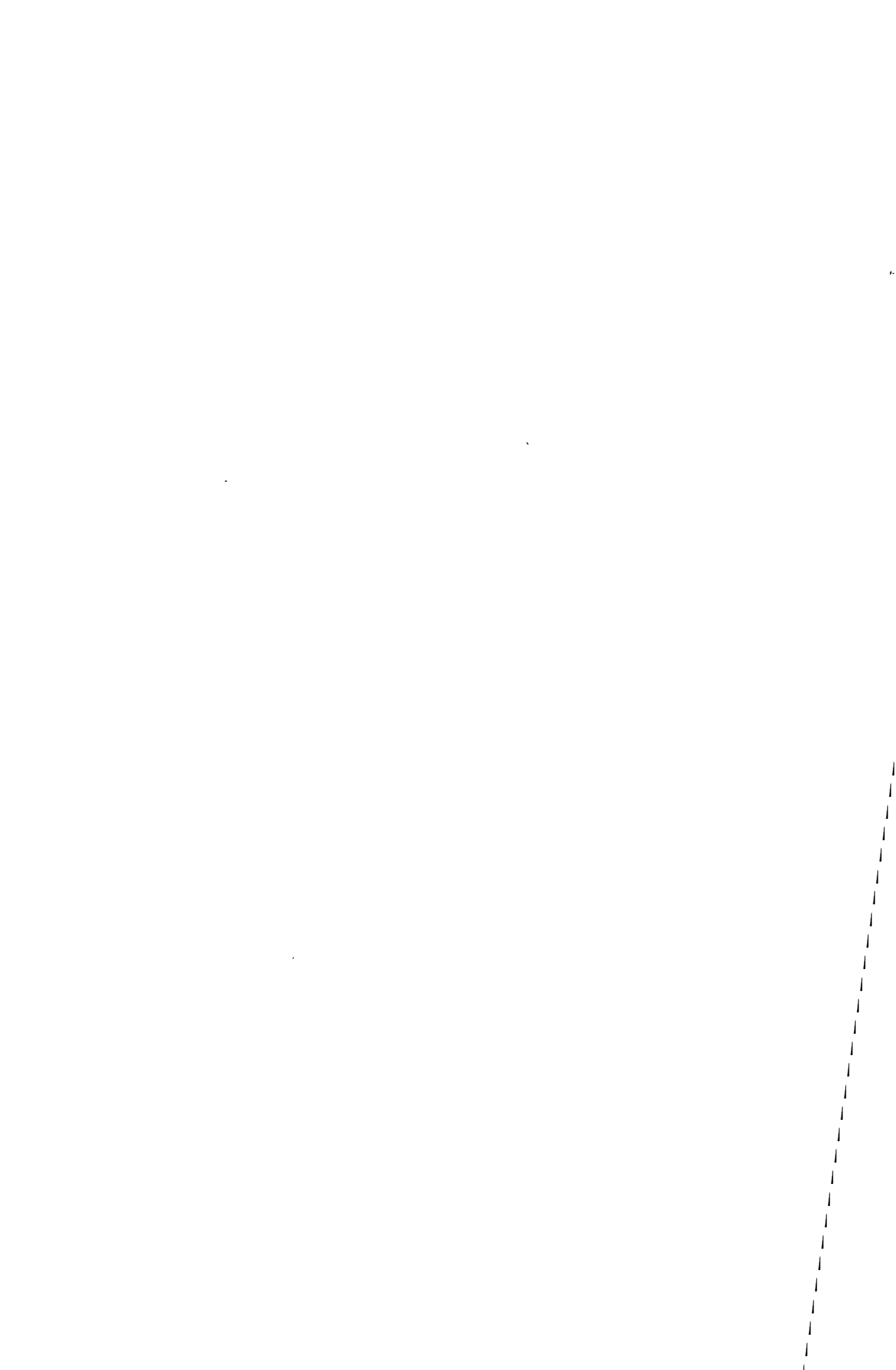
This section set out to provide some historical background on the developments of public health, health education and health promotion. Many of the issues surrounding the nature of these activities and their underpinning values have long been debated. We have examined this history with reference to the separate traditions of health education/promotion and public health. While these are closely related they have also had distinctive developments associated with different occupational groups and contexts of practice. In the context of the New Public Health these traditions have come much closer together.

Earlier in the chapter we identified some themes which can be traced through the history of public health prior to the 1970s and we have continued to make reference to these in discussion of the subsequent decades. Key points to reiterate at this point are as follows.

- There is a long history of recognising the multiple, and interacting, determinants of health operating at micro, meso and macro levels and of specific recognition of the key contributory role of social disadvantage and poverty. The emphases in practice

on specific determinants and on level of action have varied over time, and in differing contexts, and have been influenced by differing ideologies. A continuing tension has existed between a medical and a social model of health.

- Specifically the contribution of public health medicine to developing the health of the public has been a particular issue for debate. At some points there has been a predominant view that public health = public health medicine but this has been strongly called into question in the emergence of New Public Health. The recognition that differing sectors and occupational groups have contributions to make to achieving public health and that working intersectorally is the most effective approach to action has now achieved broad acceptance.
- There have been competing views on the relative contributions to be made by individuals and states to the achievement of public health.
- While there has been unbroken attention to the prevention of disease as a component of public health actions this has been complemented by recognition of the promotion of positive health. This attention to positive health has traditionally been stronger in the health education and promotion tradition than in public health – if this is understood as public health medicine.
- Concerns to address inequities in social conditions, and specifically inequities in health have been present within public health, if examined over a long period. Such concerns were relatively obscured in the period leading up to the emergence of New Public Health and the production, in the UK, of health policy documents.
- In that health education, to a certain extent, enjoyed a tradition distinct from public health, the existence of a ‘radical’ approach oriented towards action on the underlying determinants of health should also be noted during the period which preceded the strong emergence of health promotion. Individual values such as autonomy, empowerment and responsibility for health were also embedded in approaches to health education practice in the period before the emergence of health promotion in the 1980s.



SECTION THREE: WHO PUBLICATIONS STATEMENTS AND DECLARATIONS

Health promotion emerged as a new concept and discipline in the 1980s in response to:

- acknowledgement of the holistic nature of health;
- appreciation of the limitations of high tech medicine in improving the health status of populations;
- recognition of the broad determinants of health and particularly the impact of the environmental factors;
- criticism of attempts to manipulate behaviour through educational approaches which overlooked environmental constraints on behaviour and the absence of free choice - generally associated with the notion of victim-blaming (Ryan, 1976; Rodmell and Watt, 1986).

The subsequent development of health promotion was accompanied by considerable debate about its nature and purpose. Much of that debate was reflected in – and indeed subsequently informed by – major WHO documents and international conferences on health promotion. It is pertinent, therefore, to revisit some of these documents to identify the key issues to emerge, which are indicative of the key values of health promotion. Furthermore, the centrality of the content of these documents to the training of health promotion professionals has assimilated these values into the doctrine of health promotion.

WHO Documents

The constitution of the World Health Organisation (WHO, 1946) adopted a holistic conceptualisation of health including physical, mental and social components and emphasising positive well being as well as the absence of disease or infirmity. The Alma Ata Declaration of Primary Health Care (WHO, 1978) reaffirmed this view. Taking forward the Health for All movement, launched at the 30th World Health Assembly Health in 1977, it acknowledged health as a ‘fundamental human right’ and noted the unacceptability of inequality in health status between and within countries. It recognised health as a major social goal and one that requires action by a number of different sectors, as well as the health sector. Furthermore, it identified the reciprocal relationship between health and social development - on the one hand economic and social development being necessary for achieving health and narrowing the health gap and on the other, health contributing to economic and social development.

Alma Ata, in addition to recognising health as a right in itself, also noted that people have the *‘right and duty to participate individually and collectively in the planning and implementation of their own health care’* (para 4). It saw appropriate education as a vehicle for developing the capacity of communities to participate. Primary health care was identified as the key to attaining Health for All targets. It should be noted that in this context primary health care, as distinct from primary medical care, includes all the services that might contribute to prevention such as education, housing and agriculture in addition to health.

A number of strands start to emerge from this document which permeate subsequent

WHO documents:

- a holistic view of health;
- health as a worthwhile goal in itself;
- health as instrumental in achieving a socially and economically productive life;
- health as a right (and ipso facto the unacceptability of inequity in health);
- responsibilities for health -
 - the duty of governments to create the conditions to support health and enable community participation; and,
 - the duty of individuals to participate individually and collectively;
- involvement of a range of different sectors in promoting health;
- the need for community and individual participation.

In January 1984 WHO set up a new programme on 'Health Promotion'. A discussion document on health promotion (WHO, 1984) saw it as a '*unifying concept*' bringing together '*those who recognise the need for change in the ways and conditions of living, in order to promote health*'. It identified social responsibility and personal choice as key elements. It also saw the '*inextricable link between people and their environment*' as the basis for a socio-ecological approach to health.

In line with this socio-ecological thinking, health was defined 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.

Similarly health promotion was defined as:

the process of enabling people to increase control over, and to improve, their health.

Basic resources for health were identified as including:

- income, shelter and food;

but also:

- information and lifeskills;
- supportive environments providing opportunities for making healthy choices;
- health enhancing conditions in the economic, physical, social and cultural environments.

The document outlined the key principles of health promotion as:

- the involvement of the whole population in the context of their everyday life and enabling people to take control of and have responsibility for their health;
- tackling the determinants of health i.e. an upstream approach, which demands the cooperative efforts of a number of different sectors at all levels from national to local;
- utilising a range of different but complementary methods and approaches from legislation and fiscal measure through organisational change and community development to education and communication;
- effective public participation which may require the development of individual and community capacity;

- the role of health professionals in education and advocacy for health.

Health promotion was seen as demanding an integrated approach. Its primary focus of improving access to health by tackling health inequalities and increasing opportunities for health would be best achieved through:

- development of an environment conducive to health;
- strengthening of social networks and social support;
- promoting positive health behaviour and appropriate coping strategies;
- increasing knowledge and disseminating information.

A number of potential dilemmas were identified. These included the risk of overemphasis on dictating how individuals should behave – an ideological position that has been referred to as *'healthism'* and which is in conflict with the commitment to voluntarism which underpins the rest of the document. The problem of focusing on individual behaviour rather than the social and economic determinants of behaviour was identified, together with the possibility of increasing inequality by providing information without addressing the capacity for control. Finally, in line with the commitment to an integrated approach to health promotion, the risk of appropriation by one particular professional group and the exclusion of other professional groups and lay people was also recognised.

The Ottawa Charter developed at the First International Conference on Health Promotion (WHO, 1986) was a response to *'growing expectation for a new public health movement'*. It built on many of the key principles set out in the discussion document referred to above (WHO, 1984) and reiterated the definitions of health and health promotion. It expanded the list of pre-requisites for health to include peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity and recognised health and its maintenance as a major social investment.

Three broad strategies for working to promote health were identified:

- advocacy – to ensure the creation of conditions favourable to health;
- enabling – through creating a supportive environment but also giving people the information and skills they need to make healthy choices;
- mediation – between different groups to ensure the pursuit of health.

The Ottawa Charter listed five main action areas, which have consistently been referred to in subsequent documents and have provided a conceptual framework for health promotion throughout the world:

- build healthy public policy;
- create supportive environments;
- strengthen community action;
- develop personal skills;
- reorient health services.

The statement that health is created where people *'learn, work, play and love'* signalled the emergence of the settings approach. It required an inter-sectoral response and also the involvement of individuals and communities. The role of health services

was seen as reoriented away from curative services towards prevention and sharing power both with other sectors and with lay people.

While individuals were seen as having responsibility for their own health this responsibility should also include concern for others - explicitly moving beyond an individualistic towards a collective concern for health. Furthermore, this was contextualised within an over-riding societal responsibility to create the conditions which enable people to make healthy choices and have control over their health. Caring, holism and ecology were seen as essential issues.

This multi-level responsibility for health is encapsulated by:

- caring for oneself and others;
- being able to take decisions and have control;
- ensuring that society creates the conditions that allow all members to attain health.

The Second International Conference on Health Promotion in Adelaide (WHO, 1988) affirmed health as a fundamental human right and also as a sound social investment. It focused on healthy public policy as a means of creating supportive environments which would be health enhancing in themselves, and would also make healthier choices both possible and easier. It recognised the central importance of addressing the needs of underprivileged and disadvantaged groups in order to close the health gap within countries. It also placed responsibility on developed countries to ensure that their own policies have a positive impact on developing countries. Public accountability was seen as *'an essential nutrient for the growth of healthy public policy'* emphasising the importance of community action and clear communication between governments and communities. The need for alliances and an integrated approach across the different sectors and levels of government was recognised. Overall healthy public policy was seen to be:

characterised by an explicit concern for health and equity in all areas of policy and an accountability for health impact.

The need for strong advocates to put health on the agenda of policy makers was identified together with the need to develop the advocacy, enabling and mediation skills of those responding to the 'new public health' challenges.

The Sundsvall Conference (WHO, 1991) addressed the issue of supportive environments for health. It identified 2 key principles which should inform the Health For All movement – notably equity and the interdependence of all living things. Both physical and social aspects of the environment were seen to impact on health and four key aspects were highlighted –the social dimension; the political dimension; the economic dimension; and, the need to use women's skills and knowledge. There was recognition of the influence of social norms and culture on behaviour and the challenge to traditional values stemming from changing lifestyles with consequent social isolation and lack of a sense of coherence. Again the need for integrated and coordinated action across sectors and at all levels was recognised, but the capacity of communities to take local action was also emphasised. At the community level four *'public health action strategies'* were identified:

- strengthening advocacy;
- enabling communities through education and empowerment;

- building alliances;
- mediating between conflicting interests to ensure equitable access to supportive environments.

The key elements of a '*democratic health promotion approach*' were seen to be empowerment and community participation. There was also recognition of the importance of education as a basic human right in itself but also as a means of bringing about political, economic and social changes.

There was strong recognition of the global dimension and a call to establish mechanisms for international accountability. Health, environment and human development were seen to be inextricably linked.

The Jakarta Declaration on Leading Health Promotion into the 21st Century (WHO, 1997) was developed at the Fourth International Conference on Health Promotion. It endorsed the commitment to health as a right and as essential for social and economic development and reiterated earlier definitions of health promotion. It envisaged the '*ultimate goal*' of health promotion as increasing health expectancy through action directed at the determinants of health in order to:

- create the greatest health gain;
- contribute to reduction in inequities;
- further human rights;
- build social capital.

In identifying the pre-requisites for health there was greater emphasis on human rights, social security and the empowerment of women than in previous documents. However, overall, poverty was seen to be the greatest threat. New challenges to health included demographic changes such as an ageing population and urbanisation; lifestyle changes such as more sedentary behaviour and increased drug use; civil, and domestic violence; and re-emerging infectious disease. Globalisation and transnational factors were also seen to impact on health.

The Jakarta Declaration stated that there is '*clear evidence*' that:

- comprehensive approaches to health development are the most effective;
- particular settings offer practical opportunities for the implementation of comprehensive strategies;
- participation is essential to sustain efforts;
- health learning fosters participation.

It identified the current challenge as releasing the potential for health promotion in different sectors and at all levels of society. Breaking down barriers between sectors and creating partnerships for health were seen as essential. While there was emphasis on involving communities and families this document also focused on the issue of investment and public/ private partnerships. Indeed this was the first of the international conferences to directly involve the private sector. Overall the priorities for the twenty first century were:

1. Promote social responsibility for health.
2. Increase investments for health development.

3. Consolidate and expand partnerships for health.
4. Increase community capacity and empower the individual.
5. Secure an infrastructure for health promotion.

Much of the thinking of the Jakarta Declaration informed the first resolution on Health Promotion which was passed at the Fifty-First World Health Assembly in May 1998. In addition to the first four of the five priorities listed above, it also called on all member states to:

- Strengthen consideration of health requirements and promotion in all policies; and
- Adopt an evidence-based approach to health promotion policy and practice, using the full range of quantitative and qualitative methodologies.

As it moved into the twenty first century, WHO (1998) identified the following key values underpinning the Health for All movement:

- providing the highest attainable standard of health as a fundamental human right;
- strengthening the application of ethics to health policy, research and service provision;
- equity-orientated policies and strategies that emphasise solidarity;
- incorporating a gender perspective into health policies and strategies. (p,v)

The Fifth International Conference on Health Promotion held in Mexico in 2000 focused on 'Bridging the Equity Gap'. Unlike the previous international conferences, it included a Ministerial Programme and issued a Ministerial Statement signed by some 87 countries including the United Kingdom. (WHO, 2000a) The statement acknowledged that:

the promotion of health and social development is a central duty and responsibility of governments, that all sectors of society share' and concluded that 'health promotion must be a fundamental component of public policies and programmes in all countries in the pursuit of equity and health for all.

The statement also accepted the evidence that good health promotion strategies are effective. The commitment to action included positioning health promotion as a fundamental priority at international, national, regional and local levels; ensuring the active participation of all sectors; and, preparing country-wide plans of action.

A strong theme to emerge from the Mexico conference was the need to:

work with and through existing political systems and structures to ensure healthy public policy, adequate investment in health, and facilitation of an infra structure for health promotion. (WHO, 2000b p21)

This would require:

- democratic processes;
- social and political activism;
- a system of equity oriented health impact assessment;
- re-orientation of health services;
- improved interaction between politicians, policy-makers, researchers and practitioners;
- strengthening existing capacity for implementing health promotion strategies and supporting synergy between different levels (local, national and international).

A number of delegates to the Mexico Conference published an open letter to the WHO Director General expressing concern about some of the issues in her address to the conference (Mittelmark et al., 2001), particularly the narrow conceptualisation of health promotion. The implications of the content of the letter will be discussed more fully in Section 5, but it is worthwhile at this point identifying the key principles which emerge.

- Health promotion has a broad focus as encapsulated in the Ottawa Charter and goes beyond individual lifestyle change and risk factor reduction.
- Health promotion is qualitatively different from disease prevention notably through its emphasis on empowerment.
- A 'health promotion' approach obligates practitioners from whatever sector or background to:
 - *'encourage openness and participation;*
 - *strive for the empowerment and autonomy of others;*
 - *hold equity and justice as the highest of principles'*. (p3)

Themes/core values to emerge from the documents:

A comparison of the key terms included in the Health Promotion Glossaries produced in 1986 and 1998 (Nutbeam, 1986 and Nutbeam, 1998) provides an interesting insight into the change of emphasis over this 12 year period – see Table 3.1. In the latter document there would appear to be greater emphasis on evaluation and related issues such as goals, outcomes and indicators. Strategies are more explicitly addressed, notably empowerment for health; settings; supportive environment; intersectoral collaboration; partnership; mediation; and, sustainable development. There is concomitantly less emphasis on individual behaviour modification and mass media which perhaps signals the direction in which health promotion has evolved. New terms to emerge include health literacy, health development, investment for health, social responsibility for health and social capital.

The key concepts and issues which emerge from the WHO documents – many of which are defined in the glossaries – will be discussed more fully below in order to explore the fundamental values and principles underpinning them.

Health

Health is consistently conceptualised holistically and as including a positive well-being dimension. An instrumental view of health also emerges – health as the means to achieve a socially and economically productive life (WHO, 1986); health as a '*resource for everyday life*' (WHO, 1986). '*Good health is increasingly recognised as a pre-requisite if communities are to be enabled to fight against poverty*' (Brundtland, 2001 p96) The reciprocal relationship is noted at a later point in the same presentation '*poverty perpetuates ill health*' (p98).

There is also recognition of the limitations of high tech medicine in promoting health (Brundtland, 2001; Green, 1996) and the importance of a constellation of environmental influences ranging from macro economic and political factors through to

Table 3.1: Terms included in the Health Promotion Glossaries 1986 and 1998

Term	1986	1998		1986	1998
Basic Concepts					
Health	✓	✓	Healthy islands		✓
Health promotion	✓	✓	Healthy public policy		✓
Health education	✓	✓	Inter-sectoral policy	✓	
Health for All		✓	Infrastructure for health promotion		✓
Disease prevention	✓	✓	Intermediate health outcomes		✓
Primary health care	✓	✓	Intersectoral collaboration		✓
Public health		✓	Intervention programme	✓	
Lifestyle	✓	✓	Investment for health		✓
Action Research	✓		Lay care	✓	
Alliance		✓	Legislation	✓	
At risk group	✓		Life events	✓	
Behavioural modification	✓		Lifeskills	✓	✓
Community	✓	✓	Lifestyle conducive to health		✓
Community action for health		✓	Living conditions	✓	✓
Community development	✓		Mass campaign	✓	
Community involvement	✓		Mass media	✓	
Consciousness raising	✓		Mediation		✓
Consumer group	✓		Medicalization	✓	
Consumerism	✓		Network		✓
Coping	✓		New public health	✓	
Decision-making skills	✓		Occupational environment	✓	
Determinants of health		✓	Occupational health	✓	
Ecology of health	✓		Ottawa Charter		✓
Economic environment	✓		Partnership		✓
Empowerment for health		✓	Perceived health	✓	
Enabling		✓	Physical environment	✓	
Epidemiology	✓	✓	Positive health	✓	
Equity in health		✓	Pressure group	✓	
Fiscal policy	✓		Quality of life	✓	✓
Health advocacy/advocacy for health	✓	✓	Re-orienting health services		✓
Health behaviour	✓	✓	Risk behaviour	✓	✓
Health choice	✓		Risk factor	✓	✓
Health communication		✓	Self help	✓	✓
Health development		✓	Self help group	✓	
Health expectancy		✓	Self care	✓	
Health gain		✓	Self esteem	✓	
Health goal		✓	Self empowerment	✓	
Health indicator	✓	✓	Settings for health		✓
Healthism	✓		Social capital		✓
Health knowledge	✓		Social epidemiology	✓	
Health literacy		✓	Social inequality	✓	
Health outcomes		✓	Social movement	✓	
Health policy	✓	✓	Social networks	✓	✓
Health professional	✓		Social planning	✓	
Health promoting hospitals		✓	Social responsibility for health		✓
Health promoting schools		✓	Social support	✓	✓
Health promotion evaluation		✓	Stress	✓	
Health promotion outcomes		✓	Supportive environment for health		✓
Health-related behaviour	✓		Sustainable development		✓
Health sector		✓	Total environment	✓	
Health services	✓		Victim-blaming	✓	
Health status	✓	✓	Well-being	✓	
Health target		✓	Wellness	✓	
Healthy cities		✓			

the quality of the immediate physical and social environment. The corollary of this is the need for reorientation of health care and, as noted by Nutbeam (1998), the acceptance of responsibility across all sectors for the health impact of their activities.

Rights and Responsibilities

Health is recognised as a fundamental human right and ipso facto the responsibility of society to address the prerequisites of health and create conditions supportive of health including access to basic resources. Valuing health as a right necessarily leads to concern to tackle inequity.

Health is also viewed as a responsibility – societal; communal; and, individual. The issue of ‘social responsibility for health’ emerged strongly at Jakarta and was discussed as a theme at Mexico. Discussion documented in the Mexico conference report (WHO, 2000b) indicated that the term means different things to different people. For some it refers to governmental responsibility for narrowing the health gap and for creating the conditions for individuals to participate. Others use the term to describe corporate and private sector responsibility not to damage health and, further, to promote health. It is also applied to individuals in relation to taking responsibility for their own health and - particularly women - for family and community health. It is, however, more conventionally used in relation to the responsibility for policy and action and Nutbeam (1998 p20) defines it as:

Social responsibility for health is reflected by the actions of decision makers in both public and private sector to pursue policies and practices which promote and protect health. (WHO, 1997)

Once there is commitment to promote health, actually acting in ways which are socially responsible depends on being able to predict the effects on health – an area addressed by the developing field of health impact assessment.

Ziglio et al. (2000a) argue that if health is an essential personal and social resource, it requires investment. Health promotion can therefore be considered an investment strategy to ‘*maintain and create health equitably*’. Such investment should be ‘*integral to sustainable social, economic and human development policies*’. (p149)

Nutbeam (1998) defines investment for health as:

resources which are specifically dedicated to the production of health and health gain. They may be invested by public and private agencies as well as by people as individuals and groups. Investment for health strategies are based on knowledge about the determinants of health and seek to gain political commitment to healthy public policies. (p15)

There has been increasing emphasis on the role of investment for health in recent years and particularly subsequent to the Jakarta conference. This could be taken as signalling a shift in values towards health as instrumental to the achievement of other goals – notably economic development. (This thinking has also been evident in some UK documents - for example the justification for including Health Education in the school curriculum in Curriculum Guidance 5 (NCC, 1990) made reference to health as a resource for the creation of wealth.) Clearly health and economic development are inextricably linked. The key question in relation to values is what is the primary motivation - wealth to create health or health to create wealth? Authors such as Doyal

(1981) have been critical of the expropriation of health to serve the needs of capitalist economies. The Verona Initiative (WHO, 1999) was set up to develop the investment for health approach. It is premised on an explicit central concern for health i.e. promoting health through social and economic development.

Great harm can be done to health by misguided public policies or private investment alike. The Investment for Health approach offers practical measures to prevent this – by building social and economic strength together with health improvement in an equitable, empowering and sustainable way. (Ziglio et al., 2000b p4)

The Verona Initiative affirms its commitment to the key values of health promotion – human rights, justice, equity and social cohesion. It identifies its core principles as:

- focus on health;
- full public participation;
- genuine inter-sectoral working;
- equity;
- sustainability;
- a broad knowledge base.

Equity and Inequality

Deriving from the fundamental value of social justice, a central concern of the Health for All movement - and, indeed, health promotion - has been to reduce inequality in health both within and between countries. There is a vast literature on inequality, which is largely beyond the remit of this study. However the Acheson Report (1998) provides a detailed analysis in relation to the UK context. While some variation in health experience is unavoidable, much of this variation can be attributed to unequal opportunity – i.e. social inequality. The use of the term equity introduces greater precision. Whitehead (1990) makes the important distinction between inequality, which can simply apply to any variation and inequity:

The term 'inequity' has a moral and ethical dimension. It refers to differences, which are unnecessary and avoidable but, in addition, are also considered unfair and unjust. So, in order to describe a certain situation as inequitable, the cause has to be examined and judged to be unfair in the context of what is going on in the rest of society. (p5)

Nutbeam (1998) makes the point that:

Equity in health is not the same as equality in health status.

He also states,

Equity means fairness. Equity in health means that people's needs guide the distribution of opportunities for well-being. (p7)

Voluntarism, Empowerment and Control

A key principle of health promotion is the notion of voluntarism – i.e. individuals are encouraged to make free choices about their health and health related behaviour. This was aptly summarised in the North American Society of Public Health Educators Code of Ethics (SOPE, 1976) - ***change by choice not coercion.***

As already noted, enabling people to take control of their health is integral to the definition of health promotion. Commitment to voluntarism would therefore confer a

responsibility to ensure that individuals have the power to make free choice. The capacity to make such free choices is in part the product of a whole range of personal capabilities including personal autonomy and the process of developing these is referred to as self-empowerment. Nutbeam (1986) defines self empowerment as:

the achievement of personal autonomy through the development of and use of life skills for health.

Self empowerment is a process designed to restore decision-making capabilities and to equip individuals with a belief in their autonomy, together with the skills necessary to enable them to decide what to do about their own health, their family's health and the health of the community. (p124)

However, environmental circumstances may act as a barrier to free choice. Commitment to voluntarism would therefore include the responsibility to ensure that environmental conditions are supportive of free choice. This might involve advocacy on behalf of those less powerful. Alternatively – and more consistent with general principles of enabling and empowerment – it could entail building individual and community capacity to take action to tackle environmental constraints. Nutbeam (1998) defines enabling as:

*taking action in **partnership** with individuals or groups to empower them, through the mobilisation of human and material resources, to promote and protect their health. (p7)*

Empowerment has become the sine qua non of health promotion. Nutbeam (1998) defines it as:

a process through which people gain greater control over decisions and actions affecting their health. (p6)

He also makes the distinction between individual or self empowerment (referred to above) and community empowerment:

individuals acting collectively to gain greater influence and control over the determinants of health and the quality of life in their community and is an important goal in community action for health. (p6)

It should be noted that while there is commitment to freedom of choice this, in accordance with democratic principles, is clearly within the context of a sense of responsibility for fellow human beings.

Health Education

Although the limitation of focusing on knowledge as a means of influencing behaviour is well recognised it is worth re-iterating strongly that knowledge still remains a pre-requisite for health. Brundtland (2001) sums this up as:

knowledge is necessary, but not sufficient. (p96)

Furthermore education is frequently simply equated with the development of knowledge, with little acknowledgement of its contribution to the development of skills, values and motivations. However there is recognition of this wider remit within the WHO documents discussed above. Critics of health education often focus on environmental constraints on health-related behaviour and indeed health. As will be apparent from the discussion above the issue of creating supportive environments has been a central concern of health promotion. What has often been overlooked is the contribution of education to this endeavour. Sundsvall (WHO, 1991), in particular,

recognised the importance of education in achieving social and political change. Tones and Tilford (2001) have argued for an expanded view of education which, in line with Freirian thinking and the concept of emancipatory education, includes its role in consciousness raising and the development of the sense of community, motivation and skills needed to take action to address health concerns. Tones also identifies a further role for education in professional education and advocacy. Education can therefore have a dual function – on the one hand developing the personal resources needed to make healthy choices and on the other developing the capacity for activism to tackle environmental problems either directly or through the development of healthy public policy.

Health education, as conceptualised above and as defined in the 1986 Glossary (Nutbeam, 1986) includes both social mobilisation and advocacy. More recently Nutbeam (1998) has taken a narrower view of education, controversially subsuming these areas which create pressure for healthy public policy and supportive environments within health promotion. Health education is defined as comprising:

...consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge, and developing lifeskills which are conducive to individual and community health. (p4)

Health literacy, a relatively new concept, is further defined as representing:

the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health. (p10)

Health literacy includes the capacity to take action to improve both individual and community health and is in itself integral to empowerment.

Definition of Health Promotion

Tannahill's early definition of health promotion describes three overlapping sets of activity – notably health education, prevention and health protection. Brundtland (2001) states that:

promoting health means reducing risks to health and modifying behaviour that affects it. (p97)

Nakajima (1991) refers to health promotion as health activism - through social and political processes. There are numerous references to health promotion as action and often in the context of public health. Mittelmark et al. (2001) refer to health promotion as a core function of public health. Health promotion is fundamentally about action – but more importantly about enabling people to take action to improve their health. It, therefore, like health education, has a double focus – one in addressing the conditions in which people live to ensure that they both contribute to health and are conducive to participation and the second in developing the capacity of individuals and communities to make healthy choices. Nutbeam (1998) sees health promotion as '*a comprehensive social and political process*' (p1) which includes actions designed to develop individual capability and also action designed to make the social, environmental and economic conditions more conducive to health. Health promotion recognises that:

all actions to promote health occur within a social context'(WHO 2000b).

Kickbusch (1986) emphasises the need for participation and the involvement of different sectors.

It opens up the field of health to become an inclusive social, rather than an exclusive professional activity.

and

Health promotion strategies need to be integrated, intersectoral and participatory. (p1)

A characteristic feature of health promotion had been its consistent allegiance to the five action areas set out in the Ottawa Charter. The Jakarta Declaration confirmed this commitment and emphasised that comprehensive approaches which use a combination of these strategies are more effective than single-track approaches. Over the last 25 years the Ottawa Charter has become the mantra of health promotion. Brundtland (2001b) comments that:

the Ottawa Charter provided inspiration and ideas for many in public health.

Kickbusch (2001) quotes Lester Breslow who refers to the Ottawa approach as '*the third great public health revolution*'. This draws attention to the lack of a precise distinction between health promotion and public health within the WHO documents discussed here. Furthermore the terms are at times used almost interchangeably with perhaps greater emphasis on public health as a 'movement' or goal and health promotion as action to achieve the goal. McQueen (2000) notes:

the challenge for health promotion [has been] to define its niche in relation to public health. (p96)

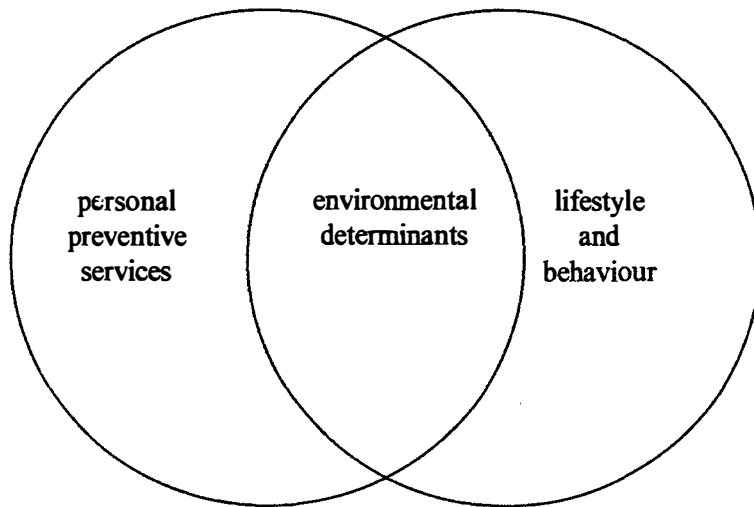
He raises the question if epidemiology had always been seen as the '*science*' of public health, was health promotion the '*practice*' of public health?

Nutbeam (1998) draws on the Acheson Report (1988) to define public health as:

the science and art of promoting health, preventing disease, and prolonging life through the organised efforts of society. (p3)

From this perspective, public health would therefore encompass the influence of the total environment on health. It would also include personal preventive health services (Nutbeam, 1986) – a point of distinction from health promotion. The emergence of the 'new' public health signalled a greater emphasis on living conditions and lifestyle as determinants of health and the need to create supportive environments for health. Ecological understanding of health is common to both health promotion and the new public health. Clearly there is considerable overlap between health promotion and the new public health in both spheres of interest and areas of activity - as summarised in Figure 3.1.

Figure 3.1: Health promotion and public health



public health ___ new public health ___ health promotion ___ health education

Rather than the nature of the activity itself being central to definitions of health promotion, some would argue that the distinctive feature is the ideology and principles underpinning health promotion activity and its commitment to core values. Tones (1989), for example, has described health promotion as the militant wing of public health.

Other writers focus on health promotion as a process, but again the nature of the process is indicative of an underlying value position.

health promotion is about social processes for health, its essence lies in empowerment. (Kickbusch, 2001)

The much quoted Ottawa Charter definition of health promotion is both process and outcome orientated. It is this definition that the WHO Department of Noncommunicable Disease Prevention and Health Promotion has selected as its response to 'What is health promotion?' on its website's list of frequently asked questions.

i.e. 'Health promotion is the process of enabling people to increase control over, and to improve their health.' (<http://www.who.int/hpr/nphfaqs.htm> [accessed 3/11/01])

This and other definitions included on the website are derived from The Health Promotion Glossary (WHO, 1998). Taking the notion of process further, WHO (2000b p19) states:

health promotion is an inherently political process as it is essentially concerned with individual and community empowerment. Health promotion often necessitates actions which require political processes in the form of resource allocation, legislation and regulation. (WHO, 2000b p19)

Health promotion is clearly not about process per se but about particular processes consistent with the ideology and values of health promotion. Sindall (2001) proposes, for example, that including the principles and approaches of health promotion in chronic disease care would place greater emphasis on:

- patient empowerment;
- development of health literacy by patients, families and communities;
- holistic care;
- development of systems to support this approach.

McDonald and Mussi (1998) identify ‘the distinctive voice of the health promotion profession as one that combines’:

- theory of the problem – a social and economic analysis of health and its determinants;
- principles of the solution – commitment to a clear set of principles;
- integration of the response – bridging the boundary between strategy development and hands-on implementation of strategy.

Applying this framework to the conceptualisation of health promotion emerging from the foregoing discussion of the various WHO documents:

- the theory of the problem – an ‘upstream approach’; a socio-ecological analysis of the determinants of health;
- principles of the solution – empowerment; participation; intersectoral approach; comprehensive approach;
- integration of response – working at all levels and across all sectors.

Summary

The core values which emerge from the documents include:

- commitment to health as a fundamental human right;
- responsibility to promote health;
- equity;
- a holistic view of health including well-being;
- an ‘upstream’ view incorporating social, environmental and personal influences – based on a broad view of the determinants of health;
- empowerment;
- participation;
- working in partnership with individuals, communities and organisations.



SECTION FOUR: CONTRIBUTIONS FROM KEY INFORMANTS

Introduction

A key element in the programme of work was to invite contributions from key informants – health promotion specialists and health promotion/public health lecturers. Initially contact was made by post with the intention of further telephone or face to face discussion where necessary. The aims were:

- to identify the ways that health promotion and public health are defined;
- to elicit the values associated with health promotion and with public health and identify respondents' perceptions of consensus and conflict between values for the two activities;
- to seek perceptions of any barriers to practicing in accordance with core values.

Method

A short set of open ended questions was sent out to the named managers in all health promotion/health development units in England and to 39 academic health promotion and public health lecturers listed on the regularly updated database used for distributing the LMU Centre for Health Promotion Research newsletter plus others in these roles who write regularly on health promotion and public health. Questions were deliberately broad and open ended to avoid constraining responses and imposing categories. Similarly no restriction was placed on the length of responses. It was our intention to enable respondents to articulate their conceptualisations in their own terms. Participants were invited to respond by paper or by electronic means. Letters were sent out in the first week of August with requests for return by early September and a deadline of September 15th, 2001.

The questions posed were:

1. How do you define health promotion?
2. What do you consider to be the core values of health promotion?
3. Would you say that there is consensus around the core values identified? If you feel that there are different value positions could you describe and locate these?
4. What have been the key influences on the development of core values in health promotion?
5. Are there any barriers to acting in line with these core values when undertaking professional activities in health promotion?
6. How do you define public health?
7. What do you consider to be the core values of public health?
8. Would you say there is a consensus about the core values that you have identified for public health? If you feel that there are different value positions could you describe and locate these?
9. What have been the key influences on the development of core values in public health?
10. Are there any barriers in acting in line with these core values when undertaking professional activities in public health?
11. Could you identify those values which you feel are common to health promotion and public health?

12. Are there any conflicting values - if so, which?
13. Are you aware of any current debates, either in your own field or more generally, about health promotion/public health and the relationship between them - if so please summarise and indicate your position?
14. Are there any other observations you would like to offer on values in health promotion and public health?

The questions were more challenging than would normally be included in a postal study. For this reason a high response rate was not expected. Essentially the exercise was designed to offer the opportunity for others interested in public health and health promotion to contribute their views about values.

The analysis of the postal responses and completion of the literature based sections 1-3 of the report allowed the final synoptic section to be drafted. Sections 4 and 5 were circulated to respondents for validation. No substantial issues were raised.

Analysis

All the written responses to each question were brought together and analysed qualitatively in order to identify common themes and also differences. In the presentation of results there is also some limited use of frequency counts where this seems useful. While the responses for each question have been summarised we have also attempted to provide a flavour of the diversity of responses through the use of quotations and diagrams.

Results

25 responses were received to the postal questionnaire. Several contributors also provided copies of papers they had written, or offered references to relevant literature. 4 more people contacted us to say they were unable to respond and giving reasons: retirement, shortage of time, and difficulties in answering the questions. The people who responded had the following positions:

- academic posts in health promotion and/or public health (8).
- specialist health promotion/ health improvement/public health practice roles (17).

We did not ask for an account of respondents' roles and responsibilities. It has been recognised that some people holding academic posts also have practice responsibilities and that practitioners frequently make significant contributions to academic courses. We would wish to see the two groups as overlapping constituencies with some shared, but also with distinctive concerns.

The findings are presented as follows: the first part analyses the definitions offered for health promotion and for public health, the values associated with the two activities and respondents' perceptions of the influences on these values. Perceptions of consensus and conflict between health promotion and public health values will then be described and the barriers identified to working in line with what were identified as core values. The section will conclude with contributors' observations on current debates about health promotion and public health and their associated values. Not all contributors answered all questions posed hence where there is quantification in

particular questions the total may be less than 25.

Definitions of Health Promotion and Public Health

All but one of the respondents who offered definitions for the two terms provided separate ones. The one combined definition of health promotion/public health was:

the organised and efficient efforts of society to promote health and well being.

Illustrative examples of the definitions offered are provided below to indicate the range of views.

Health promotion

The process of enabling people to increase control over and to improve their health.

Enabling people to achieve their full potential and intervening in those structural factors that prevent them from doing so.

Raising health status of individuals and communities through evidence based practice, consultancy and partnership working.

The process of delivery of knowledge and understanding of the holistic nature of well being and enabling individual access to determinants of mental, physical, social and environmental health in all life stages.

Public health

The science and art of preventing disease, prolonging life and promoting health through the organised efforts of society.

An approach to health improvement of communities that addresses physical, social and economic determinants and recognises that health is created and destroyed in society.

New public health is health promotion plus preventive medicine, health surveillance and needs assessment.

Promoting health through the general efforts of society.

The science of health promotion and disease prevention in populations.

The main difference between the two sets of definitions was the number of references to the Ottawa Charter statement, (or minor variations of this) in defining health promotion and the use of the Acheson definition (or minor variations) in defining public health.

A simple content analysis of all definitions provided for each of the two terms revealed differences in the nature and frequency of concepts and phrases included. In the lists below the numbers indicate the frequency with which terms appeared in the definitions provided:

Box 1: Terms Associated with Health Promotion and with Public Health

Health Promotion	Public Health () = no. times mentioned
Empowering (8)	Preventing disease/preventive medicine (8)
Enabling (7)	Promoting health (7)
Raising/improving health status (7)	Organised efforts of society (6)
Process (5)	Science and art (5)
Increase control over (4)	Population focus (4)
Mental/physical/social/environmental (3)	Needs based (2)
Preventing disease (2)	Epidemiology and communicable disease control (2)
Delivery of knowledge and information (2)	Disease/medical model (2)
Achieving potential (2)	Addressing socioeconomic determinants (1)
Evidence based (2)	Addressing physical determinants (1)
Protecting health (2)	Process (1)
Response to modifiable determinants of Health (2)	Health promotion plus--- (1)
Maintaining health (2)	Control over (1)
Achieving health (1)	Enabling (1)
Holistic health (1)	Planned activity (1)
	Disease surveillance (1)

The above is a relatively crude exercise, but serves some illustrative purposes. It gives an indication of the differing emphases in defining the two terms especially if those items at the top of the lists are noted. It also reveals the range of ideas associated with the terms and offers some preliminary indication of the similarities and differences between health promotion and public health. Health promotion definitions tended to pick up more strongly on health promotion as a process involving empowering and enabling and increasing control. Definitions of public health specified the organised efforts of society, a combination of science and art, disease prevention and control, and a population focus. Promoting/improving health was reflected equally in both lists. In offering definitions some people emphasised that public health was more than health promotion. The additional elements were those closely identified with the public health medicine functions of disease prevention and control. Others defined public health as public health medicine.

Further comments were made about defining the two. Seeking to define them separately was challenged by one respondent as '*time expired and divisive*' and many respondents emphasised the importance of identifying common themes. The difference in understanding between Europe and the UK was referred to in some responses - for example:

The distinction between defining public health in the UK and in Europe with the result in the UK being a default to public health medicine.

Other comments included:

The need to distinguish between health promotion as an outcome, activities and way of working.

Promoting health is not service delivery of programmes, or sticking plaster

answers to identified health issues. It should be a strategic method of identifying ways to establish lasting and sustainable methods of accessing well-being in a community, where no boundaries of exclusion exist in any areas.

Core values of health promotion

A large and diverse set of key words emerged in the responses. When the lists of values reported by individual respondents were compared there were considerable variations in the number and combination of core values offered (1-15 with a mean of 5). Only two values were common to 10 responses: equity and empowerment.

Core values of public health

Five people stated that the values were - or hopefully were - the same. A few others indicated the close similarity together with some comment:

...as health promotion but with more understanding of the material reality of the body and of risk;

...as health promotion plus health protection and more population based;

...core values the same plus prevention.

There was also a small number of people who reported being unable to identify, or were unsure of, the values of public health. The combined list of 'core values' and the number of mentions of each for health promotion and for public health is given overleaf. The words used by respondents have been retained.

Box 2: Reported Core Values of Health Promotion and Public Health

Health Promotion	Public Health () = no. times mentioned
Empowerment (10)	Equity (6)
Equity (10)	Evidence (based) (5)
Participation/involvement (7)	Population perspective (5)
Tackling/reducing inequalities (6)	Empowerment (5)
Autonomy/self determination (6)	Justice/fairness (4)
Respect (5)	Tackling inequalities (4)
Sustainability (5)	Primacy of disease prevention (3)
Partnerships (5)	Partnerships (3)
Evidence based (4)	Positivist research (2)
Beneficence/non maleficence (3)	Fairness (2)
Equality (2)	Equality (2)
Voluntarism/choice (2)	Beneficence/non-maleficence (2)
Capacity building (4)	Autonomy/self determination (2)
Advocacy (2)	Collaboration (2)
Inclusiveness (2)	Health protection (2)
Holistic (2)	Identify local needs (2)
Human centredness (2)	
Health (2)	
Strategic approach (2)	
Enabling and achieving change (2)	
Plus 1 mention each of: compassion, quality driven, ecology, freedom, non positivist, knowledge, liberty, respect and promote diversity, democracy, collaboration, activism, development, inclusive, locally driven, preventive practice, community/population perspective, human rights, identifying and implementing good practice, reflective practice, community development.	Plus one mention each of : compassion, utilitarian respect, freedom, holistic positive health, need, acceptability, democracy, capacity building, protection, quality driven, monitoring and evaluation of good practice, cross disciplinary reflective programmes, knowledge, need, medical model, paternalistic, proof, strategic, surveillance, commissioning, cross disciplinary programmes, capacity building, non victim blaming, integration.

The values which were mentioned at least twice have also been grouped into terminal values and instrumental values. The latter have been further divided into nature of actions and the processes of working. It is acknowledged that many of the values listed as instrumental might be terminal ones from other perspectives.

Box 3: Terminal and Instrumental Values for Health Promotion and Public Health

Health Promotion	Public Health
<i>Terminal values</i>	<i>Terminal values</i>
Equity	Equity
Equality	Equality
Justice/fairness	Justice/fairness
Autonomy/self determination	Autonomy
Empowerment	Empowerment
Health	Prevention
	Protection
<i>Instrumental values</i>	<i>Instrumental values</i>
<i>About activities:</i>	<i>About activities:</i>
Tackling health inequalities	Tackling health inequalities
Evidence based	Evidence based
Holistic	Population perspective
Capacity building	Health protection
Strategic	
Enabling and achieving change	
<i>About processes:</i>	<i>About processes:</i>
Partnerships/collaboration	Partnerships/collaboration
Participation/involvement	Identify local needs
Voluntarism/choice	Positivist research
Advocacy	Paternalist
Beneficence/non maleficence	Beneficence/non maleficence
Respect	
Sustainability	
Inclusiveness	

In the terminal values there are only small differences - prevention and protection in relation to public health and health in relation to health promotion. Reference to the earlier Box 2 does however indicate what seem to be differences in the degree of consensus around some of the shared terminal values - notably a more frequent emphasis on empowerment and autonomy/self determination in the case of health promotion. For the instrumental values related to activities the difference lies with the holistic nature of health promotion and the population based and health protection focus of public health. Evidence based and addressing inequalities were shared by both. Finally the instrumental values around process differ rather more with partnerships/collaboration and non/maleficence/beneficence being the shared values. The emphasis in health promotion appears to be on aspects of 'working with' and in public health more towards tasks and ways of working. It should be emphasised that these comparisons are made on the basis of small numbers although the substance of further comments was supportive of them. This summary leaves out a large number of values which were only listed once. An alternative presentation which also uses the

idea of instrumental and terminal values and which incorporates the additional values is provided in Figures 4.1 and 4.2. These show up the wide variety of ‘processes with people’ associated with health promotion.

Figure 4.1: Values and Health Promotion

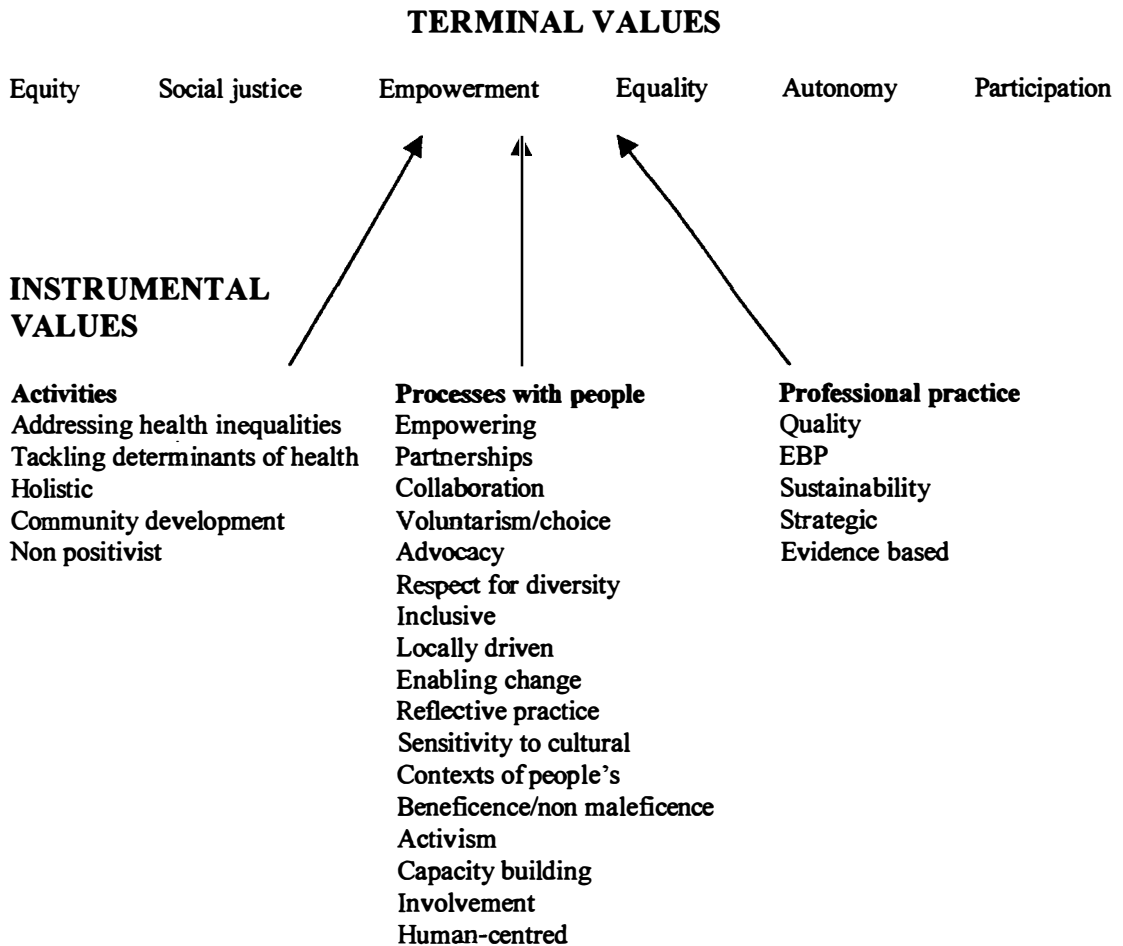
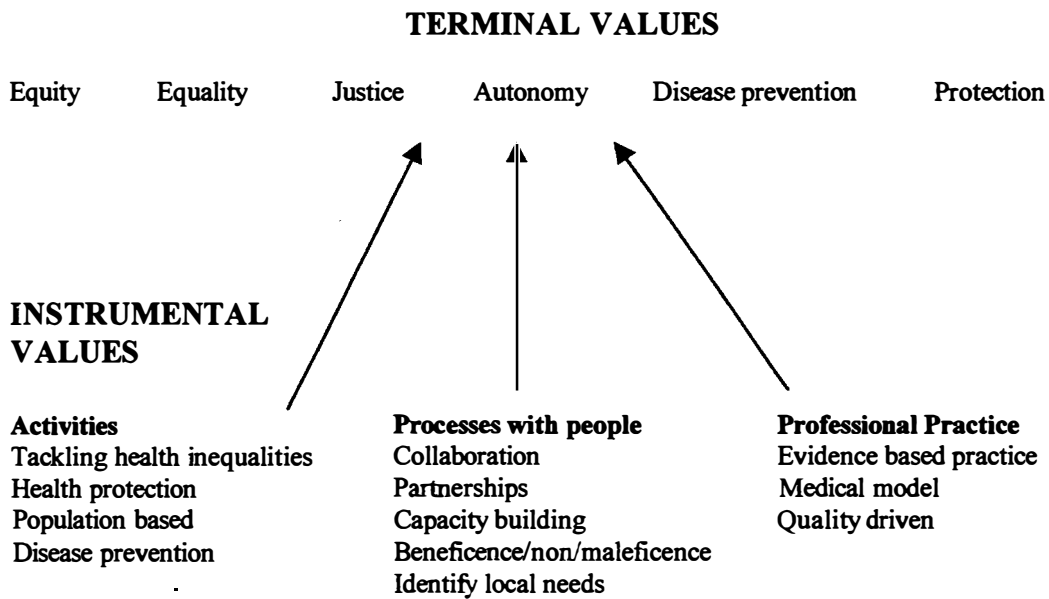


Figure 4.2: Values and Public Health



Influences on values of health promotion and public health

Health promotion

A wide variety of influences on health promotion values were listed although the WHO and specifically the Ottawa Charter was the only specific influence mentioned by more than three people. International influences, taken together, were those most frequently mentioned. Influences have been grouped such that the diversity of responses is illustrated. The total number of mentions for the items grouped in each category are provided simply to give some impression of the frequency of responses. It would be feasible to present alternative groupings.

<i>International- general and health promotion</i>	13
WHO and European initiatives	
HFA 2000	
Ottawa Charter	
International work especially in Canada	
General international	
Globalisation	
<i>Influential groups and individuals</i>	6
Key change agents	
Core group of theoreticians	
Professional groups	
SHEPS	
Committed and political driven groups and individuals	
HDA	
<i>Public health</i>	5
New Public Health agenda	
HAZ	

Public health movement
Desire for better health - to be equally distributed
Relationship with NHS

Political- P and p factors 6

UK Conservative Government
Political agenda
Economic pressure
Power and control
Need to challenge medical power

Ideological 6

Collective unconscious
Western scientific model -support for and reactions against.
Synthesis and application of knowledge
Relationship with community development
Redefining health from the 1940s
Early rooting in health education -unhelpful

Inequalities agenda 2

Inequalities in health and social processes
Evidence on inequality

Public health

While international influences were also mentioned frequently it is clearly the variety of influences grouped as associated with public health medicine practice that emerged most strongly in answer to this question.

International - general and health promotion 10

Alma Ata
Ottawa Charter
HFA 2000
WHO Regional Office for Europe
Shifting the Balance

Related to practice of public health medicine 25

Acheson report
Faculty of Public Health Medicine
Professionalisation of public health medicine
Occupational positioning
Public health practice standards.
SHEPS Code of Conduct and Principles of Practice/
Medical profession
Consultants in communicable disease
Environmental health
Competition for status with clinical medicine
Epidemics

Sanitary reform
Evaluative culture

Individuals 8
Individuals in Canada: Lalonde, Epp, Labonte
In UK: Sir Richard Doll, Ashton and Seymour

Political - P and p 7
History and politics
1997 election and Government policy
New political agenda
Restructuring health services
Power and control
Capitalism

Ideological 6
Medical model
Government ideology
Evidence based/evaluative culture

The state of health and the Inequalities agenda 4
Recognition of health inequalities
Desire for improved health and well being
Changing public health issues
Reduction in communicable disease

Social movements 3
Community development in 1960s - nationally and internationally
Citizenship and rights based movement

General 1
Media

To what extent is there consensus on core values of health promotion?

The responses were divided broadly between those who perceived consensus in theory and/or practice (Group A) and those - a larger number (Group B) - who did not perceive that consensus existed. In group A observations were sometimes made with reference to specific occupational groups. The type of comments made in the two groups A and B were:

A) Consensus

Yes - health promotion has a social theoretical framework.

In theory - mostly. In practice lifestyle change model expected.

Core values in theory – attract people to health promotion but in practice traditional model of lifestyle change.

Possibly - the elites write and act as if there is a consensus – in other writings health promotion as apolitical health education.

Partly - especially among health promotion and public health professionals. In other professions a tendency to focus on lifestyle issues.

B) No consensus

No - health promotion is common speak. Each actor and agency putting their own values into the melting pot.

No - the lifestyle agenda is dominant rather than the wider public health.

No - health education and lifestyle is the core.

No - value positions are identified and influenced politically.

Probably not - there is still a strong lobby for the creation of a profession/service structure labelled as 'specialist health promotion'.

Depends on who you ask and what training they have received. If you ask a medical person they may think of it as information giving or screening.

One comment summed up the situation:

Broad consensus among most health promotion colleagues who have health promotion in their job title but no consensus among a wide range of professionals who are interested in health promotion.

To what extent is there consensus on core values of public health?

There was more variation in responses for this question in line with the greater variation in responses to the question on core values of public health. There were also more people who did not respond to the question:

Yes- there is consensus (2)

There is a degree of consensus (4)


No (10)

No answer (5)

Unsure (2)

Comments from different position on the continuum from consensus to no consensus are:

Consensus

- 
- Yes - very central to current political vision.*
 - Probably - they are certainly reflected in the standards of public health practice.*
 - Less so than for health promotion - the medical model is still dominant.*
 - No - there is a clash between the medically based disease and technical model*

and the health promotion model - especially in the UK.

No - depends on background training and job.

<i>No - clinical governance</i>	<i>v process;</i>
<i>evidence based practice</i>	<i>v process/peer evaluation;</i>
<i>community/population interventions</i>	<i>v individual freedom;</i>
<i>utility in priority setting</i>	<i>v justice.</i>

There is total confusion between traditional public health medicine and the 'new public health'.

No consensus

What values are common to health promotion and public health?

While the answer could partly be deduced from earlier answers this question required respondents to specifically address this issue. A number of people stated that HP and PH values were the same - or they should be if health promotion and wider public health are considered but different if the comparison was with public health medicine.

I think the 'new public health' and health promotion share a great deal in values and approach on paper but in reality public health medicine and health promotion as professionals have different values'.

Where they were seen to be broadly the same prevention and protection was indicated as one area where there was a difference between the two. From those people who listed what were seen as common values, the only examples which were stated by several people were 'tackling inequalities in health' and 'overcoming structural barriers'. The common values listed are grouped into values related to processes of working and values related to desirable outcomes:

Processes of working

tackling inequalities in health (4)

overcoming structural factors that prevent people reaching potential (3)

emancipatory practice

collaborative working

influencing policy and strategy development

building alliances to support collective action

wanting to help people

population perspective

Desirable outcomes

freedom

equality

health and well being of public

Are there conflicts between the values in health promotion and public health?

The answers of those people who saw the values of the two as the same were

consistent with earlier responses in reporting a lack of conflict. A few others reported that there shouldn't be conflict and saw health promotion and public health as coming closer. Where values were broadly seen to be the same there were nonetheless some differences noted in the emphases accorded to specific values:

If there are there shouldn't be. The focus on partnership and community development in public health means values are more clearly aligned.

Not actually in conflict but the emphases are different.

Where points of conflict were identified comments included:

medical hegemony;

empowerment;

medical model versus social model;

the nature of what constitutes 'evidence based';

disease focus in public health medicine;

public health seen to be better;

individualistic component of health promotion v population focus of public health;

public health linked with screening and immunisation;

public health dominated by management agenda;

public health disease focused and reductionist;

One respondent drew out a number of clear points of difference.

Health Promotion

non-positivist

holistic

structural

humanistic

Public Health

positivist

technical

individual

medical

Barriers to acting in line with core values in undertaking professional activities in health promotion and public health.

Respondents were invited to comment separately about health promotion and public health.

Health Promotion

A large number of barriers were identified. These are grouped for ease of presentation and interpretation although it should be noted, as indicated in the previous question that alternative groupings are possible:

A) Targets

- National targets encourage top-down at the expense of bottom up approaches
- Inappropriate targets
- Politicians want short/medium term results while the values imply a long term
- Targets put pressure to adopt profession-led rather than client-led approach.
- Service specifications don't always match what is effective
- Service provider rather than needs driven
- Targets set by public health do not always support core values
- Government driven programmes

- Time scales

B) Government and national policy

- Government strategy
- National public health policy
- Policy-practice gap
- Department of Health
- Government ministries
- Capitalism
- The way Britain is governed

C) Institutional and Funding

- Political requirements for high profile activity, short term results and reporting detract from long term capacity building
- Lack of partnerships and joined up working (2)
- Short term funding
- Silo mentality in funding
- Having to bid for individual pots of money for every little thing
- Pressure of time may militate against good partnership working and participation

D) NHS

- NHS structure
- Political barriers in ever changing NHS
- Difficulties in knowing how overall health system works in relation to health issues and health promotion
- Organisation inertia
- NHS institutions do not want to confront structural inequalities
- Dominance of medical profession
- Embedded professional self interest
- Power of medical discourse
- Lack of partnerships and joined up working
- Medical model may not see the need for partnership and participation
- Commissioners' views of health promotion and public health
- NHS structures do not want to confront structural inequalities
- Ameliorist view of professional practice

E) Related to health promotion itself

- Relatively weak position of many health promotion services
- Common view of health promotion/public health relationship
- Lack of adequate leadership and knowledge based consensus
- Seen by many as that part of public health that deals with lifestyles
- Expectation that health promotion will work on individualistic approaches
- Not all front line health promoters have had opportunity to explore values and may work on medical model

F) Criteria of success

- Definitions and criteria for success and quality and how to measure them.
- Performance management
- Effectiveness v equity
- External expectations may militate against equity

G) Directly related to values

- Valuing autonomy is in conflict with the desire for equity
- Rhetoric is social but practitioner acts are still individual
- Values suggest holistic nature of health but this is rarely achieved
- Values not shared by all professionals
- Partnership approach challenges different sectors core and hidden values
- Medical model versus social model

Public Health

Some people noted the same issues as for health promotion. Some respondents made no distinction between health promotion and public health in answering these two questions but there were others who added the qualifying comment:

The same as with health promotion but less so.

A) Targets

- National targets can encourage top down at the expense of bottom up approaches
- Targets put pressure to adopt professional led rather than client led approaches
- Targets dictate activity outside core values.
- Inappropriate targets
- Time scales

B) National and Political factors

- Economic capacity redefines need
- Requirements for high profile activities short term results and reporting requirements take time from long term capacity building
- National pressures
- Capitalism
- The way Britain is governed
- Political pressures
- National public health policy - sometimes
- In democracy limit to popular mandate/support for anti-poverty measures

C) Funding

- Short term nature of funding
- Budgets
- Public health marginalised within budgets

D) NHS and other Organisational factors

- NHS structure
- Health care emphasis
- Performance management

- Personal conflicts
- Line management
- Lack of critical mass speaking coherently
- Some confusion about roles and responsibilities in a fast changing work environment
- Lack of partnership/joined up working
- Changing NHS
- NHS structures do not want to confront structural inequalities
- Ameliorist view of professional practice
- Commissioners' views of health promotion/public health
- Information gap and lack of compatible data
- Occupational positioning

E) Related to public health

- Differences in values of partner organisations
- Differences in values of professions
- Medical model
- Relatively weak position of many health promotion services
- Health promotion has come to be seen by many as that part of public health that deals with lifestyles
- Expectations that health promotion will work on individualistic approaches
- Not all front line health promoters have had opportunity to explore values and may work on medical model
- Not defined enough to influence the public health issues at a local level
- Lack of legitimate leadership and too much professional protectionism
- Misunderstanding of roles

Criteria of success

- The trilogy of economy, effectiveness and efficiency.

Directly related to values

- Paternalism;
- Potential conflict between utility principle and need to reduce inequalities;
- How far to go in terms of positive action- equality of opportunity v equity.

The last specific question invited people to identify debates about health promotion and public health and state their own positions on these. A few people did not answer this question and a few others indicated that they would prefer to discuss through interview or made references to their own publications. The debates identified fell broadly into groups:

- the nature of health promotion and public health and their interrelationships;
- the implications for health promotion specialist practice;
- issues for training;
- other.

Illustrative comments are provided below from each group.

Health Promotion and Public Health and their interrelationships

A number of respondents returned to the distinctions between the new/wider public health, public health medicine, health promotion and health development and also to the confusions that currently existed. A comment was made that, currently, this was *the* issue. Diagrams from published literature presenting alternatives for conceptualising the relationships were offered. These will be discussed more fully in Section 5. The variety of relationships – conceptual and operational suggested by respondents is shown in Figure 4.3

Descriptions of the alternatives and comments were offered:

*Either Public health medicine as a sub set of health promotion;
Or - Health promotion as a subset of public health medicine?*

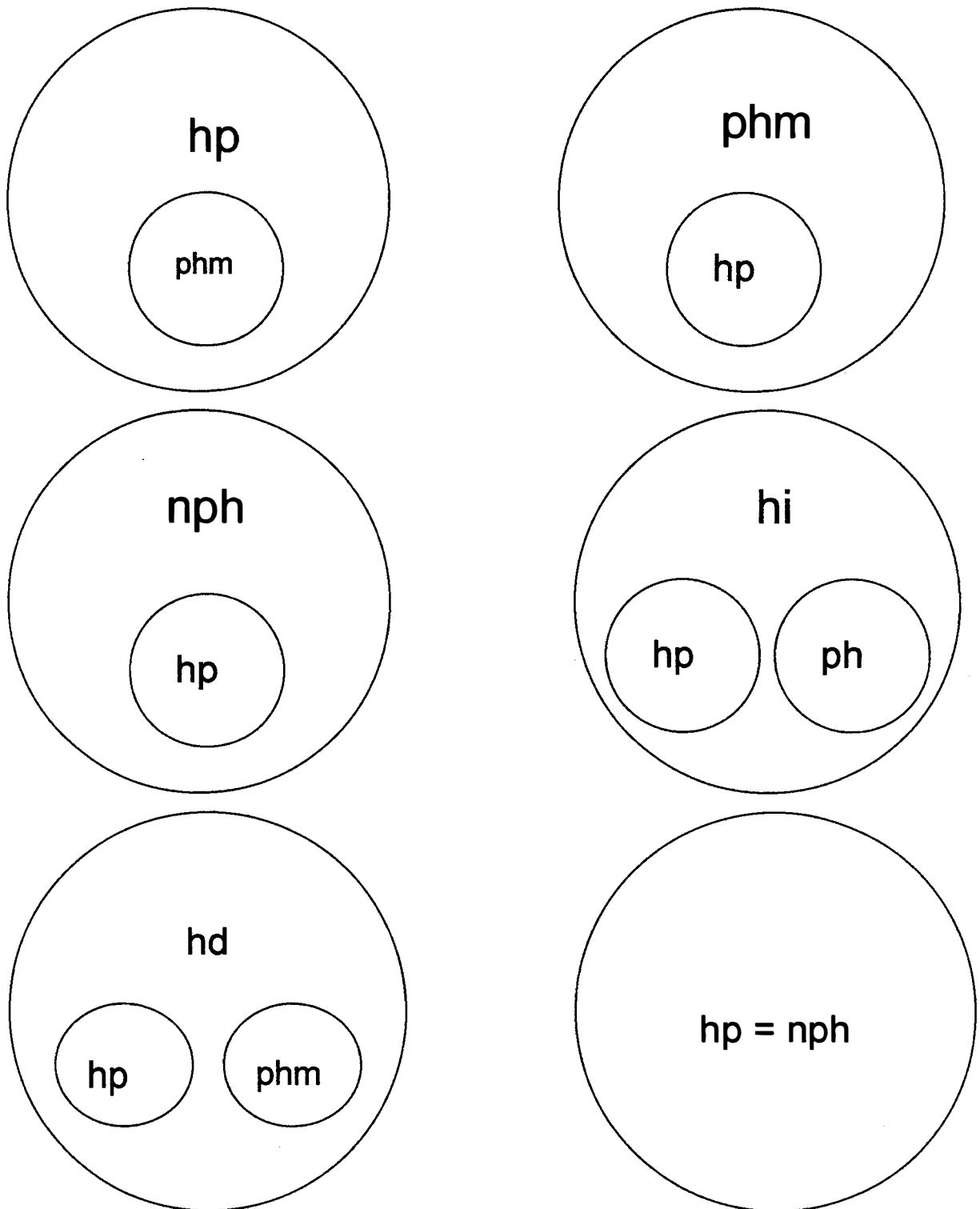
A few years ago I would have seen health promotion as the overarching term with public health - viewed as public health medicine as a subset. Now public health has assumed the wider agenda and health promotion is often seen as the subset- often defined by others in health education terms.

In education and professional development both terms are used. Health promotion for health improvement carried out by individual practitioners and public health as strategic planning carried out by specialists (e.g. health promotion specialists).

The key question about whether health development is the term of the future was raised:

Health development as the overarching term to include health promotion and public health medicine etc?

Figure 4.3: Views about Interrelationships: Alternative Conceptualisations Reported by Respondents



KEY hp= health promotion; hi=health improvement; phm = public health medicine; hd = health development; np =new public health.

Specialist practice

This was the debate raised most frequently and particularly as it related to health promotion practice in a context of the wider public health. Some comments simply noted the development.

The move to the abolition of health promotion specialists and the introduction of multidisciplinary public health.

Workforce development - HDA, FPHM and SHEPS.

Multidisciplinary public health and the role of health promotion.

One person reflected anxieties about the changes:

I feel health promotion is being marginalised. Pressure is being put on us to become public health specialists. Health promotion specialists have a different function and competence. Each is equally important in public health.

It feels more like Public Health regaining its power and influence over areas that health promotion as a profession had taken on since the 1980s.

Other comments specifically addressed the role of the non-medical practitioner in public health:

Debates about the non-medical public health specialist. The pay discrepancies between public health and health promotion. Who is best placed to take a broad position in representing HP and PH in PCTs.

Role of non-medical practitioners in public health. I support recognition of this.

A particularly topical concern noted was the future relation of public health to primary care:

Impending changes to the framework of the NHS. The positioning of public health in relation to primary care. The role of public health especially in relation to needs analysis.

Finally a timely observation:

I feel this has been going on too long. We are both essentially the same profession. The over emphasis on the public health specialist debate is leading us down the road of professional protectionism. What we should be focusing on is how to maximise population health and our fitness to deliver that function with others.

Training

Debates about training were also frequently raised. The first issue was about the differences in existing training:

In undergraduate medical education public health interventions address more specific outcomes whereas in health promotion may be more concerned with

process and individuals.

The second issue was the assumptions that may have been made about existing training and skills in the drawing up of recommendations for professional development:

Currently a debate about how to upskill health promotion specialists to public health specialist level. This ignores all existing skills and assumes public health specialists already have health promotion skills and competencies which is not the case.

There seem to be lots of people leaving HP for PH or retraining - doing an MPH after an M.Sc in Health promotion.

Third - an indication of alternative ways to address the training matter:

at least two positions:

- *needs led - determine what is required to improve health/reduce inequalities, identify existing skills/capacity and gaps and recruit/train to meet them;*
- *use part of existing workforce with accredited and professionally structured training system and impose that on all disciplines to achieve consistency of output (genetically (sic) modified public health doctors) and ensure professional survival.*

Finally respondents were invited to add any further observations on values in public health and health promotion. A selection of comments is provided here and the issues raised will be discussed further in the final section:

Health as a value needs explanation.

Both fields have worked hard at improving communication and developing core competencies so that there is a greater emphasis on evidence based work in health promotion and more emphasis on community led work in public health. This needs to be encouraged.

Often difficult to justify as results long term and difficult to assess.

Conflict with medical views of treatment/judgments. I predict this will be worse in the primary care new world.

Health promoters are doers usually. Public health tends to be about strategy and research.

Health promotion has been misdirected in response to medical protectionism in public health to distinguish itself from public health and try to invent a separate role for itself.

Continued focus on blaming the individual.

Lack of sustainability and subsequent compromising of core values.

Do not conceal the political nature of values behind a technical or

professional facade.

The need for actions to implement initiatives and policies designed to make a profound impact not the superficial indent made under current conditions.

Discussion

Consulting with those working ‘in the field’ was one strand in the development of this report. While acknowledging the important contribution of a wide range of professions to health promotion/public health practice, we took the decision, in this small study, to restrict our canvas of views to those engaged in specialist health promotion/public health in the UK. It should be re-emphasised, therefore, that any observations drawn from this element of the work are offered tentatively since they are derived from a relatively small number of people from selected constituencies. At the same time they are drawn from people who are actively engaged in thinking about the questions posed and, in many cases dealing with the implications of the issues raised either in practice - or in the training of others for practice. The issues they raise will be considered further in the final section and only brief comments are made here.

We noted varying degrees of similarity in the definitions proposed for health promotion and public health. In some cases small differences were specified such as public health being health promotion plus preventive medicine. In others, even where some common elements were included there were clear differences in the flavour of definitions. For some public health is definitely equated with public health medicine with implications for ‘ownership’ and core values. Taking the definitions for each term as a whole and noting the frequency with which specific sub terms were used we noted differences in emphasis between the two. We specifically stepped back from specifying whether participants should define ‘public health’ or ‘public health medicine’ in the construction of the questionnaire and it would appear from the responses that individuals focused on one or the other. In describing the *core* values of the two areas a large number of values were proposed in both cases. There was a fair measure of overlap between the specific values listed for each term but a difference in emphasis as far as specific values were concerned. When terminal and instrumental values were categorised there were small differences. Put very crudely there was a stronger emphasis in health promotion on processes around involvement, participation, autonomy, contributing to empowerment and in public health on what the definition describes as the ‘organised efforts of society. An interesting omission was any reference to theory based practice although evidence based practice was mentioned.

The questions about consensus and conflict in core values were intended to push further the issues that may have already been addressed in earlier answers. The extent to which conflict was noted appeared to relate to the extent to which earlier answers reflected attention to public health medicine rather than to some concept of ‘*wider* or *new* public health’. Not all respondents were directly engaged on a day to day basis in professional health promotion/public health practice with the need to harmonise practice and values and address the associated issues. There were no clear differences, however, between the responses of those who were practice based when compared with those designated as academics. What was apparent was the number and diversity of barriers to working in line with values. A variety of issues relating to values

emerged from the postal response including: whether there is consensus on the core values of health promotion and of public health and the extent to which values are shared; the gap between core values in theory and practice, the tension between the medical and social models of health; the continuing emphasis on lifestyle issues in practice contexts; and individual versus population levels of action. These issues will be raised in the final section of the report

SECTION FIVE: DISCUSSION AND CONCLUSIONS

Introduction

This section draws on material from the earlier sections plus additional literature in order to arrive at provisional conclusions on the nature of the activities of health promotion and public health, their interrelationships, and their associated values. The section also provides brief consideration of selected issues that have been raised earlier: the case for prevention as an activity within health promotion, the future of health education within health promotion and public health, the future of designated health promotion practice and training for practice. Finally a number of recommendations will be offered for consideration by UK policy makers, the Health Development Agency, sectors involved in public health, and training institutions.

The previous sections have provided four related contributions to examining health promotion, public health and values. The first offered a critical reflection on the nature of values and closely related concepts, on health as a value, the activities of health education, health promotion and public health and identified issues for further consideration. The historical background in Section 2 extended the discussion of the evolution of health promotion from health education and described developments, over time, in public health. Section 3 provided a focused analysis of the conceptual development of health promotion based on the series of documents from the WHO, beginning with Alma Ata (WHO, 1978). Finally Section 4 presented a summary of current ideas about health promotion and public health, the relationships between them, and the systems of values with which they are associated. These were derived from a questionnaire sent out to UK health promotion and public health specialists and academics in these disciplines.

The complexities of the relationships between public health and health promotion will have become apparent from these earlier sections. In this final section, we will consider if a point has now been reached where there are areas of agreement - even perhaps the emergence of a common perspective on the nature of public health and health promotion and the relationships between them. This final section is principally designed to stimulate further reflection and discussion.

The Concept of Health

The dimensions of health which emerged clearly in the Alma Ata document (WHO, 1978) and which permeated succeeding WHO documents were identified in Section 3, namely: health as a worthwhile goal; holistic; health as instrumental to achieving a socially and economically productive life; with subjective and objective elements; and health as a right. In developing the health of individuals and communities shared responsibilities have been identified, different sectors involved, and a need for both community and individual participation asserted. The relative emphases on these dimensions of the concept of health have varied over time. Where health as a value is concerned there is the notion of it as a terminal value - as a right and a goal in itself. It is also seen as an instrumental value - necessary for the achievement of other valued goals. This can be stated in a general way as *health as a resource for living* - or

specifically where health is *a means to a socially and economically productive life*. This instrumental value can also be viewed in two ways. Health enables people to achieve what is assumed to be a desired goal for them - a socially and productive life as they would define this for themselves. Alternatively, and this is probably the more usual meaning in the literature, health is seen as instrumental to the achievement of goals defined by societies. The value attached to health shifts from self actualisation in the first interpretation to contributing to society's needs in the second i.e. from individual to collective interest. Interestingly, in the empirical study, there was little explicit reference to health as one of the stated core value of health promotion or of public health - perhaps this was so self evident that respondents did not actually include it.

An important tension in efforts to promote health has been to achieve a balance of responsibilities between the individual and the collective. Too great an emphasis on the individual - especially in a context of socio- environmental and economic constraints - has been defined as victim blaming. By contrast too great an emphasis on the collective has generated comments about restrictions of freedom and criticisms of paternalism and the 'nanny state'. Various resolutions have been sought - one being the creation of situations which leave individuals, as one respondent stated, with the '*freedom from*' constraints in order to have the '*freedom to*' assume fuller responsibility for health. Individual responsibility for health can be conceived in two ways. It can be the responsibility for adopting behaviours which have been normatively defined as health promoting. Alternatively, it can be the responsibility for health related decisions and their consequences, where health has been subjectively defined, and the actions taken to promote it are not necessarily those normatively defined. A further individual responsibility is to contribute to collective health through participation in community actions and political processes designed to secure healthy public policy.

What is clearly apparent from the literature is that health, viewed in positive and holistic terms rather than with reference to disease, while not dominating all those contexts where activities described as health promotion take place, is more pervasive than hitherto and, arguably, dominates thinking and practice in some contexts. A focus on positive health comes with a set of questions for those engaged in professional practice:

- Is there a need to develop a consensus definition of positive health which will satisfy those who need to be supportive of actions designed to achieve this outcome?
- How much do we know about strategies and methods for promoting positive health?
- Is there a sound evidence base on effective ways to achieve positive health?

Health Promotion

The analysis of the WHO documents in Section 3 revealed that during the past 20 years, which saw the rapid development of health promotion, there has been some consistency in WHO thinking about core principles. The degree of consistency can, of course, be debated as can the extent to which WHO ideas have been influential in all those contexts where health promotion activities take place. In the contributions from key informants to this project we noted a greater degree of consensus around the

definitions of health promotion than we did for public health. In the case of health promotion the consensus broadly reflected the WHO thinking illustrated in the use of the Ottawa statement (or minor variations of this):

health promotion is a process of enabling people to increase control over, and to improve their health. (WHO, 1986)

Informants associated the health promotion process with specific activities and ways of working oriented towards the achievement of a number of terminal values. There was a degree of congruence between what is advocated in WHO documents and what people who are actively involved in specialist health promotion and public health, or as health promotion/public health academics, described as health promotion. This might be expected since WHO was identified as the single most important influence on thinking about core values. Nonetheless there was, at the same time a breadth and diversity in the definitions of, and comments offered about health promotion, as noted in Section 4.

While it would not be appropriate to place too much weight on the findings from a relatively small empirical study they raise a number of questions.

1. If there appears to be some measure of agreement about the nature and the associated values of health promotion is this confined to the particular groups involved in this study or is it shared widely?
2. Should we aspire to achieving consensus on these matters, or even to reaching a situation where we say that *health promotion is* and *health promotion should*?
3. Have we reached a point where some activities can be *prescribed* and others *proscribed* as belonging to health promotion? If so who, if anyone, has the authority or power to define these? Can we assume that anything that conflicts with agreed core values is proscribed?

With reference to the first of these questions it needs to be stressed that consideration of the ideas of the WHO, and of those people involved either in specialist health promotion or in academic training for such practice in the UK, does not provide a fully representative view of the total constituency of people involved in health promotion. For example, those who undertake health promotion in the context of a variety of other occupational roles are not included, nor are lay views. Some perceptions of the thinking of other professionals were reported in comments made by key informants. The most frequent comment was made about health professionals, especially doctors, who were alleged to think that health promotion is largely health education and about changing lifestyles. A similar finding was also reported by French (2000). Evidence of this use of health promotion to mean predominantly health education focused on lifestyle change can also be identified in many of the accounts of health promotion activities provided by health and other professionals. The health promotion movement is a relatively new one and has developed at different rates across sectors and professional groups within countries, between countries, and between parts of the world. It would be premature to expect a high degree of consensus, even should this be seen to be desirable. In the early stages of the development of health promotion relatively few countries and contexts initially held a broad conception of the activity. Our experience of working for many years with students from a wide range of countries has shown that the broad conception of health promotion associated with the Ottawa Charter only achieved wider dissemination during the last 10 years or so. Further evidence that this understanding of health promotion has still to be fully

disseminated was drawn from the Eastern Mediterranean Region of WHO (EMRO). In 2000 EMRO set up a process across the countries of the region for exploring with key representatives of national agencies the movement from health education to health promotion and developing plans to begin such developments. There was little evidence from EMRO participants in a developmental workshop to support this process of change that the WHO ideas of health promotion were already familiar. The focus in most of their countries was on health promotion as health education, or as Information, Education and Communication (IEC) which, for some, was the preferred term (Dixey and Tilford, 2001). Paradoxically the expressed learning needs of some participants were focused on enhancing health education theory and practice rather than developing holistic health promotion.

There is one easy answer to the second question if we leave aside, for the moment, whether the term health promotion continues to have a future. In that we have policies which promote intersectoral and inter-professional alliances to promote health it is desirable that all involved should broadly, if not entirely, agree what health promotion is, and how it should be carried out. Where consensus is lacking, activities in one sector may undermine those in another, especially if these activities are informed by contradictory values. As multidisciplinary working continues to develop it is reasonable to expect that the extent of consensus will increase. Other initiatives may influence the development of consensus. The National Occupational Standards (Care Sector Consortium, 1997), designed for broad groups of health and social care professionals, were informed by principles and values broadly in tune with much specialist health promotion thinking. At this point it is reasonable to conclude that despite a degree of consensus about the meaning of health promotion it remains a contested definition and differing views of what it is prevail in differing countries, contexts, and sectors. At the practical level this has the consequence that differing, and at times, contradictory activities, underpinned by differing philosophies, will be taking place in the name of health promotion. This is not by definition a bad thing if differences are made explicit. However in such a situation conflicts of values are likely to be present with consequences for intersectoral working.

If we address this question more generally, and especially the second part, i.e. that 'health promotion should' and the third question about whether some activities can be prescribed and others proscribed as part of health promotion there are no simple answers. Furthermore, how should any prescriptions be arrived at? It is clear that there is a degree of consensus about the nature of health promotion, the processes to be associated with it and the values which should inform it. It would, therefore be feasible to dissociate health promotion from processes and values which contradict this core. One quite clear statement on this has been made by Downie et al. (1996)

...health education and other aspects of health promotion are activities committed to certain views of the nature of the self and what makes it flourish, and to views of a well ordered society. No doubt there are a large number of acceptable ways of living one's life, all of which lead to the flourishing of human personality, but not every way is acceptable. Similarly, there are no doubt several acceptable forms of social and political organisation, but not every way is acceptable to those involved in health promotion. If these positions are not shared by health educators and health promoters then why

adopt such slogans as 'Be all you can be' or why deplore the 'health divide'.
(p170)

They state three principles:

1. It is important to encourage people to clarify their own values.
2. That the methods used in doing this should be flexible and imaginative.
3. Health promoters are committed by their profession to believing there are right and wrong attitudes to life and its values.

It is the third principle which is of particular interest. Although there is broad measure of support for certain terminal and instrumental values whether professionals would sign up to this statement, in this form, is less certain. The letter to the Director General of the WHO, discussed later, is an example of a confident expression of what health promotion should be. More generally there are national organisations such as the Society of Health Promotion Specialists and international ones such as the International Union of Health Education and Promotion which offer guiding statements on health promotion. Guiding statements are not, however, the same as prescription and many would view the notion of prescription as dissonant with much that is prized in health promotion. There is, in general, considerable reluctance in pluralist and multicultural societies to be prescriptive about values, except in the case of foundational values such as justice and truth. We will return to this issue after discussing the definitions of public health and the interrelationships between health promotion and public health.

Public Health

Where public health was concerned we identified in the postal responses rather less consensus on definition than for health promotion. The definition used in the Committee of Enquiry into the Future Development of the Public Health Function and Community Medicine chaired by Sir Donald Acheson (DoH, 1988):

public health is the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society'. (p63)

or minor variations of this, was the one most commonly provided. Although the Ottawa Charter is also referred to as a seminal influence in public health only a very small number of respondents - those who made little or no distinction between public health and health promotion - used the Ottawa definition to define public health. The responses appeared to differ most clearly according to whether the term public health was conceived in relation to public health medicine, or to a wider concept of public health, mostly described as new public health. In general, the single most important distinguishing element of public health was its emphasis on prevention of disease and protection of health - although this was not specified by all respondents. Where health promotion and public health were seen to be virtually identical it was these activities of prevention and control of communicable disease that singled out public health as being different.

Relationships Between Health Promotion and Public Health

The relationships between public health and health promotion reported by our respondents can be presented as circles with varying degrees of overlap - complete where health promotion is seen to be the same as public health, significant overlap where the differences lie mainly in the relative emphases on processes in health

promotion and prevention and control of disease in public health - and much less overlap where more distinctions were made between the two activities. In the latter case this was mainly where 'public health' was being equated with public health medicine. The idea of overlapping spheres has also been used by Scott Samuel (1998). The variety of relationships suggested by study contributors were presented in section 4, Figure 4.3. An earlier study by French (2000) of the perceptions of health promotion held by 16 health promotion specialists and 17 public health specialists also reported on the perceived relationships between health promotion and public health. He concluded from his study that it was extremely difficult to logically separate health promotion and public health conceptually, although distinct historical developments and occupational positions could be distinguished. He stressed that we must be clear what we are talking about:

The term health promotion is variously and interchangeably used to describe a set of principles, as a goal, as a set of action programmes and as an occupational title. The term public health is similarly used. However, when a fundamental analysis of aims and methodologies is undertaken at a conceptual level, the two concepts appear to be difficult to separate. p184

A contribution to elucidating the relationships between the activities of health promotion and public health has been offered by Macdonald and Mussi (2001). They proposed three alternatives (Figs 5.1, 5.2 and 5.3).

Figure 5. 1: The relationship of health promotion to public health medicine in operational and funding terms

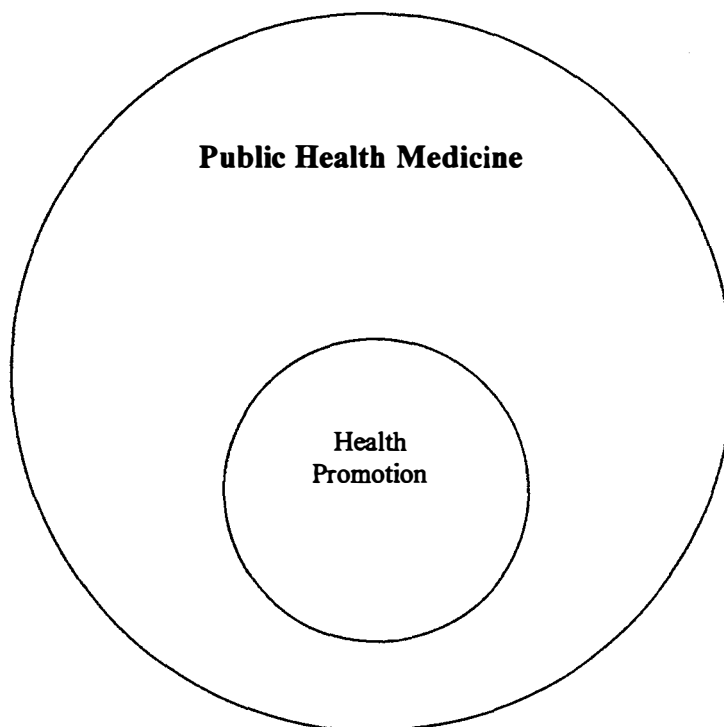


Figure 5. 2: The relationship of public health medicine to health promotion in conceptual terms

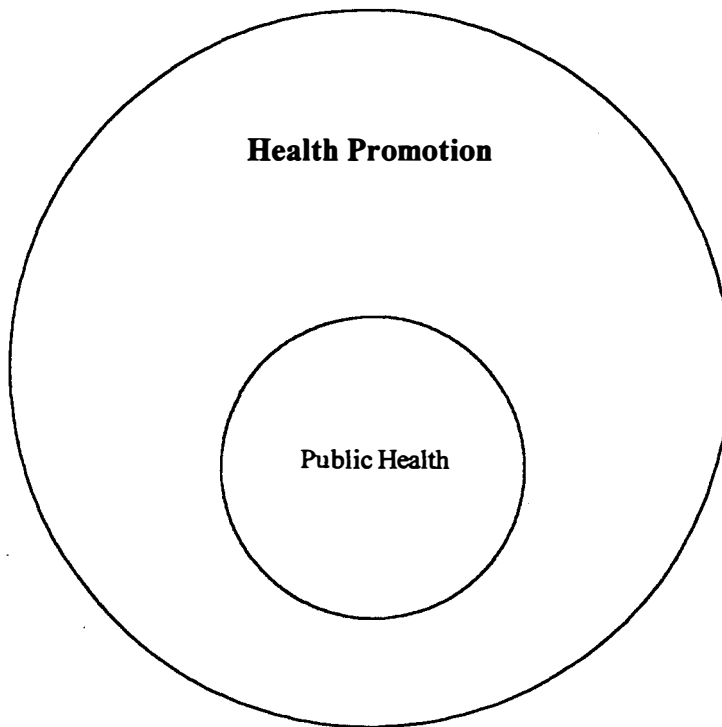
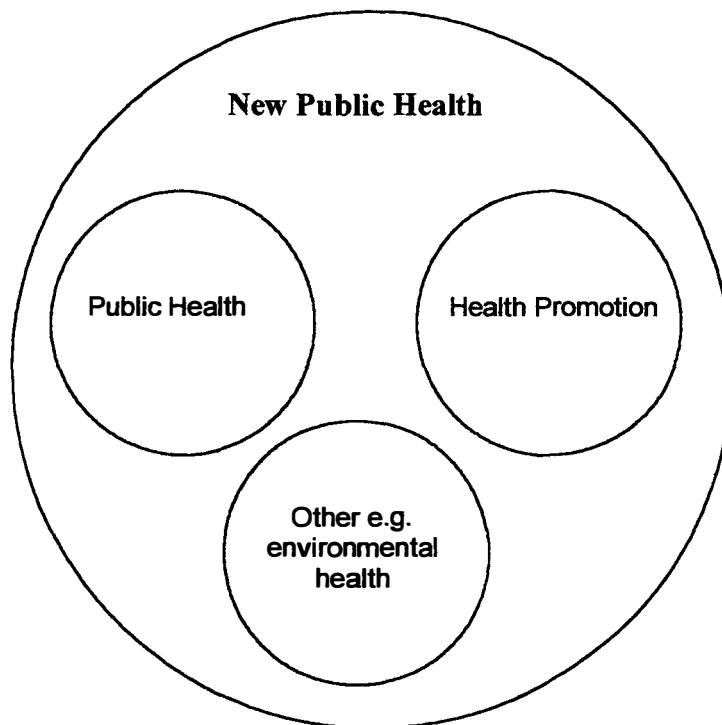


Figure 5.3: The relationship of health promotion and public health medicine to improving population health in conceptual terms.



Various consequences result from the existence of alternative understandings of terminology and the relationships between functions. A number of our respondents reported the confusions which result. It is likely that difficulties in communication will

arise where the words 'public health' are associated with different entities - public health medicine, wider/new public health, or old public health. Similarly the existence of differing conceptions of health promotion ranging from a narrow concern with lifestyle change through to addressing all the factors which enable people to increase control over, and to improve their health, and with little or no distinction from wider public health, can be a source of confusion. Clearly these various interpretations will determine whether or not a distinction is perceived between health promotion and public health. A number of questions emerge:

1. If health promotion = public health do we need both terms? As the more recent term would it make sense to drop health promotion? Or, alternatively, should health promotion be retained?
2. If public health is associated with a broad set of activities, when conceived as new public health, but also with a narrower set in the context of public health medicine how do we resolve the confusions that can arise?
3. If there is a need for an umbrella term would it make sense to have a term other than public health - whether this is health development, health improvement, public health promotion or some other neologism.

Where the first question is concerned we might say that such a change has, to some degree, happened. The Saving Lives: Our Healthier Nation document, for example, did not distinguish health promotion from public health and appeared not to recognise the distinctiveness of UK specialist health promotion practice from health promotion activity (conceived mainly as health education) as a function of a number of other roles (DoH, 1999). In line with this a point of view was expressed in the postal responses that seeking to draw any distinction between health promotion and public health was time expired and divisive. If this is the case, to use both terms would seem unnecessary, although the question of which to retain still remains. A small number of respondents opted for the adoption of public health as the umbrella term. Others, while recognising the close similarity between health promotion – as understood by specialists - and the public health function, did not go on to suggest that there was no longer a need for health promotion as a term. There was evidence, at the time of the survey, of commitment to retaining the broad concept of health promotion while resolving some of the confusions between health promotion and public health. There were specialist health promotion units committed to retaining the label health promotion. After considerable debate some academic courses have chosen to retain the label health promotion – alone, or in association with public health. Most importantly the Society of Health Promotion Specialists has not changed its name. There are three key reasons offered, each open to debate, for retention of the term health promotion:

1. There appears to be clearer understanding of this term than there is for public health with its alternative conceptions as new, or wider public health, and as public health medicine. However this clarity is more evident in specialist practice than it is elsewhere where, as we have noted, there is widespread use of health promotion to mean health education.
2. Notwithstanding the rhetoric of the new public health there is the problem of dissociating public health from the dominance of the medical model and perceptions of ownership by public health medicine.
3. Arguably the more important reason is that there are values and ways of working integral to health promotion which are of particular relevance and best continued by linking with the term health promotion rather than public health. These might

include, for example, the strength of commitment to achieving consistency between the processes of working with individuals and communities and the desired outcomes. It might be argued that these valued processes are now quite strongly linked with new public health, although a number of our respondents pointed out there is a gap between rhetoric and practice.

To raise these issues is not to suggest that it is necessarily desirable to retain all terms which have been used to date, especially if confusion is seen to be a problem. As suggested in the postal responses, if there is commitment to common themes in public health and health promotion the retention of the term health promotion is backward looking. Others might make the opposite comment that the health promotion term as the newer and the much debated term is the more forward looking.

Health development

While confusion can be lived with and French (2000) observed that '*practitioners appear to be able to tolerate and in some cases welcome some confusion about the aims, objectives and terminology of health promotion*' there was also evidence from our postal responses that this was not seen as a satisfactory situation. There have been many suggestions for resolving current confusions. The fact that no solution acceptable to all has yet emerged is evidence of the difficulty in achieving a satisfactory resolution. It could also be that professional boundaries and the defence of existing occupational categories is acting as a barrier. The first section in the report provided some discussion of the use of the term health development and one proposal of how this might link to the other terms in use. The adoption of health development, both at a national level and in some local contexts, indicates that it is seen to be useful in practice. One respondent suggested that those in health promotion who think this term's days are numbered will look to adopting health development in order to distance values and practice from what is seen as the narrowness of common interpretations of public health. A further advantage of health development was pointed out - which would apply to any other new terms suggested. Those using it would need to explain what they mean and this would inject clarity into the debate. Indeed any new term would need to be subjected to the same debate and critical scrutiny that accompanied the emergence of health promotion. Other terms suggested as the umbrella category include health improvement and public health promotion and also the retention of public health. One advantage of each of the terms health development, health improvement or public health promotion is that they convey the idea of action, while the term public health implies a state. The existing activities of health promotion and public health medicine can be conceptually linked to any of the first three terms if used to represent the umbrella for public health activity. All three terms are relatively free of 'baggage' from the past although health improvement may already be seen as too closely associated with health sector actions. Learmonth and Macdonald (2000) summarised the pros and cons of the various terms. We have noted the particular confusion attached to public health and the difficulty of knowing what conception underpins the use of the term. If we are looking for one term that would leave us with health development or public health promotion as preferred alternatives.

There are some factors militating against the adoption of health development, in addition to those mentioned in Section 1. While it may, to some extent, simplify issues in the UK, in an era of globalisation we have to consider the wider world. The term

public health has a long history, and is universally used, and this situation is likely to continue. Health promotion as a concept has now been widely disseminated and it could add to confusion to suddenly replace its use by the term health development. While it would be entirely legitimate to describe health promotion and public health as contributing to health development raising the latter to become the higher order term may not, therefore, be a world wide solution. Public health promotion might gain wider support since it could be argued that the term is easily seen to derive from both public health and health promotion. It can safely be predicted that, in the absence of any initiative to resolve current confusions, gradual evolution of terminology and the activities to which terms relate will occur with the possible resolution of current difficulties. In the short term a local UK solution could be to opt more actively either for health development or public health promotion and communicate widely the nature of the associated activity. The alternative is to stay with the existing terminology but to develop working definitions for use in specific contexts etc. For example this has been the approach of the Cochrane Collaboration Public Health and Health Promotion Field. Its proposal, on the basis of international consultation is to retain both terms and define them as:

Health promotion comprises efforts to prevent ill health and enhance positive health. The overall aim is to increase the control that individuals have to influence their health in a positive way.

Public health encompasses the assessment of the health of populations, formulating policies to prevent or respond to health problems, promoting healthy environments, and generally promoting health through the organised efforts of society. Public health promotes societal action to invest in living conditions that create, maintain and protect health (Cochrane Collaboration Health Promotion/Public Health Field, 2001).

Consensus and Conflicts on Values

The nature of values and their importance in health promotion and public health was discussed fully in Section 1 of the report. The empirical study asked participants to identify the core values of health promotion and public health and to comment on consensus and conflict on values issues. We saw this as important in relation to current practice and for identifying issues that need to be resolved if the two functions are to have a common future. Since there continue to be differing conceptions of the nature and purposes of health promotion and public health it is to be expected that the different conceptions will be associated with some differences in values. The differences may range from relatively small ones resting mainly on the relative emphases on specific values through to large differences where there are major contradictions. Across the competing conceptions there may be a small number of values to which all would give support. Health as a value may be one that is fully shared - other shared values may be those broadly associated with democratic society rather than specifically with health promotion or public health. Beyond the area of consensus, differences are likely to exist between, for example, the values prioritised within health promotion as described in the WHO documents and those prioritised within a preventive model of health education. Even the values of equity and reduction of inequalities, while widely supported, would not necessarily be central to all practice designated as health promotion.

We noted in the earlier discussion in Section 3 the focus on specific values within the WHO documents. There was also some degree of consensus in the postal responses on core values of health promotion – equity, empowerment and involvement/participation being mentioned most frequently, followed by tackling inequalities, autonomy, partnerships, respect, sustainability and evidence based. In the case of public health there was again a small number of values that were mentioned more frequently than others but there was less consensus than for health promotion. Equity received the highest number of mentions, followed by population perspective, evidence based, empowerment and justice/fairness. Over and above the areas of agreement on the values of health promotion values of public health there was a large number of values mentioned by only one or two people.

We do not wish to generalise from a relatively limited exercise. Respondents views may not accurately reflect those that would be found in a more extensive study of all those with involvement in health promotion and public health. Furthermore, those actively involved in these activities may not be equally keen to support and promote a common core of values. Nonetheless there is a sense that there is a greater readiness than in the past to endorse the common terminal values identified in the previous section for health promotion. It is less clear in the case of public health because of the new public health/public health medicine confusion.

We were interested to know where the points of conflict are seen to be in relation to public health and health promotion values - both conceptually and operationally. For those people who conceived health promotion and public health as relatively distinct conflicts on core values were identified. These included conflicts on the use of a medical model, on an individual versus population level of action, on empowerment as a goal of health promotion and the nature of evidence as a basis for practice. Those who conceived the values of health promotion and public health as the same nonetheless noted the conflicts that occurred in practice. With reference to the most commonly cited core values one particular area of conflict was specified - that between promoting both autonomy and equity at one and the same time. Promoting autonomy fully can appear to work against the achievement of equity, while the full pursuit of equity places limits on autonomy. Some balance has thus to be achieved between these two prized values. The point of balance depends on which value takes precedence with the resolution related to various factors including the nature of political structures, the contexts of practice and the target group concerned. Downie et al's (1996) analysis of autonomy is a useful one in arguing that autonomy includes self determination, but also self government, where to be self governing is to guide conduct in terms of values. In exercising autonomy attention could also be given to equity - if this was part of an individual's value system. We noted earlier the development of autonomy in the context of the considerate way of life in schools projects.

Can we be prescriptive about health promotion and public health and their associated values?

Earlier in this section we raised the question of whether it was appropriate to make single definitive statements of the kind '*health promotion is*' and '*health promotion should*' and from where such statements should emanate. To comment further on this requires that we revisit ideas raised in Section 1 and say a little more about the nature

of the activities of health promotion and the wider public health and their legitimate spheres of activity. We can begin by picking up Kelly and Charlton's (1995) observation that health promotion contained within its theory and practice contradictory elements of modernism and post modernism. Efforts to generate one agreed specification for the activities and processes of health promotion and the means by which actions are to be evaluated, and which privilege the scientific tradition as the way to develop knowledge, broadly places it in the modern tradition. In contrast, to propose that health promotion is characterised by the features listed below places it in the post-modern tradition:

- health conceived relative to specific situations;
- eclectic in the use of methods to answer its research questions although preferring an interpretivist methodology;
- does not prize rationality in analysing and structuring responses to health concerns;
- adopts a social rather than a medical model; and
- emphasises change rather than progress.

Much of what can be described as core thinking of health promotion or, as some of our respondents described as 'the ideas of the elites' is imbued with post modern ideas. To the extent that health promotion is seen as closely aligned to wider public health the latter can similarly, therefore, be categorised as post modern. For those respondents who made a distinction between health promotion and public health one way was to describe health promotion as post modern and public health as modern. However, despite some strong influential voices promoting post modern thinking if we take into consideration the full range of conceptions of health promotion there is much that strongly reflects modern ideas. In practice there is also a great deal of activity which falls neatly and comfortably within a modern tradition. This is the case whether one looks at specialist practice in, for example, the UK, the full spread of health promotion practice, or the activities of WHO. As Kelly and Charlton (1995) observed:

Despite claims to the contrary the approaches to health promotion used by the WHO in particular, and by the many national and local health promotion agencies in general, remain locked into technicist, scientific, and above all expert driven practice. (p81)

Various inconsistencies and tensions result from the mix of modern and post modern elements in health promotion and public health. Kelly and Charlton identified inter alia:

- a language of empowerment but experts remaining firmly in control of the discourse of health promotion;
- rejection of the medical model in favour of a social model but, in basing the latter on causal explanations, the discourse may be different but the epistemology remains the same.

A key tension is observed in the debates about the nature of evidence to be used in demonstrating the effectiveness of health promotion and public health interventions. Many of the barriers to working in accordance with preferred health promotion values identified earlier were related to post modern-modern tensions. There are clear gaps between post modern rhetoric and actual practice and a quite a few respondents referred to these.

There is little evidence that the contradictions between modern and post modern that crosscut theory and practice in health promotion are likely to change in the short term. The question is whether this complicated situation needs to be resolved, or whether the complexity should be acknowledged and ways to negotiate it, identified.

Rather than attempting to adjudicate between the modern and the post modern we can examine health promotion from within the critical theory tradition which, it may be claimed, has aspects of both modern and post modern. This is an important perspective to draw on if health promotion is understood to be about change in order to secure valued goals - those of equity, participation, empowerment and justice. Freire's work, a strong influence on the analysis of empowerment within health promotion, is part of this intellectual tradition. In critical inquiry the aim is to achieve understanding of situations through a dialectical process, exemplified in the Freirian educational method, and to use the results of enquiry in efforts to bring about change. This is not a value neutral process - it is informed by, and committed to specific values such as equity and action to reduce oppression. Research in this tradition balances attention to the processes of inquiry and the acquisition of the information needed for use in achieving desirable changes. With reference to process the ways that knowledge is acquired should not, it is argued, be oppressive. Interpretivist research approaches, where there is attention to developing more equitable relationships and the use participatory methods are, therefore, typically preferred. At the same time interpretivist research may not lead to the type of information needed to underpin efforts to secure change. This can be gained from positivist surveys, or even the use of experimental studies. Although less acceptable in terms of process their use may be supported - if conducted ethically - as a means to achieving desired change. Hunt's research on housing in Scotland offers a good example of balancing respect for participatory processes of enquiry and the achievement of appropriate evidence for achieving the goal of improved housing (1993).

To the extent that an argument can be put forward that there is an accepted health promotion perspective - based on those values which can tentatively be identified as core ones - such a perspective would fit quite comfortably within the critical theory tradition of bringing about change for the better through participatory and empowering processes. While such an 'ideal' may inform practice it is inevitably constrained by factors in some of the institutional contexts where health promotion is practiced. The empirical study provided many statements on the gap between the ideal and what can be achieved in practice. It can be suggested that the move in health and social policy to a fuller commitment to reductions in inequalities, together with actions designed to bring this about, is a more appropriate climate in which to secure the valued goals of health promotion. Tensions between what is proposed in theory and what can be achieved in practice should be reduced.

The constraints within which much occupational health promotion is practiced, and the ways that these can be modified, is a central issue if the values informing 'core' health promotion and public health - when viewed as more or less identical - are to be fully pursued. If social change is necessary in order that the health of people be fully promoted there are limitations in the extent to which this has been seen as possible within the NHS which is widely expected to deliver on rather different goals. This point has emerged from HAZ evaluations where the root causes of health inequalities

are widely recognised, but the extent to which health agencies alone, or even working in partnerships, can address these was questioned (Tilford, Percy Smith and Green, 2002). At the same time the acknowledged progress in the development of intersectoral partnerships addressing regeneration issues, and a wider range of activities directed towards the root causes of health does indicate a move in the appropriate direction.

So far we have given some support to the notion that there is a quite widely recognised model of health promotion, as far as specialist practice is concerned, but that this is set within a context of alternative perspectives. Is it, therefore, appropriate, to be more explicit in promulgating what have tentatively been identified as 'core' values of health promotion. Following on from this, should we propose to marginalise particular values and practices within the health promotion movement? Some sense that it might be considered appropriate to do this can be gained, as noted earlier, from the observations of Downie et al. (1996) and from the open letter from an international group of influential health promoters and sent to the WHO Director General following the Mexico Conference (Mittelmark et al., 20001). Dr Bruntland was taken to task for emphasising the importance of chronic and infectious disease control and the need to fight tobacco. Concerns were also expressed about the new organisational location of health promotion in the WHO - together with chronic and infectious disease control. A particular remark in her statement to the conference was seen as particularly contentious because of what it appeared to imply about the nature of health promotion:

Promoting health means transcending the narrow slot traditionally labelled 'health promotion';

She then went on to say:

Promoting health means reducing risks to health and modifying behaviour that affects us. (Bruntland 2001, p97)

These comments appear to differ from the dominant thinking in the WHO documents as discussed earlier, and reference was made by some postal respondents to her apparent misunderstanding of the nature of health promotion. The actions she went on to specify as part of the process of promoting health were, however, consistent with Ottawa Charter and other principles: providing knowledge about the determinants of health; building consensus around ways knowledge can be put into practice in differing settings and communities; and encouraging healthy public policies that help people themselves to take action necessary to put knowledge into practice. At the same time her definition for promoting health, and the degree of emphasis on disease prevention, invites comment. It almost seems that her comments about the meaning of health promotion would have been more appropriately directed to what many label as traditional health education. Furthermore her comments on evaluation also seemed to be somewhat out of line with WHO's own publications on health promotion evaluation (WHO, 2000) where she said that:

the evidence that many aspects of health promotion make a difference is always measured in terms of reduced risks for disease, or for improved health outcomes, including quality of life measures. (Brundtland, 2001 p5)

The letter writers said:

In our view it is this linkage of health promotion with specific diseases and risk factors that is narrow and does not reflect the essence of health promotion. That is not health promotion as we teach it, as our students and

public health workers practice it , and as it has developed as a core function within public health.

Later they outline the essence of health promotion:

When (these) people are working on matters relevant to health, following a health promotion approach obligates them to encourage openness and participation, strive for the empowerment and autonomy of others, and hold equity and justice as the highest of principles. (Mittelmark et al., 2001 p3)

This explicit statement about the essence of health promotion accords with the area of consensus in our study but the full range of comments in this letter also triggers questions. Are the writers suggesting that health promotion should not be associated with specific diseases and risk factors or that such an element was being inappropriately highlighted. It seems that it may be the latter which is the focus of comment although this is not entirely clear. Concern about the organisational merging of disease prevention and health promotion focused particularly on the potential impact on health promotion:

the organisational format chosen downplays health promotion's role in empowering people to take positive health action and it negates totally what has already been achieved. (p4)

While supporting much of the substance of this letter a few responses can be offered. The first response is to the writers' point that health promotion is not associated with specific diseases and risk factors in contexts of practice, or on courses in which health promotion and public health specialists are trained. While a cogent case might be made for the desirability of such a situation it is not one which currently prevails. The second statement that there are few areas of the world where health promotion is equated with a focus on the individual, and where lifestyle change and risk factor reduction is the order of the day, is also one where there is evidence to the contrary. For example, the institutional focus on health promotion as lifestyle change and risk factor reduction was frequently mentioned by respondents as a barrier to achieving key health promotion values. A cursory glance at the full range of what is labelled as health promotion literature would also furnish considerable evidence of the amount of activity geared to lifestyle change and risk factor reduction.

To recap, the influential group of signatories to the letter cited above, and the number of countries with which they are linked, suggests that we may be at a point where there is some measure of support for saying that '*health promotion is*' and '*should be*'. Presumably there is also some readiness to identify those activities that do not conform - labelling these, perhaps, as something other than health promotion. What would fit in with such a view and who should define it? Those areas around which we have identified some measure of consensus - drawn from the WHO publications published over a period of time, from the professional and academic informants in our survey, from the letter to Health Promotion International discussed above and widely used health promotion textbooks concern processes and desired goals and particular values. If there is agreement that health promotion should achieve these goals, using only defined processes, then it logically follows that certain activities are to be wholeheartedly rejected or at least, thoroughly scrutinised. Persuasive methods, programmes developed without consultation on needs, those that do not encourage appropriate participation, fail to involve empowering processes or consider issues of equity, and certain kinds of research might all be rejected as inappropriate within health promotion. If, however, the greater commitment is to achieving such valued goals of

health promotion as equity and of health there may be some acceptance of processes and activities which conform to general ethical practice, but would go beyond those specifically recommended in health promotion. These alternative positions would be:

- The necessity for specific instrumental processes in seeking to achieve defined terminal goals i.e. congruence between means and ends.

OR

- Acceptance of a variety of instrumental processes in order to maximise the achievement of terminal goals. The ends justify the means.

The commitment to the first position entails accepting that the desired end goals may not be as fully achieved as in the second scenario while the second requires careful specification of what counts as the limits to ethical practice. The clearest difference between health promotion and public health emerging in the empirical study was about processes which suggested a tendency towards the first alternative for health promotion and the second for public health.

Answering the question about **who** should make statements on what health promotion should, and should not be, is also not easy. There is some degree of unease about groups of individuals, or even about representative bodies such as SHEPS, presuming to make such statements. While the guidance from bodies such as WHO is clearly influential, concerns might well be expressed if it was claimed that WHO was able to decree what health promotion should, or should not do. A discipline that values inclusiveness and participation of communities in its activities can not easily resort to expert led pronouncements. Related to this is the long standing debate about the professionalisation of health promotion. This has been commented on by French (2000) with particular reference to the development of a specialist common language, one of the markers of a profession:

Many practitioners also perceive themselves to be working on behalf of their communities and believe that a specialist language is one of the markers for a detached and elite form of professionalism that is at odds with such a focus. However a counter current of thought concerned with the systematisation of health promotion practice, including the development of evidence based practice, is also evident among practitioners....There appears to be an unresolved conflict between the need to develop and use an agreed specialist language and a desire not to exclude non-professionals from making a full contribution to the theoretical development of health promotion. (p177)

Public health, as public health medicine, has long been recognised as a profession and the debates which have characterised health promotion on this matter have only assumed greater relevance with the emergence of new public health.

We will now comment in a little more detail on four particular issues – the place of prevention in health promotion, the future of health education, the future of designated health promotion practice and training for public health and health promotion practice.

Is there a place for prevention within health promotion?

The letter to Dr Bruntland, discussed above, usefully drew attention to the conceptual place of prevention in health promotion. Does it have a place or not? It is not necessary to take issue with the processes and goals of Ottawa style health promotion,

and especially the focus on positive health, in order to ask the question. In practice we are not yet in a position to achieve positive health for all, although it is a key aspiration and, therefore, it can be argued that the nature of the response to prevention of ill health has still to be addressed. In practice a great deal clearly does go on in the name of health promotion that is disease focused, despite the observations to the contrary in the joint letter. The fact that it does occur reflects not only the continued existence of the different perspectives on practice, and/or the pressures to account for activities with reference to particular criteria, but also the relatively weak power of specialist health promotion to impose its preferred approach. If the constraints were not in place would preventive activity be dropped? A coherent case could be made for this with reference to the core values and processes and drawing on the Penrith Paradox (Macdonald and Mussi, 2001). This proposes that action on the underlying determinants of health is most likely to achieve health promotion goals but most activity is targeted at individuals. Nonetheless it may still be important to consider whether prevention does have a place in health promotion. It may be useful to consider this with reference to smoking as an issue, especially as this was the issue raised in the open letter.

There is a wealth of good analysis of the social factors related to higher risks of smoking and of the links between social and individual factors. Those people who are most disadvantaged in society are more likely to be heavy smokers and are more likely to experience tobacco related disease. The international efforts to secure a Framework Convention on Tobacco Control, and also national policies in many countries, have placed an emphasis on acting on social and environmental causes in order to reduce uptake of smoking, and to make cessation easier. That policies have been sufficiently broad to address the root causes of smoking is much less apparent. Action on tobacco related policy and environmental action alone does not necessarily impact positively on the most disadvantaged smokers. Raising tobacco taxes, for example, leads to an increase in the proportion of low incomes which is spent on tobacco and can result in increases in deprivation unless there are other policies in place designed to address disadvantage. Smoking cessation interventions which include financial support for nicotine replacement for disadvantaged smokers and which are accompanied by tobacco related policy and environmental action can enable people to give up smoking. Success in giving up, especially where there are histories of a lack of earlier success can empower individuals as well as influence levels of tobacco related ill health (Nicholds and Tilford, 2001). Given the proportion of ill health that is tobacco related, and its prevalence in most disadvantaged communities, it is difficult to argue that some attention to prevention is not consistent with the core values of health promotion. Addressing the root causes of inequalities would have the greatest impact on tobacco use but where this is clearly not happening – or happening very slowly - comprehensive programmes combining policy and individually focused action are able to progress valued health promotion goals. Catford (1999), for example, noted that WHO's Tobacco Free initiative provides an excellent opportunity for health promotion's values, principles and strategies to be put into place. If it is accepted that smoking prevention can be an appropriate activity to pursue within health promotion there are certain caveats, derived from core values, which would need to be applied:

- that people do make an informed choice to opt out of smoking and into smoking cessation;

- that programmes acknowledge wider social constraints and place smoking cessation in the context of institutional activities which are designed to address social and environmental influences on smoking;
- that the processes of working with individuals and groups incorporate a participatory model of working which seeks to empower through building up efficacy and providing a supportive structure;
- that health promotion and public health specialists and the localities in which they are located advocate for policy actions designed to reduce health inequalities;
- that smoking cessation programmes are accountable in terms of valued health promotion processes such as participation and empowerment, as well as outcomes such as the numbers of people who have quit smoking. It is interesting to note that the organisational association of health promotion with prevention in WHO has been viewed positively, as well as negatively. Sindall (2001), for example, has seen it as offering a strategic opportunity for really getting the principles of health promotion into the management of problems of chronic disease:

The principles and approaches of health promotion need to be embedded across the continuum of care as part of the second wave of reforms. (p216)

There is clearly an acceptance here that ill health as well as positive health can be a focus for health promotion. Such a viewpoint can be supported in a number of ways, some already identified in the specific example of smoking prevention:

- promotion of positive health and other Utopian goals of health promotion does not, necessarily, lead to the prevention of ill health. Promotion of mental health is an example where this is frequently debated;
- reorientation of health services towards prevention is one of the principles of the Ottawa Charter;
- lay perceptions of health include the absence of disease (Blaxter, 1990; Herzlich, 1973; Cornwell, 1984);
- if we care about equity and the reduction of health inequalities in health promotion can we disengage from some focus on prevention?

Prevention can be primary, secondary or tertiary. Sindall focuses on tertiary prevention which is most open to challenge within health promotion. He makes the point that the needs of those suffering from chronic diseases are not adequately met and says:

An important point for health promotion is that the call for change promotes an approach to chronic disease care that places a far greater emphasis on patient empowerment, on the development of health literacy on the part of families and patients and communities, on holistic care and on the development of systems that can support this approach. (p216)

Whither health education?

A further, and, we would argue, a particularly important question is about the role of health education in health promotion. This has been a theme in the earlier sections and it is appropriate at this point to return to it. We have noted continuing reference to activities that can be described as health education within the WHO documents and one of the principles of the Ottawa Charter is the development of personal skills, which it can reasonably be concluded requires educational processes. We explored the meaning of health education in the first section and examined the developments in thinking in health education, over time, in Section 2. Recently there has appeared to be

some marginalisation of health education within health promotion together with a tendency to equate health education solely with a preventive medical approach. Some academic courses responded to the perception that educational processes were being obscured in much health promotion writing by retaining both terms in their titles until very recently - even when health education was conceived as nested within health promotion. We would wish to argue that health education - if understood as defined in Section One as:

any intentional activity designed to achieve health or illness related learning – some relatively permanent change in an individual's capability or predisposition,

still has a significant place within health promotion (Tones and Tilford, 2001 p30). Whether it can be successfully argued that health education, informed by the full range of approaches with which it has been identified, is acceptable within the emerging consensus view of health promotion is more contentious. This is particularly relevant in the case of the adoption of a preventive model - where efforts are made to change knowledge, attitudes and behaviours to reduce risk factors for ill health or, promote positive health. To achieve success requires the adoption of processes, such as persuasion, which do not fit with those we have already identified as core processes of health promotion. However, we can ask if those behaviour change situations where empowered clients freely enter into activities - patient education ones for example- and consent is given to the use of methods which are likely to achieve an individually designed behaviour change can be acceptable within health promotion.

We noted earlier the restricted processes that are integral to some applications of an educational model, where the focus is essentially on information giving and getting messages across plus some development of understanding. By contrast, an education for empowerment model entails a more extended analysis of process - development of knowledge and understanding, facilitating the clarification of values, development of individual attributes such as self efficacy and self esteem and decision-making skills and other action competencies that enable individuals to take action on the basis of decisions in line with their own values. Working within the precepts of this model does not necessarily mean that health in terms of conventionally measured goals will be enhanced - although it would be if health were defined in terms of self esteem, efficacy, self actualisation, and a sense of empowerment. It also means that individuals and groups may not necessarily choose to act to reduce those factors that sustain inequities and ill health in society. Critical consciousness raising may have occurred but it may not have led to action.

Picking up the critical theory thread we might consider what light this sheds on the issue of appropriate and effective health education (See Tones, 2002 for further elaboration). Unlike in the use of a mainstream empowerment model, where values may be clarified but specific ones are not intentionally advocated, it should be clear from earlier discussion that in a critical model specific values associated with the achievement of change to achieve desired goals will be promoted. Some ideologies, norms, practices and their associated values would, by definition, be seen as unhealthy and not tolerated. Acceptance of inequalities - of class, gender and race - could fall into such a category. The degree of consensus that currently exists about redressing inequality would suggest wider acceptance of values associated with equity than hitherto. The intellectual tradition to which a critical education model belongs is a

respectable one and there are contexts where practice informed by these ideas might be viewed as non-problematic. Work with adults in community settings and with young people in non formal settings, where a critical education model has frequently been adopted, poses relatively few problems. It is less clear that it can be advocated in schools. While it is apparent that schools promote societal values - implicitly or explicitly, and especially through the hidden curriculum, the advocacy of specific values within curriculum areas such as Personal, Social and Health Education, has typically been challenged when these appear to diverge from the traditional values in education. To move to the adoption of a full blown Freirian approach where critical reflection is intended to lead to praxis has been contentious. We noted earlier the lack of acceptance of such ideas in schools when they informed the Health Careers schools project in the 1970s (Dorn and Nortoft, 1982). More recent work in health promotion in schools in a number of countries has revealed examples of praxis (Tones and Tilford, 2001).

Questions can be raised about a critical approach if we consider media advocacy which has been described by Chapman and Lupton (1994) as the use of mass media as a means of critical consciousness raising in pursuit of social and political change. We can question whether the selective presentation of material - the so called 'framing the debate' to achieve desired change - is any more laudable than when the same process is used in the pursuit of lifestyle behaviour change. Chapman and Lupton do have a valuable riposte which doesn't make the question unnecessary but suggests that the ends may justify the means especially in situations where there is considerable opposition:

'We were a handful of earnest idealists just spitting into the wind of the real determinants of drunk driving, diazepam dependency, and teenage cigarette use. Whatever aggregated little gains we might have made in changing community knowledge and attitudes, these were swamped day after day by major structural determinants of drug and alcohol abuse such as price, licensing policy, and especially the promotional activities of the drug and alcohol industries. (p, ix)

The future of designated health promotion practice

A key issue at the current time is the future of specialist health promotion within public health. Because of the apparent lack of understanding of the specialist role portrayed in the 1990s health policy documents, A Contract for Health (DoH, 1998b), Saving Lives: Our Healthier Nation (DoH, 1999) and the Chief Medical Officer's Report on the Public Health Function (DoH, 1998a) concerns have been registered. These include the survival of the existing specialist health promotion professional group and, more generally, the survival of what is seen to be distinctive about health promotion and its ways of working. Comments were made in the postal survey that the current development of public health specialists has pushed both health promotion and public health into occupational protectionism to the possible detriment of promoting the health of the public. Others indicated the importance of resolving current problems. One focus of this particular report is the health promotion contribution to promoting the public health. If this contribution is distinctive and necessary to achieving public health goals how can it be retained? This does not necessarily require the retention of

existing professional titles. This has been described succinctly by Macdonald and Mussi (2001):

... Rather than wholesale structural changes based on arguments about professional boundaries and territory, a more sensitive and impartial analysis is required of the sorts of competencies and theoretical understandings and principles of practice that are going to be needed to make significant improvements to the population health in this country. The task is to focus not so much on what various professionals doing health promoting health are called but to focus on what this activity is or should be like. (p8)

Catford (1999 p2) in calling for a Health For All value system has emphasised the strengths a health promotion perspective would specifically bring to this and described it as:

- person focused - with a strong consumer/citizen orientation;
- holistic health -including mental and spiritual;
- values dominant - particularly regarding health disparities;
- determinants based - with a socio-ecological perspective;
- social capital - with emphasis on partnerships and alliances;
- reaching out - by engaging, connecting and horizontal networking;
- cutting edge - through innovation, risk taking, boundary riding;
- capacity building - with communities, organisations, workers.

It could be argued that this is little different from many conceptions of the new public health. At the same time there is evidence from literature and survey respondents that it is the ideas of public health medicine, rather than new public health, that are dominating some current discussion and practice. The gap between the new public health rhetoric of official documents and specific actions was noted by respondents. In addition the poor understanding of what constitutes specialist health promotion in public health documents has also been noted. It is, therefore, important to ensure that the strengths of health promotion - and new public health when conceived as much the same as health promotion - are not obscured. Macdonald and Mussi (2001) have provided a valuable contribution to identifying what is distinctive about health promotion. They identify the combination of three components:

theory of the problem - a social/economic/environmental analysis of health determinants in comparison with a biomedical analysis;

principles of the solution: a commitment to promoting health in accordance with values;

integration of response: integration across the boundary between planning and commissioning and implementation.

They offer five observations in relation to these: health promotion specialists as a profession;

- have consistently called for a more socio-economic theory of the problem and been resolute in their formulation of a comprehensive set of the 'principles of the solution';
- are used to cross boundary activity such as inter agency partnerships, moving between policy and implementation and the development of meaningful partnerships and participation within communities;

- have always argued against short termism and have an enviable track record in developing ways of working which encourage sustainability and not dependence, and which have stood the test of time;
- have a unique and long standing track record in joint working;
- have a unique and important role to play in integrating strategic and operational perspectives and they need to be offered the organisational positioning which helps rather than hinders in this.

In the context of the earlier discussion of health education we can also emphasise that the capacity to manage the educational component of health promotion has traditionally been a particular strength of health promotion professionals. At the same time the need to move away from a traditional behavioural model towards the adoption of a critical educational approach needs to be recognised.

Training Implications

A number of implications for education and training can be drawn from our discussions and from the various documents that have in the past few years addressed education and training for public health. These were introduced at the end of Section 2. Saving Lives: Our Healthier Nation (1999) emphasised the need for training for the public health workforce. The Chief Medical Officer's Report (DoH, 1998) on strengthening the public health function in England proposed 3 categories of public health workers, as noted earlier:

1. Professionals who would benefit from a better understanding of public health;
2. Hands on public health practitioners working to promote health with individuals and communities including public health nurses, health promotion specialists, health visitors, community development workers etc; and
3. A smaller group of public health specialists to manage strategic change in organisations and lead public health initiatives.

The identification of health promotion specialists with the second groups is clearly not where they would expect to be although they were also mentioned in relation to the third category. The location in the second category suggests some lack of knowledge of specialist health promotion practice, in particular its strategic activities and its focus on catalysing and supporting the health promotion work of others.

Currently there are issues about the continuing training and education for the public health function for those who are already working in specialist health promotion. If assumptions are made by some that health promotion is largely lifestyle focused health education then professionals engaged with health promotion will be seen to require a wide range of new competencies in order to take on the public health function. If the specialist function is better understood fewer additional skills to operate at level 3 will be required. As noted in Section Four the ways that health promotion skills needed to be extended to meet the requirements for non medical senior public health specialist level was, at the time of the postal survey, a live issue. Respondents reported the existence of an assumed deficit of skills in the case of health promoters taking on a senior public health role. These were not equally matched by perceptions of deficits in those public health specialists trained in traditional MPH courses in taking on some health promotion activities. In addition to a lack of understanding of specialist health promotion activity it can also be suggested that certain preexisting areas of knowledge and certain competencies are being given higher status than others. The recent public

skills audit undertaken by the HDA (Meyrick et al., 2001) reported that public health medicine staff identified some critical skills gaps - many in team working and managing staff. Public health (presumably non clinical) and health promotion specialists reported one skills gap - consultation. They commented that this could indicate that present educational opportunities in health promotion were ensuring skills appropriate to current roles. It could also indicate, however, underutilisation of this group who could be given greater management and strategic responsibilities in public health.

There is also the important question of initial education and training of a multidisciplinary public health workforce. To date there have been MPH courses which, until relatively recently were restricted to the medically qualified, and M.Sc courses in Health Education and Health Promotion -some of which have now been rebadged as Public Health. Although the written curricula of these two groups of courses can look very similar we would suggest that there are differences in the emphases on specific aspects of the curriculum. In many ways these reflect the differences identified between health promotion and public health in the postal responses: a greater emphasis on epidemiology in public health courses and a greater emphasis on processes of empowerment, partnership working, education etc in the health promotion courses. One postal respondent made a comment, on the basis of teaching on MPH courses, of the need for more time to be given to the creation of common understanding on core values of the wider public health. We would endorse this comment. Health promoters have long needed to establish their credibility - particularly with the medical profession, because of their operational links to public health medicine - and have developed the habit of critical reflection on their theory and practice in order to establish the rationale for their existence. As a multidisciplinary subject, and a relatively new one, health promotion has drawn on other disciplines for its knowledge base and much of its theory. The theory selected and the processes through which it has occurred are continually challenged. Much specialist health promotion training has incorporated critical reflection on the development of the theoretical foundations of the discipline, its principles of practice and the methodologies for extending the knowledge base and evaluating programmes. The pressures on MPH programmes to do this have been rather less.

Future training for multidisciplinary public health can occur through courses which continue to have some distinctiveness in line with those which have existed between MPH and M.Sc health promotion courses. An argument for this would exist if there was seen to be space for different kinds of professionals to operate at the Level 3 specified by the Chief Medical Officer (DoH, 1998). The case for this may not be a strong one and could lead to the perpetuation of some people's views that MPH training is superior. At the same time, while accepting that health promotion specialists are core members of the multidisciplinary public health team there is still some reluctance among many of the existing health promotion courses to lose the health promotion badge. In the longer term the constructive strategy will be to identify the goals of public health education and training and develop appropriate curricula, organisation and methods.

It is also important to ask whether we are to think of training or education - especially in an era of occupational competencies. The CMO Report (DoH, 1998) identified a list of competencies and the NHS Plan has talked of public health skills. Training can be

defined as an induction into a prescribed set of skills, and education as induction into the understanding and examination of alternatives with no prescription of any particular model. The *educated* new entry to a profession may be less use in the short term than the *trained* one but more value in the longer term. In reality, disciplines like health promotion and public health which are essentially engaged with practice, require education which offers a mix of theory and practice, with the challenge being to secure the most appropriate mix. Helitzer and Wallenstein (1999) published a proposal for a graduate curriculum integrating theory and practice in public health. It is a problem focused curriculum built around curriculum competencies in: theory of aetiology and interventions; research methods; programme planning, management and evaluation; policy development and health and disease context; and the interrelationships between these areas. As a curriculum it notably lacked any particular focus on education.

It could be argued that the full spread of activities that might be involved in public health at the strategic level is broad. If the intention is to train for this complexity can this reasonably be achieved? We also have to ask if all areas of specialist knowledge and skills will be equally valued. Currently those skills which are seen as part of medical training - even if they can be acquired by non medics through other courses, as is the case in some countries - are better rewarded. This is a real issue for those working in health promotion. If there is parity between public health specialists there should be no reason not to have specialisms within this broad area. In practice this naturally happens as people emphasise some aspects of work rather than others. Whether specialisms should be formalised within education and training is a matter for discussion.

Conclusions

This project has examined the nature of health promotion and public health, their associated values and relationships between the two activities. While national and international literature has been drawn the empirical element of the study was confined to the UK which, as noted earlier has its own distinctive health promotion and public health history. Notably there has been the existence of specialist health education and health promotion practice, in addition to the incorporation of these activities within other roles. We have examined conceptual changes over time and emphasised that definitions have been contested. This contested nature of health, health education and health promotion has been widely recognised and commented on and it has been part of specialist training in health promotion to address this matter (Beattie, 2000; French and Adams, 1986; Seedhouse, 1995; Tones and Tilford, 2001; Naidoo and Wills, 2000). It was observed in the postal responses that those who undertake health promotion in the context of roles other than the specialist one have had less exposure to these debates. It was also suggested that public health training has been less concerned with definitional debates. Earlier, within the health education era, where the idea of different approaches to practice was accommodated, there was relatively little confusion. The emergence of health promotion and clarification of its relationship with health education created a new complexity. The term health promotion was used by some to describe a broad set of actions in accordance with the Ottawa Charter and by others to describe what had previously been labelled as health education. Both health education and health promotion were related in some way to public health - for many years viewed largely as public health medicine. Operationally this was most significant

in the UK for specialist practice, as health education in local authorities and, post 1974, in the health authorities as health education and later as health promotion. There were, and continue to be, tensions in the relationships with public health, many of which were identified in the postal responses. The emergence of new public health was often welcomed in health promotion - since both activities shared more than hitherto. However, as a consequence of this development of new public health other issues emerged. These arose from the apparent failure of the 1990s public health policy documents, as noted above, to recognise specialist health promotion and its associated activities in outlining ideas for the public health workforce. Concerns were generated about the continuation of this professional group and the particular mix of activities that it prized. Currently the task is to identify the most appropriate way that public health can be promoted and to ensuring the contributions of health promotion - even if not labelled as such - to this function. In doing this there are significant implications for existing professional groups and some polarisation of views has occurred. Some of the problems in resolving issues at the present time are essentially to do with the values that many associate respectively with health promotion, with public health medicine and with new/ wider public health. To the extent that there are differences in values between these functions there is some concern that those values which are more strongly identified with health promotion, may be threatened if a strong health promotion voice is lost.

Notwithstanding the body of support for the definition of health promotion originating from the Ottawa Charter differing understandings of health promotion continue to exist throughout the contexts where activity labelled as health promotion takes place. These different interpretations are informed by contradictory ideologies, and result in a diversity of health promotion practice. Public health is also difficult to encapsulate in a form of words acceptable to all although the definition used in the Public Health in England (Acheson) Report (1988) is widely used. Exactly what is meant by the term new public health and the extent to which this is - or should be distinguished from health promotion is still not fully clear. Even where health promotion and wider public health are seen to be very similar some distinctions, operationally, and even conceptually, as we noted in Section 4, are still made.

We have tentatively identified a core perspective in terms of definitions and values, particularly within specialist health promotion, and this would probably be accepted by many practitioners and health promotion academics. A very large number of values have been associated with both health promotion and public health although there are a relatively small number which are frequently specified as core values. While we noted, in the empirical study, close similarities between these core values for health promotion and public health, there were also differences which it was suggested derived substantially from the meanings associated with public health medicine. In part, these differences lay in the extent of support for particular values in relation to the two terms - for example the much stronger emphasis on empowerment as a terminal value in health promotion and on prevention and protection in relation to public health.

Public health, on the basis of the literature and the empirical inquiry is seen to have a stronger utilitarian emphasis and a stronger, but not solely, population focus. Health promotion is less clear on its level of operation. In some ways it incorporates reaction against an individualistic focus especially when this is linked to lifestyle change,

although not where the emphasis is on processes associated with empowerment which may involve individuals or communities. In moving closer to the idea of wider public health and the emphasis on policy and environmental action there is a shift towards a population focus.

The influences on thinking and practice about health promotion and public health and their values, identified in the postal responses, were diverse, although WHO and other international influences stood out. The extent to which practice conforms with what have been provisionally identified as core values of health promotion varies according to context. It is a continuing fact, as one postal respondent stated, that the force of much of the rhetoric is social but the actions are still too often individual and directed towards behaviours. It was also noted that while the values suggest a holistic interpretation of health this is rarely achieved. A preference for working towards positive health is also difficult within contexts governed by the achievement of targets specified in terms of mortality and morbidity.

A large number of barriers to operating in line with values were identified in the postal responses. In the case of specialist health promotion, largely undertaken from bases within the health sector, a significant proportion of barriers were associated with the health sector context and with Government policy and targets which continue to reflect commitment to a medical model, even though wider public policy and some practice reflects broader thinking. While the barriers identified in the case of public health were comparable - to be expected since many respondents were viewing health promotion and public health (understood as new public health) as similar - a telling comment, noted earlier was:

The same as health promotion but less so.

A particular tension which has been discussed in the literature, although not brought out by many respondents, is that between values and evidence as influences on practice (Goodstadt, 2001; Seedhouse, 1995). The distinction is, to an extent, an artificial one since a commitment to evidence is itself a reflection of particular values. The tension is probably better conceived as one between two sets of values – those which we have identified as core and those values more clearly allied with public health medicine and which support a positivist view of evidence based practice. Evidence based practice was cited by some respondents as a core value for both health promotion and new public health alongside empowerment, equity, justice etc, – possibly with the nature of evidence sought being conceived more broadly than within the positivist model. These particular respondents were not conceiving values based and evidence based practice as being in opposition.

As a result of the continuing variations in the use of terminology, the relationships between health promotion and public health can be presented in a number of ways. Conceptual distinctions can differ from operational ones. This can generate confusion in theory as well as in practice. Confusion can be exacerbated by the perceptions held by one professional group about the nature and activities of another. Frequently mentioned in our empirical study were the narrow perceptions of health promotion that appear to be held by public health medicine. While practitioners may manage this confusion, it can be argued that the effectiveness of the activities undertaken in the

name of public health and health promotion must, to some extent, be compromised. Misconceptions and confusions can be barriers to collaborative working.

In their critique of health promotion Kelly and Charlton (1995) said that if it did not acknowledge its contradictions and make serious efforts to resolve them it deserved no better than to remain the object of critiques by both left and right. It is probably fair to claim that the contradictions are acknowledged and understood in the context of specialist practice but may not be across the realm of health promotion. The same point could also be made about public health but by virtue of its greater power it is under less pressure to address the contradictions in the use of the term public health. The adoption of health development, or some alternative, as an umbrella term to which both health promotion, public health medicine and other public health activities can be related has been considered. Some support was given to this although this might only be a local UK solution and might not receive wide support.

The general move to the idea of public health specialists, although not universally welcomed in health promotion is well underway. It is necessary to continue to identify the distinctive contributions that specialist health promotion practice can make to the future public health function and advocate for the survival of these contributions. A key aspect of this distinctive contribution is the values - both instrumental and terminal- which appear to be more consistently and strongly associated with health promotion than they are with public health, probably because of the association of the latter with public health medicine. We have also concluded that health education, especially using a critical empowerment model, still has an important part to play in health promotion and public health.

In whatever way we look at health promotion and public health we see evidence of values at work. Values influence the ways that health issues are understood, the ways that knowledge and theoretical bases are developed and the nature of strategies identified for health improvement. Values also influence the selection of activities that are undertaken to promote health and the priorities accorded to actions, the balance between activities at individual and population levels, the relationships with individuals and communities who participate in initiatives, the goals which are being sought, and decisions about means and ends in achieving the goals. In common with all other areas of public life where values are engaged there will be differences of view derived from the different values positions held by those actively involved. There will also be areas of agreement. We have supported the view that there is a measure of consensus around a small core of values for health promotion and wider/new public health but in the full complexity of these activities there are many values held. The extent to which the core values should be prescribed has, and will continue to be an area for debate. The complexities of the current situation may be uncomfortable for some but creative for others. The complexities do, however, need to be made fully explicit and the ways for working within them, identified. As stated at the outset this document was concerned with discussion of values in health promotion and public health and with producing a document designed to stimulate further discussion. We conclude with a number of recommended activities for future consideration.

Recommendations

- To consider whether the confusions surrounding the use of public health and health promotion are sufficiently great that a new term is needed which would accommodate both terms and their interrelationships. If the view is that public health should be retained consideration needs to be given to resolving current confusions in the use of this term and to identifying the appropriate mechanisms for doing this.
- To consolidate ideas on what is valuable and distinctive about health promotion and identify the ways that these valued aspects can be retained in the course of delivering the public health function.
- To consider the limits of what is to be accepted as health promotion and public health in terms of values and processes and the specification, where appropriate, of what is unacceptable.
- Public health practice can be 'values led' and 'evidence led'. While these are not incompatible the tensions between these emphases need to be more fully examined and the implications addressed.
- To review the place of health education within health promotion - in general - and with reference to specific approaches to health education activity.
- To consider whether there are contradictions in working on prevention as well as the promotion of positive health for some people currently involved in health promotion and how these contradictions should be addressed in the context of working as public health specialists.
- To actively address the resolution of situations where public health skills acquired through medical training are remunerated more generously than skills acquired through other training.
- To consider the development of multidisciplinary education and training for public health There is a need to address the strengths and weaknesses of existing M.Sc and MPH programmes and identify what needs to be retained from both traditions, the appropriate balance between education and training and the location of courses. Involvement in curriculum development should involve equal participation from current public health and health promotion specialists.

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