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Citation:

Warwick-Booth, L and Woodall, JR and Cross, RM and Bagnall, A and South, J (2018) Health promotion education in changing and challenging times: reflections from the UK. Health Education Journal. ISSN 1748-8176 DOI: <https://doi.org/10.1177/0017896918784072>

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Document Version:

Article (Accepted Version)

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**Title:** Health promotion education in changing and challenging times: reflections from the UK

**Abstract:** Health education has changed in numerous ways since the inception of this journal, with many developments moving the discipline forward in ways that perhaps were not envisaged 75 years ago. Whilst there have been reported concerns about the decline of the discipline of health promotion and therefore associated worries about education, the contemporary evidence base has grown (Woodall et al 2017 in press), which we argue supports the delivery of quality education and the development of capable, skilled practitioners. Pedagogy has further developed too, and technology now enables health education to have a broader global reach through online teaching, social media and open-access publications. Many global challenges remain, and the UK context is one in which both health education and indeed practice faces major trials despite the traditions and approaches to health education developed by those educated and trained in this setting over a period of many years. We argue that the broader UK policy environment remains a challenge to current health promotion education, research and practice.

## **Introduction**

Concerns related to the perceived decline of health promotion practice and education have been reported across the world, and the field of activity has had a 'chequered history in England' (White and Wills 2011: 44). Critical analysis of the discipline has paid attention to the crisis in health promotion and its location within a political climate mismatched to its principles and ideological basis, leading to calls for action to reinvigorate the discipline (Wills et al 2008). More positive analyses suggest that health promotion education and practice offer opportunities to manage complex global health threats (Liyaganawardena and Aboshady 2017), such as climate change and other 'wicked' health issues, and to serve as forces for social change (White and Wills 2011). There have also been many disciplinary developments that are beneficial for health promotion education. Furthermore, the scope and volume of health promotion research has been growing with resulting

increases in associated publications (Lahtinen et al 2005). Health promotion journals are reporting increased submissions of manuscripts across the globe (Potvin 2013, de Leeuwe 2013). Glanz (2017) also notes that the creation of the journal pedagogy in health promotion is now enabling discussion of the art and science associated with teaching health education. Thus, research (pedagogical and beyond) is arguably developing and contributing to health promotion education.

The terms health education, health promotion and health promotion education all have varying definitions, and have been debated for years without full international consensus being achieved. Within the US seven major terminology reports have been developed over an eighty-year period in response to these on-going debates (Report of the 2011 Joint Committee on Health Education and Promotion Terminology 2012). Similar debates are evident within other contexts. Traditional health education is about the communication of messages related to health, designed to inform people in general, and enable learning which is different to the provision of education to develop health promotion competencies amongst practitioners (Seymour 1984). The term health promotion is defined within the Ottawa Charter (WHO 1986, 1) as 'the process of enabling people to increase control over, and to improve, their health'. In many countries, the term health promotion is also seen to encompass health education, and health promotion education as part of a broader strategy linked to implementation (Taub et al 2009). Health promotion education has also been defined by the WHO (2017) as 'any combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes'. The focus of this paper examines educational provision for practitioners but given that health promotion education, is also part of practice (health promotion itself), this broader context is included within our discussion.

Space for health promotion education has positively developed since the inception of HEJ, now in its 75<sup>th</sup> year of publication serving as a support for those working within both education and practice. However, in this article, we argue that major challenges remain within the UK and other high-income

countries for health promotion education and associated practice, which we understand to be the practical development, application and evaluation of health promotion interventions, based upon education. Within this paper we reflect upon the current state of health promotion education (primarily taught credit bearing programmes) within England, offering comparative analysis and critical discussion of the importance of political context in determining health promotion education and practice.

### **Contemporary health promotion education**

#### *The evolution of health promotion education*

Improving the health of both individuals and communities has been a central concern of many historical civilizations, and this concern remains evident today. Health education and promotion has evolved into a profession that involves training, certification and the evaluation of practice. The origins of these educational developments in England has been discussed by Duncan (2013) who noted the contribution of a small number of scholars in Polytechnics and Colleges who developed curricula on the theoretical foundations and practice of health education and health promotion. Since then, perhaps the significant amount of attention paid to health and its determinants, it has been argued that health promotion experienced a golden age (Johnson and Breckon 2007). Some analyses support this, however there are less positive discussions when focusing upon contexts such as the UK.

The professionalization of health promotion as a discipline has resulted in the development of quality assurance approaches, and guidance underpinning the creation of curricula. The UK Public Health Skills and Knowledge Framework (PHE 2016) outlines the core skills and competencies required for the public health workforce. The framework provides a common reference for the review and development of standards of practice and curricular for training and education qualifications for those working with public health remits. Whilst standards and guidance are useful, questions remain about them being fit for contemporary educational purposes. At the European

level there is a wide variance in the development of training, occupational opportunities and the extent to which specialization is required despite the existence of such professional standards (Taub et al 2009). Indeed, the content of such education is often debated. Yassi et al (2017) note that educating practitioners with interdisciplinary knowledge about the ecological threats to health is not enough. Educational provision within this field is about competency development for impactful practice, rather than simply increasing awareness of the issues. Educational approaches need to ensure that the modelling of attitude and commitment is essential to support both community engagement and suitable policy-making. Thus, ensuring that health promotion education is firmly embedded within practice contexts.

Furthermore, it has been suggested that classroom teaching for health promotion is less relevant given the age of the internet, many forms of social media and access to greater levels of information. Learners expectations have also changed, challenging educators to diversify their approaches. Hence there may be a need to adapt teaching to include online methods, fieldwork and blended approaches (Glanz 2017). However, traditional health education approaches remain relevant for example, action learning and some classroom delivery are still useful. There needs to be a balance between the old and new, whilst recognising the many opportunities that technology can deliver for both health education and practice.

### *Workforce challenges in the UK*

The demand to train a 'health promotion' workforce is no longer what it was in the UK, in contrast to some middle and low-income countries. This is arguably politically driven. For example, in Ghana the Ministry of Health is in support of health promotion generally and sees the value of it for tackling the social determinants of health (Klutsey, 2010, Addai et al 2012). Ghana has a structure for its health promotion workforce, although under-staffed/under-resourced as is typical in similar

contexts. In Zambia a relatively recent change of government has also signalled renewed interest in health promotion (The Health Press 2017). In turn these changes led to a demand for health promotion training which equips the workforce. Whilst both countries are working to increase the capacity of their health promotion workforce through in-country training there are still workers looking elsewhere for opportunities to develop and learn, hence the persistence of demand for courses in high-income countries. Dixey and Green (2009) comment upon a partnership approach between a training college in Zambia and a UK University as a mechanism to tackle the sustainability of the health workforce in Zambia, in response to 'brain drain'. The partnership offered opportunities for professional public-health development in-country through educational provision. The educational provision was well received, and arguably strengthened workforce capacity (Development Solutions 2014). This contrasts to the reduction in workforce budgets for health promotion education within the UK, potentially stagnating both the learning and development of practitioners.

#### *Online approaches and access*

However, the development of massive open-access online courses (MOOCs) has opened up access to health promotion education for many. This is a positive tool in addressing some of the training difficulties experienced particularly within economically poorer areas of the world, enabling access for both health professionals as well as the wider public (Liyanagunawardena and Aboshady 2017). Given the many health challenges facing lower-income countries, including the increasing burden of non-communicable diseases, health education is arguably of the utmost importance. There are now a range of free courses which have been useful in educating workers about Ebola (Coughlan 2014). Therefore, E-learning is capable of addressing some of the existing gaps in educational provision and potentially tackling in-country challenges including cultural barriers to the open discussion of sexual health promotion (Liyanagunawardena and Aboshady 2017). However, despite the potential of these options, there are still issues in terms of uptake, with linguistic and cultural barriers at play, as

well as limited access to digital technology and low levels of internet connectivity (Aboshady et al 2015). However, critical analyses of MOOCs show high numbers enrolling but fewer completing, and issues with both learning processes and assessments have been highlighted (Keramida 2015).

Liyanagunawardena and Aboshady (2017), argue for the further development of MOOCs to meet the needs of specific populations by tailoring courses to different language requirements and including downloadable content as mechanisms to further unlock the potential of these approaches. The landscape of health promotion and its associated reach is changing, with digital development offering interesting opportunities as well as challenges (Lupton 2014).

Comparatively, health education in higher-income countries has remained the same for many years, leaving gaps between theory and practice in relation to socio-political activity as the focus of health promotion education, and the reality of practice focused upon individual behaviour change (Whitehead 2004). Furthermore, the development of health promotion education has been accompanied by an increasing demand for demonstrations of effective interventions for example in relation to behaviour change, health status indicators (Kok et al 1997) and more recently social return on investment (Masters et al 2017). Evaluation research is often a standard component of health education modules within university credit-bearing programmes, with a view to enabling practitioners to support demonstrations of effectiveness. However, this is complicated territory and may not be positive for the discipline given that proving effectiveness is difficult. These approaches are linked to the impact of shifts within policy direction, and market forces.

### *The impact of market forces*

Furthermore, western educational provision has also received critical attention, given its increasing marketization and the associated implications of this. Brown (2015) analyses the changing higher education landscape with the UK since the 1980s, when the process of marketization began. He

notes that this includes the introduction of student fees, and subsequent price rises, changes in research funding and reduction in subsidies in several areas. The Coalition Government (2010-2015) advanced the speed of this process through increasing fees, deregulating student number places and relaxing market entry rules. Ultimately the cost of education is now predominantly borne privately, whilst questions remain about how these changes relate to efficiency, effectiveness and innovation. Higher education can produce many benefits (McMahon 2009), and can be for the social good in subject areas such as health promotion given its potential to produce future practitioners, contribute to social justice, health improvements and human rights. However, the marketization of the context in which health promotion education is delivered is restricting the number of students who can afford to access qualifications. Feo (2008: 227) argues that within the context of public health training, education has become 'an individual consumer good to be acquired in the marketplace', as specialist training, is only available at the postgraduate university level. The marketization of higher education has also had an impact upon working conditions for staff within the UK. Allimer (2017) notes the blurring of work and personal time for staff and increased job insecurity across the sector, whilst asking about the implications of this in relation to teaching quality. We also question the likely impact of these changes upon staff health and wellbeing, suggesting that there are many opportunities for health promoting universities, given that some studies show that the UK is facing a mental health crisis in the workplace, with many suffering from anxiety and depression (Isherwood 2017). A more positive reflection on current western higher education provision would suggest that whilst postgraduate provision is university-led, this has resulted in developments in the quality and standards of such health education, as well as the 'production' of skilled and reflective practitioners. Some UK Universities are also working to build health promotion capacity in lower-income countries through distance learning and blended curriculum development, thus offering broader scope and more opportunity than critics recognise. However, distance learning courses within UK universities charge expensive fees, thus not everyone can afford to access them.



In terms of UK health promotion education, the reducing number of under-graduate and post graduate courses with the term 'health promotion' in the title is evidence of health promotion's general demise. This has been accompanied by more focus upon Masters in Public Health within some institutions, which have less focus upon the social determinants of health, and a more biomedical basis. Health promotion simply isn't 'in vogue' in the UK like it is elsewhere in the world – particularly in England. Scotland and Wales seem to be in a slightly different position which is likely down to political agendas (Thompson et al 2017). The changing policy context affecting higher education and therefore health education delivery is reflective of a broader administrative turn, raising further questions about challenges facing the discipline.

### **Policy contexts, health education and health promotion**

#### *English Policy*

The future of health promotion in England has received critical scrutiny because of structural reorganization in which practitioners have been moved into local authority, and fragmented as a result. White and Wills (2011) argue that there is no comprehensive picture of the impact on health promotion practice resulting from policy changes such as the commissioner/provider split and the introduction of a health care market which occurred under the UK New Labour government (1997-2010). Since 2013, under the UK Coalition governance, decision making in relation to public health shifted from the National Health Service (NHS) to Local Authority (Kneale et al 2017). The White Paper, *Healthy Lives, Healthy People* (Department of Health 2010), outlined a 'new era for public health, with a higher priority and dedicated resources'. The NHS Five Year Forward view (NHS England 2014) went on to argue for 'a radical upgrade of prevention and public health'. However, despite some positive policy discourse in relation to public health, the government have focused upon structural reforms and efficiency savings within the NHS (Kings Fund 2015), whilst public health

has remained the poorer neighbour in terms of priority setting as has frequently been the historical case.

The move of public health practice to Local Authority in England involved the creation of a ring-fenced budget approach for dedicated health promotion interventions, arguably serving as an opportunity for a broader base of work encompassing determinants such as housing, open spaces, education and creative arts (White and Wills 2011). However, this is no longer the case after the implementation of austerity. The BMA (2016) note that the combination of austerity and welfare reform within the UK has resulted in reduced public spending through budget cuts to specific departments. Local authority budgets have been cut by central government, as have resulting public health ring-fenced allocations. The Kings Fund (2017) notes that the central cuts have impacted (albeit unevenly) upon public health services with less provision now being funded in areas such as smoking cessation, alcohol and drug use services. Public health funding has been reduced by £200 million in 2015/16 and it is proposed that a further £600 million will be cut by 2020/21, with local authorities having to make decisions about which services they fund, and which they do not (RSPH 2017). It is likely within this context that the contemporary requirement for evidence of effectiveness has been used to support budget cuts (Kneale et al 2017). Whilst policy-makers frequently note the importance of preventing ill-health, this is not supported by associated funding. The majority of health funding in the UK is spent upon treatment services, rather than prevention (BMA 2017).

Given that the Ottawa Charter (WHO 1986), details both enabling and empowering ways of working in support of individual and community health, including community development the overall policy context within England since 2005 has eroded the broader practice base of health promotion, with a resulting implementation of silo working, fragmented delivery and a narrow disciplinary focus upon behavioural change, somewhat contrary to the disciplines founding ethos. The impact of the UK

policy changes has been to halt progress in reducing inequality and poverty, and to increase negative health and wellbeing outcomes due to a lack of focus upon health in all policies (BMA 2016). Policy makers need to pay attention to the implication that austerity and fiscal policies have upon health, and associated outcomes given that these policies have undermined health promotion (Ifanti et al 2013). However, this seems unlikely in the UK given the more immediate issue of Brexit and its potential impacts.

### *The global policy context*

However, there are some positive policy changes worthy of note, within the broader global arena. There are recently published European and global health promotion charters, indicating support for the discipline and related education. The Vienna Declaration was adopted at the European Public Health Conference in November 2016 (EUPHA 2016). The Shanghai Declaration was also adopted in the same month at the 9<sup>th</sup> Global Conference on Health Promotion (WHO 2016). The Vienna Declaration has identified issues needing to be addressed within the future practice of health promotion, offering contemporary guidance to the public health community (Tilford 2017). Practice also remains strong in contexts like Sub-Saharan Africa, with health education in high demand within these areas. Health promotion in the UK has followed a different trajectory to other similar countries (high-income, global 'north') such as Canada, Norway and Australia. In such countries health promotion is arguably faring better in comparison (Wise, 2008, Thompson et al 2017) although there are some critics in these contexts (Hancock, 2011). Publications such as the Australian Journal of Health Promotion and the Scandinavian Journal of Health Promotion are perhaps testimony to this. This is interesting to note given the very similar political contexts (broadly neoliberal). In Norway the recent Public Health Act is underpinned by health promotion principles (Fosse and Helgesen, 2017). Perhaps this difference is, in part, due to national political drivers. In the UK context we are witnessing a move away from social and liberal values and the

consequent systematic dismantling of the welfare state (Thompson et al 2017). The focus on the individual in public health policy at the expense of the structural factors which determine and influence health is further evidence of this.

The current policy direction in some contexts such as the UK and Greece has been criticised for being neoliberal in focus. Neoliberalism can be defined as the advancement of markets and associated capitalist restructuring as mechanisms to increase economic growth, ongoing since the 1970s (Maskovsky and Kingfisher 2001). However, analyses treating neoliberalism as a 'totalizing discourse' governing everything need careful consideration (Carter 2015: 375). Neoliberalism has been cited as leading to medicalization and the individualization of risk however, other more positive discourses about community health and wellbeing still exist. Johnstone (2017) notes the potential of community assets in improving health and wellbeing, and the related development of new resources by Public Health England including guidance on community engagement (NICE 2016) and the family of approaches to health and wellbeing (South et al 2015). The development of the Sustainable Development Goals is also worthy of note. These are a new, universal set of goals, targets and indicators for use by UN member states as a mechanism to shape their own policy and practice until 2030. They are broad in scope, and note the importance of tackling growing wealth (Melamed and Ladd, 2013). Thus, if drawn upon, they offer some challenge to neo-liberal policy direction.

Furthermore, libertarian paternalism has also entered policy discourse, in approaches that nudge individuals in a healthier direction (Jones et al 2013). Simply noting that neoliberalism is affecting health promotion, or that the discipline itself is contributing to it including within its educational focus and content, is not a complex enough analysis (Bell and Green 2016). For example, educational content can challenge the dominant discourse by illustrating the importance of charters and the reduction of inequalities but can also focus upon the importance of evidence based practice, and the success of smaller scale projects taking place within discrete settings which are at odds with a broader social determinants perspective (Thompson et al 2017). Ayo (2012: 104) argues

that the manner though which contemporary health promotion is employed within Western neoliberal societies reflects and reinforces prevailing political ideology. Health promotion practice can be described as a product of social, cultural and economic influences that in some contexts are at odds with the value base of the discipline at the point of its establishment. Questions do remain about these discourses and to what extent they side-line the social determinants of health and approaches that focus upon social justice (Carter et al 2015), both educationally and within practice. Despite negative policy discourse in some places being viewed as a challenge to health promotion education, and related practice within the broader context of the impact of neoliberalism, there are some positives to note. Given increasing societal concerns about health, health promoters and educators are still presented with some opportunities to promote both health and wellbeing.

### **Changing discourses and implications for practice**

Health promotion has the attention of policy-makers, institutions and the media (Ayo 2012). Being healthy and pursuing a state of healthiness is also engrained within the dominant discourse of contemporary western countries particularly in England. However, critical commentators suggest that the context of neoliberalism within a broader capitalistic culture is driving health promotion at the level of the individual (Crawford 2006). Healthism is the idea that individuals should work to maximize their own health (Peterson and Lupton 1996) which will in turn be beneficial for wider society and cost the state less. There are clear moral tones to the direction of western healthy lifestyles culture and associated health promotion. Whilst there are benefits to healthy behaviours such as physical activity and nutrition, attention should also be paid to the intent to champion self-regulation and the individual control of health at the expense of the evidence base around the social determinants of health (Ayo 2012). Interventions within England are following a similar pattern, targeting individual level change, rather than focusing upon the social determinants of health. For example, focusing upon smoking cessation and healthy lifestyles rather than turning attention to the

causes of the causes. Thompson et al (2017) offer the example of specialist projects to deal with homelessness within inner city areas, which do not tackle its root causes via political and institutional pathways. So, can health promotion education work to challenge this? Some health education courses are based upon the social model of health, and ensure that the politics and policy of health underpin the modular content as a mechanism to educate future practitioners about the social determinants of health. There is also a large and growing evidence base about the importance of social inequalities and social determinants of health, with several key thinkers driving forward the evidence base; Marmot (2017), Wilkinson and Pickett (2009), Shrecker and Bamba (2015) to name a small number of examples. A theoretical agenda is evident within the health promotion research literature as well as some educational provision and this can be used as a tool by educators to encourage upstream thinking amongst practitioners, and may serve as a starting point for generating activism (Whitelaw et al 1997). However, the wider societal context has led to people based within practice contexts reporting feelings of moral distress as they are part of a minority workforce within broader systems which do not value their input (Sutherland et al 2015), despite the WHO (2016) citing the need to develop a workforce which is able to tackle the social determinants.

### **The need for health education and health promotion**

Whilst there are many challenges remaining in terms of the changing technological landscape and political directions that are detrimental to health and wellbeing, health promotion education and health promotion practice have been developing as a discipline, and are still required to contribute to efforts to reduce inequalities, improve health and espouse values which serve as a challenge to consumerism and individualism (Feo 2008). Furthermore, policy-makers are recognising the need to move to more preventative models, especially as such approaches can achieve efficiency savings, which leaves room for education and practice. We argue that there is a clear case for the contemporary need for health promotion education, within the UK and further afield. Tones et al

(1990) wrote about the case for needing health education as a mechanism to safeguard learning about health, culture and experiences so that benefits can be derived from the prevention of illness. They also noted the increasing concern with economic growth and productivity within contemporary Britain. Both points remain pertinent at the time of writing. There is still much work to be done (Thompson et al 2017).

We can draw upon the evidence base about the current state of the world's ill-health, the persistence of inequalities, political turmoil, and the numbers of people living their lives without basic human rights being met (Sim and Mackie 2016), as starting points for making the case for health promotion education and practice. "We have to stand together to present the evidence for health, not the sometimes dangerous rhetoric of would-be power" (Sim and Mackie 2016; A1). Contemporary health promotion education offers the opportunity for transformational learning related to the importance of the social determinants of health, the need to challenge victim-blaming cultures and associated hardening social attitudes as well as lessons associated with understanding that health is political (Bambra et al 2005). This calls for the communication of knowledge (via health promotion education) of the wider factors at play which determine health such as both the political and commercial determinants of health, trade rules, welfare policies, economics and the environment (van Schalkwyk 2017). Given these many challenges, Erwin Campbell and Brownson (2017) suggest that public health practitioners need additional training to ensure adequate skills such as policy analysis, evaluation, cross-sectoral working and communication. Whilst the world is in such a state of flux, health education curriculum can be used to equip future practitioners. Further development of the field as a profession and discipline is required to enable people to act. Therefore, health promotion education requires scaling up to ensure skilled professionals with appropriate competencies (Petrankova and Sadana 2007). Yassi et al (2017) argue for the defrosting of the old paradigm in the teaching of both population and public health, specifically within the Canadian context. Thus, the knowledge, attitudes and skills being taught need to be revisited in

order to be redeveloped as more suitable mechanisms to support the implementation of approaches better able to respond to contemporary challenges. The importance of learning is central to tackling the many challenges that have been noted here, as it underpins workforce development (Welter et al 2017) which can then serve to improve population health (Koh 2010).

## **Conclusion**

If successful health promotion education is based upon producing practitioners who embody the values of the Ottawa Charter (WHO 1986), and understand the need to tackle the social determinants of health, are some UK universities producing practitioners who are then stifled by the broader political context in which they go on to work in, and the frequent practice focus upon individualistic behavioural change interventions? Is there a mismatch between the ideological basis of health promotion and current policy direction, particularly within the UK? These questions of course remain central to the discipline, and whilst debates related to these areas are likely to continue, health promotion education is still needed. It can serve as a mechanism to inform knowledge, deliver transformational learning, support advocacy and produce skilled and capable practitioners who have problem solving skills. Demand for health education is evident globally, and given the many health challenges facing the world, a case can easily be made for health promotion education and associated practice to tackle the social determinants of health. Furthermore, increased knowledge about health within the western world, digital developments which offer tools to communicate evidence and wider reach to educate, provide new opportunities for health promotion education. Whilst some contexts such as the UK offer challenges to both health promotion education and practice because of the political nature of health, current policy direction and marketization, this does not ultimately diminish need. Thompson et al (2017) argue that the principles of the Ottawa charter need to be relaunched within the UK to ensure that a stronger



emphasis on health inequalities is brought about. This may be a starting point for ensuring that health promotion education better matches services and the wider practice context.

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