HEALTH PROMOTION
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Overview
This chapter focuses on three broad areas – the concept of health, setting out the distinctive features and values of health promotion and establishing the position of health promotion vis-à-vis modern multidisciplinary public health and health education. It will:

- explore alternative conceptualizations of health
- develop a working model of health
- consider the ideology and core values of health promotion
- identify different models of health promotion
- set out the rationale for an empowerment model of health promotion
- locate health promotion within modern multidisciplinary public health
- propose a new ‘critical’ health education as the major driver and distinctive voice of health promotion.

INTRODUCTION

The primary concern of this book is to provide insight into the factors that contribute to the effective and efficient design of health promotion programmes. The way in which health is conceptualized has major implications for planning, implementing and evaluating programmes. Equally, the approach adopted at each of these stages will be influenced by the values of those working to promote health.

HEALTH AS A CONTESTED CONCEPT

Developing clear goals will depend on how health is defined. Yet, it is acknowledged that health is, as Gallie (1955) famously described, a contested and elusive concept, a
notion which is widely accepted (Duncan, 2007). Its many, often conflicting, meanings are socially constructed. Lowell S. Levin likened the task of defining health to shovelling smoke. It is difficult, to say the very least, to provide precise definitions, largely because health is one of those abstract words, like love and beauty, that mean different things to different people, a point more recently referred to by Warwick-Booth et al. (2012). However, we can confidently say that health is, and apparently always has been, of significant value in people’s lives. If we do not acknowledge the contentious nature of health and have a sound understanding of the determinants of our preferred conceptualization, it is unlikely that we will be able to develop incisive strategies for promoting it.

Defining health: contrasting and conflicting conceptualizations

A number of tensions emerge in defining health. These include the relative emphasis on:

- disease or well-being
- holistic or atomistic interpretations
- the individual or the collective
- lay or professional perspectives
- subjective or objective interpretations.

One of the most persistent distinctions between definitions of health has been whether the focus is on wellness or on the absence of disease. This is encapsulated in the classical myth of Hygeia and Asclepius (see box), but continues to have relevance to contemporary debates about the nature of health and the purpose of health promotion.

The confrontation of Hygeia and Asclepius

Hygeia was a goddess who symbolized the virtues of wise living and well-being; Asclepius was a physician who lived in the twelfth century BC and came to represent the medical view of health. As Dubos noted:

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 [sic] 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 sceptical 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.
While Asclepius is in Luther’s words only ‘God’s body patcher’, the serene loveliness of Hygeia in the Greek marble symbolizes man’s lost hope that he can some day achieve a state of harmony within himself and with the surrounding world.

Source: Dubos (1979: 131, 134)

As Dixey et al. (2013a: 14) argue, it is very difficult, if not impossible, to reach a consensual definition of what health is. Probably the best known definition of health comes from the Constitution of the World Health Organization (1946, 2006a): ‘Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.’ While this definition has been criticized because of its utopian nature, and as impossible to achieve (Blaxter, 2010), it extended the boundaries of health beyond the absence of disease to include positive well-being and firmly acknowledged the multidimensional, holistic nature of health. The Constitution further asserts that:

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

This assertion, also enshrined in numerous United Nations human rights treaties such as the International Covenant on Economic, Social and Cultural Rights (Office of the High Commissioner for Human Rights (OHCHR), 1966) and the Universal Declaration on Human Rights (UN, 1948), politicizes health and places pressure on governments to create the conditions supportive of health (WHO, 2007a). Furthermore, this emphasis on health as a fundamental human right focuses the attention of those seeking to promote health on equity and empowerment.

Saracci (1997) argues that definitions of health, such as the WHO definition, couched in terms of total well-being, essentially equate health with happiness. We have also, more recently, seen understandings about subjective health turn more towards notions of happiness, well-being, mental health, resilience and assets. This potentially makes the limits to health boundless, leading to all problems becoming ‘health’ problems and possibly unleashing unlimited demands for health services. It could arguably therefore undermine health and human rights arguments. Some argue for more attention to be paid to notions of ‘well-being’ and quality of life. Drawing on the WHO definition of health, Grant et al. (2007) highlight three dimensions of well-being – the psychological, the physical and the social.

Lay interpretations of health

Notwithstanding the undoubted difficulties associated with measurement, from a health promotion perspective, the subjective element – health as it is experienced in people’s lives – is of central importance. Potvin and McQueen (2007) argue that this
requires a ‘realignment’ of our knowledge base – first, integration of knowledge across a range of social sciences and, second, recognition of the legitimacy of lay knowledge. Buchanan (2006), who has defined health as synonymous with the ‘good life’, emphasizes the importance of subjective, autonomous interpretations:

we should shift the emphasis in the field from the rather narrow focus on producing specimens of physical fitness, to a broader concern for human wellbeing, here understood in terms of enhancing moral judgment, promoting greater self-understanding, liberating people from scientistic assumptions (perpetuating the belief that human behavior is determined by antecedent causes that only highly trained scientists can divine), advancing the cause of social justice, and promoting respect for the diversity of understandings of the good life for human beings. (2006: 302)

This draws attention to lay interpretations of health that will be considered more fully in Chapter 2. However, for now it is relevant to observe that lay interpretations are complex and multidimensional. The absence of disease is central to lay views, but resilience – the ability to cope with life – and functional capacity are also important. Social class differences have also been noted (Blaxter, 2010; Calnan, 1987), with a greater emphasis on the ability to function in lower social classes and a more multidimensional conceptualization including positive well-being in higher social classes. While lay interpretations are often taken to be different from more systematized ‘professional’ accounts, commonalities do exist. Lay accounts – particularly public as opposed to private accounts – tend to incorporate knowledge and understandings developed in expert paradigms (Shaw, 2002). One of the difficulties that we have in establishing lay beliefs about health is that much of the research that claims to explore these, actually focuses on ill-health and dis-ease rather than on more positive notions of health (Hughner and Kleine, 2004).

**Adaptation, actualization, ends and means**

Utopian visions of health, while aspirational and even inspirational, are ultimately unattainable. Humanity rarely, if ever, achieves stasis. People are constantly engaged in an often problematic process of adaptation to their environments – to their physical, material, economic and social circumstances. The dynamic interaction between individuals and their environments is recognized in definitions of health promotion as enabling people to gain control over their lives and their health (WHO, 1984). The central tenet of Dubos’ influential perspective on health is that positive health is a mirage, as reiterated by Blaxter (2010) – it is evanescent and unattainable, but worth pursuing. If health means anything, it resides in the pursuit, in engaging with these constantly changing and typically unpredictable environmental forces.

Aspects of Maslow’s (1970) notion of self-actualization resonate with Dubos’ perspective on the nature of health. Maslow defines it as follows:

Self-actualization … refers to man’s desire for self-fulfilment, namely, to the tendency for him to become actualized in what he is potentially. This tendency might be phrased as the desire to become more and more what one idiosyncratically is, to
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become everything that one is capable of becoming ... In other words, 'What a man can be, he must be.' (1970: 46)

Apart from providing a useful operational definition of psychological health and his emphasis on the importance of self-esteem, Maslow’s work has considerable relevance for the empowerment imperative of health promotion. Furthermore, it raises the issue of whether health is an end in itself – a terminal value – or whether it is instrumental for the achievement of other valued goals. The latter interpretation is encapsulated in the Ottawa Charter conceptualization of health as a ‘resource for everyday life, not the objective of living’ (WHO, 1986) and in the Declaration of Alma Ata (WHO, 1978) as a means of achieving a ‘socially and economically productive life’. Whether desired goals in this context are defined by individuals themselves or by society, generates further questions about the respective emphasis on self-actualization or collective responsibility. The Helsinki Statement Health in All Policies (WHO, 2013) from the recent WHO conference, the 8th Global Conference on Health Promotion held in 2013 in Helsinki, does not revisit the WHO’s classic definition of ‘health’; instead, it focuses on the need for attention to health in policies in all sectors. This is discussed in more detail in Chapter 6.

Coherence, commitment and control: health as empowerment

In an article published posthumously, Antonovsky (1996) declared his concern about the dominant paradigm common to both medicine and health promotion. This, he argued, is based on the dichotomous classification of people into those who have succumbed to disease as a result of exposure to risk factors, and those who have not. He urged health promoters to move away from this obsession with risk factors and adopt a ‘salutogenic model’ that views health and disease as a continuum and focuses on the conditions leading to wellness.

‘Salutogenesis’ is a key concept that focuses on the ‘salutary’ – that is, health enhancing – rather than ‘pathogenic’ – that is, disease causing aspects of health. It incorporates Antonovsky’s main theory about the factors that determine the extent to which people become healthy and experience well-being. Central to this theory is the challenge posed by coping with ‘the inherent stressors of human existence’ (1996: 15) – encapsulated in the notion of ‘entropy’ that refers to the level of disorder within systems. At a psychological level, it refers to perceptions that disorder exists. People’s worlds may be more or less chaotic. Such ‘chaos’ is held to be undesirable, whether it exists in reality or only in people’s perceptions. The salutogenic approach is, therefore, designed to reduce entropy and perceptions of entropy and, in so doing, generate a sense of coherence, which it identifies as a central attribute of a healthy person.

Antonovsky defines coherence as:

a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that one’s internal and external environments are predictable and that there is a high probability that things will work out as well as can reasonably be expected. (1979: 123)
The three main elements are comprehensibility, manageability and meaningfulness. These are concerned with how we make sense of the world around us and what we experience; how we feel about this and the extent to which we are able to manage or cope with the challenges of life (Sidell, 2010). More recently, a body of work on salutogenesis and health promotion has emerged from Scandinavia. For example, Lindström and Eriksson (2005, 2009) take a salutogenic approach to creating healthy public policy. They also argue that a salutogenic approach could be a solution to contemporary public health challenges, particularly with regards to mental health promotion (Lindström and Eriksson, 2005). See www.salutogenesis.fi for further information. A review by Harrop et al. (2007) set out to establish the evidence around resilience, coping and salutogenesis. The authors concluded that:

Although the quality of the evidence base is considered weak in terms of traditional review methods … there was considerable consistency in findings with regard to identifying factors associated with positive outcomes. This evidence suggests individual, family, community and institutional factors all play a role in buffering some of the effects of disadvantage and facilitating ‘healthy’ adaptation. (2007: 72)

Health and empowerment

The concept of empowerment will receive further consideration throughout this book. For now, we will confine the discussion to the relationship between empowerment and health. If we accept that having control is central to definitions of health, a number of alternatives follow. First, empowerment could be seen as synonymous with (positive) health. In other words, to be healthy is to be empowered! Alternatively, empowerment could be seen as instrumental – that is, as a means to achieving (positive) health. A third conceptualization is also possible. Empowerment could be viewed as both a terminal and an instrumental value. The standpoint here is that empowerment will necessarily be a key component of positive health as an end. At the same time, it will be a means, if not the most important means, to achieving disease prevention and management goals that are components of holistic interpretations of health.

The Commission on Social Determinants of Health (2007) emphasizes the importance of empowerment as a means to achieving health equity. It identifies three key dimensions of empowerment – material, psychosocial and political – and focuses attention on the structural factors necessary for empowerment. It particularly notes the disadvantaged position of women.

We might make two further observations on empowerment in the context of salutogenesis. First, two of the three key requisites of a sense of coherence – notably, comprehensibility and manageability – are concerned with beliefs about control and these also figure prominently in conceptualizations of empowerment. Second, there is
potential conflict between empowerment and the sense of meaningfulness, which is the third element of a sense of coherence. In short, while the feeling that ‘all is for the best in the best of all possible worlds’ will doubtless make people feel better, and that life, from a salutogenic perspective, is more meaningful, it may well be delusory and hence disempowering.

HEALTH: A WORKING MODEL

As may be seen in Figure 1.1, for all practical purposes, health is defined as having both positive and negative aspects. The term ‘well-being’ is used as shorthand for the positive dimension. Rather than seeing well-being and disease as opposite ends of a single spectrum, they are represented as coexisting. Furthermore, although each may influence the other, they can vary independently. For example, although well-being may be affected by the presence of negative disease states, it is possible, even desirable, to have high levels of well-being regardless of disease being present. Conversely, there may be high or low states of well-being in the absence of disease. We are quite clear that preventing and managing disease and disability is a laudable goal in its own right and a central concern of those who are professionally involved in healthcare and health promotion. However, it is equally clear that the more positive dimensions must also figure prominently in the formulation of a satisfactory definition of health. In the first place, those involved in public health and health promotion cannot ignore its
importance. But also, those measures that result in the achievement of positive goals are frequently more effective in achieving preventive outcomes than the more limited tactics employed by espousing a narrow disease prevention model.

**Being all that you can be**

The three components that make up WHO’s holistic conception of health are featured in the model. Following Maslowian self-actualization principles, it is tempting to argue that maximal health status involves ‘being all that you can be’. Healthy individuals would thus be those who had fulfilled their mental, physical and social potential. As we have argued, the attainment of complete mental, physical and social health is logically and practically impossible. Furthermore, it would be feasible to achieve high levels of potential in relation to one component of health at the expense of others. For example, the degree of commitment required to achieve maximal physical fitness might not only militate against social health and, possibly, be inconsistent with cultural norms, it might also be viewed as evidence of obsessional neurosis! Equally, a lifestyle characterized by sloth and self-abuse might lead to considerable happiness and a very successful social life, but result in an early death.

Accordingly, health must involve some kind of balance between mental, physical and social components. How, though, is such a balance to be determined? Do individuals themselves make the decision or should society decide for them? As the second option is inconsistent with the principles of empowerment (which are intrinsically healthy), only the first option is a serious contender. We will, however, emphasize later in this book the importance of healthy individuals being guided by commitment to a considerate way of life. Thus, individuals should be in a sufficiently empowered position to enable them to choose a course of action, provided only that the rights of other people are not damaged and, ideally, take action to support those who may be disadvantaged.

**Mental, social and spiritual health**

The definition of physical health is comparatively straightforward. On the one hand, it is associated with minimizing disease and disability; on the other hand, it may involve having a sufficient level of fitness necessary for achieving other (more important) life goals and/or the experience of high-level wellness or, more realistically, the feelings of well-being (allegedly) associated with a high degree of physical fitness. Well-being may thus be associated with fitness, but is by no means an identical dimension of health. A person might, for example, exhibit high levels of fitness, but limited feelings of well-being or, alternatively, high levels of well-being but minimal fitness!

Defining mental health is rather more complicated and problematic. We will confine current discussion to making just two observations. First, it is useful to consider mental health as having both cognitive and affective dimensions. The affective
dimension includes emotions and feelings and most discourse on mental health centres on this aspect. The cognitive dimension rarely features in definitions of mental health, but might be incorporated in a holistic model. ‘Being all you can be’ in cognitive terms refers to the extent to which individuals fulfil their intellectual potential. The reasons for failure to fulfil intellectual potential have been a source of considerable study and evidence of inequity in this regard has provoked concern. It is thus intimately associated with broad-based health promotion initiatives designed to address general social inequalities and break cycles of deprivation. Second, many people have asserted that any serious consideration of positive health must include the spiritual dimension. This is itself open to several interpretations, but features in Figure 1.1 in the context of mental health and well-being. It has both a cognitive element, consisting of the doctrinal aspects of, for instance, a religious system, and the emotional commitment associated, in this case, with the value system central to the notion of faith – that has been referred to as ‘an illogical belief in the occurrence of the improbable’ (an observation attributed to the American journalist H.L. Mencken). Notwithstanding such scepticism, faith can be integral to meaningfulness and the sense of coherence that is central to salutogenesis. Furthermore, religious values can underpin personal health choices and a sense of responsibility towards upholding the rights of others to health.

The importance of mental health and well-being was highlighted by the publication of the *Perth Charter for the Promotion of Mental Health and Wellbeing* (2012), which resulted from the 7th World Conference on the Promotion of Mental Health and the Prevention of Mental and Behavioural Disorders. Whilst acknowledging the importance of the holistic stance of the Ottawa Charter for Health Promotion, the Perth Charter argues that ‘health promotion in practice has largely been confined to physical health promotion’ and that therefore the Perth Charter should be viewed as ‘a first step towards the eventual integration of physical and mental health promotion’ (*Perth Charter for the Promotion of Mental Health and Wellbeing*, 2012). It sets out seven key principles as follows:

- **Principle 1**: Mental health is more than the absence of mental illness. Mental health promotion includes both preventing illness and increasing well-being.
- **Principle 2**: The foundations of social and emotional well-being develop in early childhood and must be sustained throughout the lifespan.
- **Principle 3**: Mental health promotion must be integrated with public health and requires a cross-sectional approach.
- **Principle 4**: Mental health and illness are constructed, experienced and viewed as different to physical health and illness.
- **Principle 5**: Mental health and mental illness are a dynamic balance.
- **Principle 6**: Destigmatisation of mental illness and addressing discrimination are essential components of mental health promotion.
- **Principle 7**: Mental health promotion must take place at the individual and societal levels.
Social health: individual and society

The social dimension of health is equally complex. As can be seen from Figure 1.1, there are two categories. The first of these refers to the social health of the individual; the second is concerned with the health of society itself. Three main aspects of individual social health have been identified.

**Independence:** a socially mature individual acts with greater independence and autonomy than a relatively immature individual.

**Interpersonal relationships:** a socially healthy individual is characterized by the capacity to relate to a number of significant others and cooperate with them.

**Responsibility:** a person who is socially mature accepts responsibility for others.

The distinction between the social health of individuals and the health of society is recognized in everyday parlance with references to ‘sick societies’ and ‘social malaise’. We will make further reference to this dimension of social health later in this chapter and at a number of points in this book when we consider the concerns in health promotion with powerlessness, meaninglessness, normlessness, isolation and self-estrangement that are characteristic of ‘sick societies’ and contribute to social exclusion.

PROMOTING HEALTH: COMPETING IDEOLOGIES

No science is immune to the infection of politics and the corruption of power.

Dr Jacob Bronowski, *The Ascent of Man*, BBC2, 1973

Defining health promotion

A key issue in defining health promotion is whether it is viewed as an umbrella term, covering the activities of a range of disciplines committed to improving the health of the population, or as a discipline in its own right. Bunton and Macdonald (2002: 6) suggest that ‘recent changes in the knowledge base and the practice of health promotion are characteristic of paradigmatic and disciplinary development’. They take a discipline to involve an ordered field of study embracing associated theories, perspectives and methods. A discipline would be expected to have its own ideology that would also inform standards of professional practice. Prior to our analysis of the ideology of health promotion and the values integral to different models, we will briefly clarify the distinction between health education and health promotion.

Although the generic use of the term ‘health promotion’ to describe any activity that improves health status can be traced back earlier, Terris (1996) noted that in 1945 Henry Sigerist described the four tasks of medicine as the promotion of health, prevention of illness, restoration and rehabilitation of the sick (cited by French, 2000).
However, it was not until the late 1970s that this term began to be applied in a more specific way to a concept, movement, discipline and, indeed, profession. While a systematic account of the history of health promotion is beyond the scope of this text, we should note that the roots of contemporary health promotion are in health education.

The earliest examples of health education in the context of public health would now be described as health propaganda. This typically took the form of pamphleteering, which was intended to generate political change in support of a variety of environmental health measures designed to combat squalor and provide clean water supplies. Early health education was thus seen as an adjunct to public health efforts. Indeed, Naidoo and Wills (2009) note that, by the 1920s, health education had become associated with ‘diarrhoea, dirt, spitting and venereal disease!’ With this increasing focus on personal rather than public health, health educators continued their adjuvant role in support of the medical profession. Their activity during this period essentially involved giving information and persuading people using mass communication strategies.

The dominant themes in the early health education journals of the 1950s and 1960s centred on methods of delivering information in ways that would attract attention and interest people in the substantive content of health messages. The primary concern was very much with the technicalities of delivering information. The assumption was that if people were given the ‘right’ knowledge, they would act appropriately. As we will see in Chapter 3, this grossly underestimated the complexity of the task.

Two broad paths can be traced in the subsequent development of health education. One, the preventive approach, sought evermore sophisticated ways of achieving behaviour change by means of the application of psychological theory. The other, which was more in tune with progressive educational philosophy, was concerned with enabling people to make informed choices, the so-called educational approach.

In the period following the Lalonde Report (Lalonde, 1974) on the health status of the population of Canada, a renewed interest in the importance of the social and environmental influences on health status – both directly and indirectly by shaping behaviour – brought health education under fierce critical scrutiny (see, for example, Navarro, 1976; Ryan, 1976). Of particular concern were the emphasis on individual responsibility and the failure to recognize constraints on individuals’ behaviour – most notably their economic and material circumstances. Health education was accused of ‘victim–blaming’ – a term attributed to Ryan. The essence of victim–blaming lies in attempts to persuade individuals to take responsibility for their own health while ignoring the fact that they are victims of social and environmental circumstances. Accordingly, Ryan argued that the fundamental factors governing health were power and money.

Being poor is stressful. Being poor is worrisome; one is anxious about the next meal, the next dollar, the next day. Being poor is nerve-wracking, upsetting. When you’re poor it’s easy to despair and it’s easy to lose your temper. And all of this is because you’re poor. Not because your mother let you go around with your diapers full of bowel movement until you were four; or shackled you to the potty chair
before you could walk. Not because she broke your bottle on your first birthday or breastfed you until you could cut your own steak. But because you don’t have any money. (1976: 157)

The emergence of health promotion was in response to the need to address the environmental as well as the behavioural determinants of health – the so-called upstream determinants. In effect, it marked a shift from being concerned with healthy choices to making ‘the healthy choice the easy choice’.

Health promotion includes efforts to tackle the social and environmental determinants of health by means of healthy public policy. The scope of health promotion can therefore be summed up in a simple formula:

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\text{health promotion} = \text{health education} \times \text{healthy public policy}
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We will review different models of health promotion later in this chapter. At this point, we will consider the influence of the WHO on the development of health promotion.

The contribution of the World Health Organization (WHO) to the definition of health promotion

The evolution of health promotion has been accompanied by considerable debate about its nature and purpose – debate that has exposed its core underlying values. The WHO has been a major voice in shaping the development of health promotion. Not only have its documents been a source of reference for health promotion practice, but they have also been assimilated into professional training courses – that is, they have become part of the doctrine of health promotion.

As mentioned above, the WHO has taken a holistic view of health from its inception. The ‘Health for All’ movement was launched at the 30th World Health Assembly in 1977. The following year saw the Declaration of Alma Ata (WHO, 1978), which identified primary healthcare (PHC) as the principal means to attaining ‘Health for All’ targets. Primary healthcare – as distinct from primary medical care – was envisaged as embracing all the services that impact on health, including, for example, education, housing and agriculture.

A number of key issues in the Declaration have informed subsequent thinking. In addition to emphasizing the importance of a holistic view of health, the following assertions figure in many WHO publications and declarations:

- health as a fundamental right
- the unacceptability of inequality in health within and between nations
- health as a major social goal
- the reciprocal relationship between health and social development
- the need to involve a number of different sectors in working towards health
● the rights and duties of individuals to participate individually and collectively in their own healthcare
● education as the means of developing communities’ capacity to participate.

In January 1984, the 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 recognize the need for change in the ways and conditions of living, in order to promote health’. It defined health promotion as ‘the process of enabling people to increase control over, and to improve, their health’.

Income, shelter and food were acknowledged to be primary requisites for health. Importance was also attached to the provision of information and life skills, the creation of supportive environments providing opportunities for making healthy choices and the creation of 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 – that is, an upstream approach, which demands the cooperative efforts of a number of different sectors at all levels, from national to local
● utilizing a range of different, but complementary, methods and approaches – from legislation and fiscal measures, organizational 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. (WHO, 1984)

Action was therefore seen to require an integrated effort to encourage individual and community responsibility for health along with the development of a health-enhancing environment. The document reflected a commitment to voluntarism and formally acknowledged the risk of dictating how individuals should behave. This has been referred to as ‘healthism’ – a notion that we will return to later. Other potential problems included an overemphasis on individual behaviour rather than the social and economic determinants of behaviour and the possibility of increasing social inequality if the varying capacity of different social groups to exercise control over their health was not tackled. A further concern was that health promotion might be appropriated by particular professional groups to the exclusion of others and lay people.

A series of major international conferences followed. The Ottawa Charter, developed at the 1st International Conference on Health Promotion (WHO, 1986), built on many of the key principles set out in the WHO discussion document and has been a constant source of reference. It identified three broad strategies for working to promote health:
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- **advocacy** to ensure the creation of conditions favourable to health
- **enabling** by creating a supportive environment, but also by giving people the information and skills that they need to make healthy choices
- **mediation** between different groups to ensure the pursuit of health.

The Ottawa Charter listed five main action areas that have been central to the conceptual framework of health promotion:

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

There is potentially some tension between individual and societal responsibility for health, between individual and collective responsibility, and between voluntarism and control. The Ottawa Charter handled this by seeing individuals as having responsibility for their own health, but also a collective concern for the health of others. However, there is an overriding societal responsibility to create the conditions that enable people to take control of their health. Recognition that health is created where people ‘learn, work, play and love’ heralded the ‘settings approach’ to health promotion.

The 2nd International Conference on Health Promotion in Adelaide (WHO, 1988) focused on healthy public policy as a means of creating supportive environments that would be health-enhancing in themselves and would also – in the words of the much used phrase – contribute to making the healthy choice the easy choice. In particular, it acknowledged the importance of addressing the needs of underprivileged and disadvantaged groups and emphasized the responsibility of higher income countries to ensure that their own policies impacted positively on lower income countries. It saw healthy public policy as ‘characterized by an explicit concern for health and equity in all areas of policy and an accountability for health impact’. The Adelaide Conference identified the need for strong advocates and also saw community action as a major driving force.

The Sundsvall Conference (WHO, 1991) addressed the issue of supportive environments for health. In addition to the physical environment, it recognized the importance of the social environment and the influence of social norms and culture on behaviour. It also noted the challenge to traditional values arising from changing lifestyles, increasing social isolation and lack of a sense of coherence. The need for action at all levels and across sectors was recognized and, in particular, the capacity for community action. The key elements of a ‘democratic health promotion approach’ were seen to be empowerment and community participation. The importance of education as a means of bringing about political, economic and social changes was recognized as well as its being a basic human right.

The Jakarta Declaration on Leading Health Promotion into the 21st Century (WHO, 1997) was developed at the 4th International Conference on Health Promotion. It viewed health both as a right and as instrumental to social and economic development.
It envisaged the ‘ultimate goal’ of health promotion as increasing health expectancy by means of 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.

The Jakarta Declaration built on the commitments of the previous documents and provided clear endorsement of the value of comprehensive approaches and involving families and communities. It called for strong partnerships to promote health including – for the first time – the involvement of the private sector.

Overall, the priorities set out for the twenty-first century were to:

- promote social responsibility for health
- increase investments for health development
- consolidate and expand partnerships for health
- increase community capacity and empower the individual
- secure an infrastructure for health promotion.

The first resolution on health promotion, which was passed at the 51st World Health Assembly in May 1998 (WHO, 1998a), incorporated the thinking of the Jakarta Declaration.

As it moved into the twenty-first century, the WHO (1998b) 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 emphasize solidarity
- incorporating a gender perspective into health policies and strategies. (1998e: v)

The 5th Global Conference on Health Promotion held in Mexico City in 2000 focused on ‘bridging the equity gap’. It issued a Ministerial Statement signed by some 87 countries, including the United Kingdom (WHO, 2000a), that 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 Mexico City conference emphasized 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 infrastructure for health promotion’ (WHO, 2000b: 21).
The *Bangkok Charter for Health Promotion in a Globalized World* (WHO, 2005) responded to emerging global issues by focusing attention on increasing inequalities between countries, commercialization and new patterns of consumption and communication, and also global environmental change and urbanization. It identified the following required actions:

- **advocate** for health based on human rights and solidarity
- **invest** in sustainable policies, actions and infrastructure to address the determinants of health
- **build capacity** for policy development, leadership, health promotion practice, knowledge transfer and research, and health literacy
- **regulate and legislate** to ensure a high level of protection from harm and enable equal opportunity for health and well-being for all people
- **partner and build alliances** with public, private, non-governmental and international organizations and civil society to create sustainable actions.

It further demanded four key commitments to make health promotion:

- central to the global development agenda
- a core responsibility for all of government
- a key focus for communities and civil society
- a requirement for good corporate practice.

While the primary concern of these documents has been with identifying appropriate action, they are underpinned by clear values. Indeed, it could be said that unless activity is consistent with these values, it should not be regarded as ‘health promotion’. These values include equity and empowerment – the twin pillars of health promotion – along with health as a right, voluntarism, autonomy, participation, partnerships and social justice. Consideration of rights and responsibilities, power and control generates some interesting paradoxes in relation to health education and policy interventions, which we discuss more fully later.

The 7th and 8th WHO conferences on health promotion were held in Nairobi in 2009 and Helsinki in 2013, respectively. Importantly, the Nairobi conference was the first to be held on the continent of Africa. The Nairobi Call for Action specifically addresses action needed to close the implementation gap in health and development through health promotion (Catford, 2010; WHO, 2009). One of the key themes of this conference was mainstreaming health promotion in health policy (Eriksson, 2010). Empowerment remained central. The key urgent responsibilities were outlined as follows:

- strengthen leadership and workforces
- mainstream health promotion
- empower communities and individuals
enhance participatory processes
- build and apply knowledge. (WHO, 2009)

The importance of policy was again highlighted in the Helsinki conference. Intersectoral action and healthy public policy were identified as key requirements for health promotion. The conference statement emphasizes the ‘Health in All Policies’ approach, calling for cross-governmental action and political will (WHO, 2013).

The significance of non-communicable diseases was emphasized at the Nairobi conference in 2009 and this was picked up in 2011 at the UN High-Level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (NCD). NCDs kill three in five people globally (UN, 2011) and are becoming much more of a challenge in lower-income countries. A political declaration ensued from this meeting specifically aimed at tackling NCDs. In the same year, the WHO held a world conference in Brazil on the Social Determinants of Health (WHO, 2011). This resulted in the adoption of the Rio Political Declaration on the Social Determinants of Health (WHO, 2012). The declaration upholds the core principles established by the Alma Ata conference in 1978 and the Ottawa Charter (WHO, 1986) that have been reinforced by the subsequent WHO conferences on health promotion as detailed previously. The Rio+20 Outcome Document (The Future We Want) (UN, 2012) also emphasizes these core principles. It highlights the importance of the post-2015 framework following on from the Millennium Development Goals. At the time of writing, the post-2015 agenda is still being established. Clearly, it will build on the MDGs yet needs to reflect new challenges that are being faced. For further, more up-to-date information, please see www.un.org/en/ecosoc/about/mdgs.html.

Ideology, social construction and competing discourses

Defining ideology

The original meaning of ‘ideology’ was merely the scientific study of human ideas. It has been transformed over time into a concept that includes cognitive, affective and action dimensions. Although ideologies are value laden – and it is not unusual for the term to be used synonymously with value systems – the contemporary construction of the word ‘ideology’ is much more complex.

De Kadt, discussing the ideological dimensions involved in implementing WHO’s ‘Health for All’ agenda, states that ideologies are an amalgam of fact and unsubstringated assertion. He observes that, ‘comprehensive ideologies (as opposed to partial ideologies) are commitment-demanding views about societies, their past history and present operation, which contain a strong evaluative element and hence provide goals for the future’ (de Kadt, 1982: 742).

In order to clarify the central meaning of ‘ideology’, Eagleton contrasts the emotionally charged nature of ideology, which has a ‘partial and biased view of the world’, with an ‘empirical’ or ‘pragmatic’ approach. There is, of course, a tendency for those
espousing political causes to describe their ‘pragmatic’ construction of reality as rational and based on common sense whereas opponents’ views are characterized by ideological zealotry involving, as Eagleton notes, their:

judging a particular issue through 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. (1991: 3)

Idea, values and ethics

Belief systems and doctrine are major parts of the territory of ideology. However, values and value systems feature with equal prominence. Rokeach defines values as ‘an enduring belief that a specific mode of conduct or endstate of existence is personally or socially preferable to an opposite or converse mode of conduct or endstate of existence’ (1973: 10). Following Guttman’s (2000) review, the major ethical values assumed to underpin health promotion (or, more specifically, ‘public health communication interventions’) are:

- beneficence, or, ‘doing good’
- non-maleficence, or, ‘doing no harm’
- respect for personal autonomy
- justice or fairness
- utility and the public good
- (possibly) community involvement and participation.

As we will see, the extent to which these values are actually central to the ideology of health promotion will depend on the preferred model. At this point, it is interesting to note the remarkable degree of resonance between the empowerment model of health promotion and the stewardship model (see box) developed by The Nuffield Council on Bioethics. It sets out the ethical principles that should underpin the development of healthy public policy and achieve a balance between individual and government responsibility.

The stewardship model

Acceptable public health goals include:

- reducing the risks of ill health that result from other people’s actions, such as drinking and smoking in public places;
- reducing causes of ill health relating to environmental conditions, for instance provision of clean drinking water and setting housing standards;
● protecting and promoting the health of children and other vulnerable people;
● helping people to overcome addictions that are harmful to health or helping them to avoid unhealthy behaviours;
● ensuring that it is easy for people to lead a healthy life, for example by providing convenient and safe opportunities for exercise;
● ensuring that people have appropriate access to medical services; and
● reducing unfair health inequalities.

At the same time, public health programmes should:

● not attempt to coerce adults to lead healthy lives;
● minimize the use of measures that are implemented without consulting people [either individually or using democratic procedures]; and
● minimize measures that are very intrusive or conflict with important aspects of personal life, such as privacy.


The centrality of power

Given the emphasis on empowerment in this book, it is axiomatic that individual and community power are pivotal issues in the ideology of health promotion and central to the design of health promotion programmes. Questions of power feature prominently in discussions of ideology. Giddens is quite explicit about this:

Ideologies are found in all societies in which there are systematic and engrained inequalities between groups. The concept of ideology connects closely with that of power, since ideological systems serve to legitimize the differential power which groups hold. (1989: 727)

In Fairclough’s laconic phrase, ideology is, in fact, ‘meaning in the service of power’ (1995: 18). Eagleton provides a comprehensive account of the mechanisms whereby a dominant group exerts its power and creates ‘false consciousness’:

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. (1991: 5–6) [our emphasis]

The relevance of ideology is not only measured in terms of the ways in which the power of dominant social groups is legitimized. More significant for health promotion are the
ways in which subordinate groups are ‘de-powered’ by dominant groups. Indeed, the radical ideology underpinning the model of health promotion proposed in this book is substantially concerned with empowering subordinate and oppressed social groups. Pursuing the matter of false consciousness, Eagleton reminds us of the subtle and potentially insidious ways in which people may be de-powered:

The most efficient oppressor is the one who persuades his underlings to love, desire and identify with his power; and any practice of political emancipation thus involves that most difficult of all forms of liberation, freeing ourselves from ourselves. (1991: xiii)

He does, however, caution against exaggerating the power of this ‘hegemonic’ process and optimistically notes that nobody is ever wholly mystified. Despite a capacity for self-delusion, human beings are at least moderately rational and, unless the process of domination provides sufficient gratification over time, the dominated will rebel. If this were not true, health promotion’s emancipatory strategies for critical consciousness-raising would be seriously compromised.

Ideology and discourse

Although, as Wodak (2008) argues, the term ‘discourse’ is used in various ways, there is general agreement that it is concerned with a set of ‘connected sentences or utterances’ (Litosseliti, 2006: 47) and patterns or systems of language (Lock and Strong, 2010). The notion of discourse has its roots in linguistics. It is more than mere language – rather, the thought underlying language. Accordingly, ‘discourse analysis’ involves penetrating beneath the surface of language or images and seeking out subtexts and meanings relating to wider beliefs and value systems – often their social and political contexts. As Parker (2005) argues, discourse analysis enables scrutiny of how language is mobilized to maintain (or challenge) power relations.

Discourse analysis has relevance for health promotion by providing insight into the way in which people’s ideas about health – or indeed health promotion messages – are constructed, along with their underpinning values and motivations. The concern with challenging structures of power also renders it directly relevant. It can equally be applied to professional discourse to identify the underlying ideology.

Scott-Samuel and Springett draw attention to the interrelationship between discourse and power. Increase in the prominence of discourse may increase the power of groups that it represents and conversely power relations among different groups may shape the level of influence of discourse. They assert that the dominance of public health medicine has influenced the public health discourse and led to ‘hegemonic suppression of the radical element within the public health agenda’ (2007: 212).

Critical discourse analysis focuses on power and dominant ideologies and the way these are both reflected in and perpetuated by language (Lupton, 1992; Wood and Kroger, 2000). Fairclough has referred to it as ‘discourse analysis “with an attitude”’ (Fairclough,
2001, cited by Porter, 2006) reflecting critical examination of social cultural processes as well as the scrutiny of structures within society and issues of power/control (Litosseliti, 2006; Wood and Kroger, 2000; Wodak, 2001). Porter (2006) examined the Ottawa and Bangkok Charters using critical discourse analysis. She identified a shift from a “new social movements” discourse of ecosocial justice in Ottawa to a “new capitalism” discourse of law and economics in Bangkok (2006: 75). She also contends that while the Bangkok Charter proposes actions to tackle the problems of a globalized world, its discourse may serve to perpetuate the structural determinants of those very problems.

Medical discourse and the preventive model

The history of health promotion has been marked by a struggle to distance itself from the medical model that has dominated twentieth-century discourse on health and illness. Some would contend that this break is more evident in the rhetoric than in the practice of health promotion (Kelly and Charlton, 1995). Although the medical model has been alluded to earlier, it is worthwhile considering – in the context of our discussion about ideology, power and control – the nature of the model and the origins of concern about its applicability to health promotion. The key features of the medical model have been variously seen as including:

- a mechanistic view of the body
- mind–body dualism
- disease as the product of disordered functioning of the body or a part of it
- a focus on pathogenesis – that is, the causes of disease
- the pursuit of the causal sequences of disease and an emphasis on micro causality
- specific diseases having specific causes.

The medical model is therefore very much in tune with modernist rational thought and characterized by a reductionist view of the causes of ill health, together with a mechanistic focus on micro causality.

The medical model is inextricably linked with medical practice and, more generally, with biomedicine. It shares common ideological origins and has acquired added authority as a result of its association with the power and authority of the medical profession. The dominance of medicine has itself been the subject of an extensive sociological critique – for example, its role in supporting a capitalist value system (Navarro, 1976; Doyal and Pennell, 1979); the monopolization of healthcare (de Kadt, 1982); the commodification of health and appropriation of authority over the areas that influence health (Illich, 1976); and maintaining gendered power structures in society (Doyal and Pennell, 1979; Ehrenreich and English, 1979). Deborah Lupton offers a more recent critique that carefully explicates the social and cultural construction of modern medicine and healthcare (Lupton, 2012).

The medical model belongs to a group that Rawson has termed ‘iconic models’ – that is, ‘simplified descriptions of some aspect of known reality, portraying a literal or isomorphic image of nature’ (1992: 210). It is possible, in principle, to identify a number
of different models within medical practice and, equally, the medical model can be recognized within a range of different types of professional practice. It is also worth noting, in passing, that the ascendancy of high-tech medicine in the twentieth century and marginalization of preventive medicine has not gone unchallenged within medicine itself. The work of McKeown is well known in this regard (see, for example, McKeown, 1979). The emergence of ‘The New Public Health’ has been an attempt to retreat from an emphasis on individual responsibility for health and health actions and refocus on the factors that collectively influence health status. However, critics such as Petersen and Lupton (1996) contend that ‘The New Public Health’ has not entirely freed itself from the ethic of individual responsibility. Nor has it mounted an effective challenge to the increasing disparity in wealth and power within many societies.

Application of the medical model to health promotion leads to an emphasis on prevention. This association with prevention effectively ‘rebadges’ the medical model as the preventive model.

The dominant concept is that of risk, whether viewed as a ‘property of individuals or as an external threat’ (Petersen and Lupton, 1996: 174). Furthermore, the conceptualization of risk is often narrow, ignoring the wider social and environmental determinants of health. The emphasis is on individual responsibility, which – as noted above in our comments on ‘victim-blaming’ – places the onus on individuals to reduce their exposure to risk by avoiding risky behaviour and contact with risks in the environment. The individual is increasingly held to account for managing risk and uncertainty (Arnoldi, 2009). Attempts to improve health primarily take the form of health education interventions to persuade individuals to adopt healthy behaviours and lifestyles, and avoid risk.

The preventive model has a number of consequences. As we noted above, it results in an essentially ‘victim-blaming’ approach in its disregard for the social, environmental and political factors that shape and, indeed, constrain behavioural choices.

Illich’s (1976) critique of the extension of medical control beyond legitimate concern with disease to include ordinary aspects of human experience – so-called ‘social iatrogenesis’ or medicalization of life – is well known. Including exposure to risk within the medical remit and, along with it, a whole range of behavioural and lifestyle factors, extends the notion of medicalization even further and brings substantial areas of life under expert, rather than autonomous, control. Kelleher et al. note that, along with the decline in organized religion, this has led to:

> doctors being cast more and more in the role of secular priests whose expertise encompassed not only the treatment of bodily ills but also advice on how to live the good life, and judgements on right and wrong behaviour. (1994: xii)

Moreover, the acknowledgement of expert authority over areas of life normally managed by individuals, families and communities erodes confidence in their own capacity to take responsibility for their health. By undermining self-reliance, communities and cultures are disempowered. Illich refers to this as ‘cultural iatrogenesis’, which he sees as:
‘destroy[ing] the potential of people to deal with their human weaknesses, vulnerability, and uniqueness in a personal and autonomous way’ (1976: 42).

Horrobin’s (1978) riposte to Illich accepts the existence of some undue dependence on the medical profession in matters of sickness, but notes the remarkable resistance of the healthy to accept medical advice and over-exaggeration of the power of medicine to influence people. He quotes John Owen’s sixteenth-century verse:

God and the doctor we like and adore
But only when in danger, not before;
The danger o’er, both are alike requited,
God is forgotten, and the doctor slighted. (1978: 25)

Furthermore, he contends that Illich’s portrayal of society as ‘an ignorant and unwilling victim of medical imperialism’ (1976: 29) is a misrepresentation. Similarly, O’Neill’s (2002) thought-provoking Reith Lectures draw attention to the lack of trust in contemporary society and suggest that the acceptance of treatment or advice cannot be taken as indicative of trust when no effective alternatives are available to people.

Notwithstanding these arguments, medicine is still accorded considerable expert power, a point endorsed more recently by Lupton (2012). Healthy lifestyles/healthy behaviours are prescribed by experts (Ayo, 2012). Deference to such authority provides further legitimation. It reinforces the dominance of the medical model and ipso facto the preventive model, even when the view espoused is at odds with the experiences of individuals.

What, then, is the source of this medical authority? De Kadt suggests that:

Expertise and the ‘life and death’ responsibilities of the physician are used to provide ideological justification for physician dominance in the doctor–patient (healing) context. (1982: 746)

Parsons’ (1958) concept of the ‘sick role’ throws further light on the doctor–patient interaction. When people are ill, they are unable to fulfil their normal social roles and everyday activities. Diagnosis will medically legitimate their adoption of the sick role that exempts them from their normal social obligations. However, there is a concomitant obligation to attempt to get better, by seeking and complying with medical advice. The sick role, therefore, requires submission to medical authority and compliance with a therapeutic regimen.

Formalization of the ‘at-risk’ role within the preventive model makes equivalent demands in terms of an obligation to modify behaviour and exposure to risk (Baric, 1969). Individuals are held responsible for their exposure to risk and failure to act accordingly may be attributed to ignorance at best or deliberate fecklessness at worst. Unlike the sick role, the at-risk role does not confer any rights. The outcome of this is twofold. On the one hand, it labels as deviant those who cannot or choose not to
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comply with admonitions on how to live their life, and holds them responsible for the consequences. The categorization of more and more areas of life as healthy or unhealthy effectively creates its own dogma about ways of living, coupled with the associated moral sanction of disapproval if unhealthy options are chosen. As Petersen and Lupton note:

The idealization of the ‘normal’, ‘healthy’ subject as one endowed with certain ‘natural’ capacities and inclinations fails to recognize the multiplicity of possible subject positions, and can serve to coerce, marginalize, stigmatize and discriminate against those who do not or cannot conform with the ideal. This ideal denies difference – whether this is based on social class, gender, sexuality, ‘race’ ethnicity, physical ability, or age – and the kinds of personal commitments and demands that are required of those who are called upon to conform to it. (1996: 178)

On the other hand, it creates a remorseless pressure to improve health. The responsibility for health lies with the individual (Bolam et al., 2003; Katainen, 2006). As a result it has become a requirement or moral imperative, for the contemporary citizen to strive for health (Nettleton, 2006; Petersen et al., 2010).

An overemphasis on keeping healthy has been referred to as ‘healthism’ – a term attributed to Crawford who defines it as:

the preoccupation with personal health as a primary – often the primary – focus for the definition and achievement of wellbeing; a goal which is to be attained primarily through the modification of lifestyles, with or without therapeutic help. (1980: 368)

Despite healthism’s emphasis on positive health, its focus on individual responsibility can be seen to have some parallels with victim-blaming. The no-fault principle enshrined in the notion of the sick role does not apply and is replaced by a ‘your fault dogma’. Those, therefore, who fail, or refuse, to seek health-promoting ways of life become ‘near pariahs’ (Crawford, 1980: 379) – see the box for an illustration of this. Furthermore, preoccupation with health elevates it in status to a super value – health becomes an end in itself rather than a means of achieving other values and positive health behaviour acts as a hallmark of good living. Crucially the emphasis at the individual level draws attentions away from government and social responsibility for health (Room, 2011).

**Discrimination and the obese**

Adults who are obese are more likely to report institutional and day-to-day interpersonal discrimination. (Carr and Friedman, 2005)

There is evidence that children and adolescents who are overweight or obese are more likely to be bullied. (See, for example, Janssen et al., 2004; Lucy et al., 2004; and Robinson, 2006)
Reference to our earlier discussion of health promotion will indicate that the preventive model and healthism are both inconsistent with the two central tenets of health promotion – equity and empowerment. The emphasis on individualism and lack of attention to the social and environmental factors that impinge on health – both directly and indirectly as a result of their influence on behaviour – could, in fact, increase rather than decrease the health gap in society. Health gains will inevitably be greatest in those who are most able to make changes by virtue of their relatively advantaged position.

However, even though we have argued that a preventive model is inconsistent with the values position of health promotion, we should finish on a word of caution. Rejection of the preventive model does not necessarily imply rejection of the need for biomedical knowledge or appropriate preventive action. Horrobin (1978) argues that it is inadequate knowledge and insufficiently rigorous criteria that have been responsible for the unnecessary use of screening procedures rather than the inexorable spread of medical knowledge cited by Illich (1976). Furthermore, evidence about cause is necessary to much health promotion practice – indeed, any attempts to influence behaviour in the absence of evidence that this will be beneficial would be unethical. The problem lies not so much with a biomedical interpretation per se, but with too exclusive a reliance on it and dismissal of other perspectives – that is, with the imbalance of power and the dominance of medical expert authority. Our discussion of empowerment in Chapter 3 also draws attention to the importance of knowledge and the ability to access and interpret accurate knowledge as key components of empowerment. Such knowledge and understanding can give people greater control over their own lives. It also enables them to enter into a circle of shared understanding with professionals, thereby breaking down power structures and facilitating dialogue.

Education and the discourse of voluntarism

Health education is a key component of health promotion. We propose the following ‘empirical’ definition, which centres on the process of learning:

health education is any planned activity designed to produce health- or illness-related learning.

‘Learning’ has frequently been defined as a relatively permanent change in capability or disposition – that is, the change produced is not transitory and, after the educational intervention, people are capable of achieving what they were not capable of achieving before the intervention and/or feel differently about ideas, people or events. Accordingly, effective health education may result in the development of cognitive capabilities such as the acquisition of factual information, understanding and insights. It may also provide skills in problem-solving and decision-making and the formation or development of beliefs. It might also result in the clarification of existing values and the creation of new values – and, quite frequently, in attitude change. Health education also aims to foster
the acquisition of health-related psychomotor or social interaction skills. It may even bring about changes in behaviour or lifestyle or create the conditions for the adoption of healthy public policy.

One of the most important and enduring sources of ideological argument centres on the question of rationality and voluntarism. For example, Hirst (1969) asserted unequivocally that the central purpose of all education should be rationality. The educational philosopher Baelz contrasts education with manipulation and with indoctrination:

The educator encourages his [sic] pupil to develop the capacity to think for himself, while the indoctrinator wishes to make it impossible for his pupil ever to question the doctrine that he has been taught. (1979: 32)

The concept of doctrine is equated with the notion of dogma and typically refers to some creed or body of religious, political or philosophical thought that is offered for acceptance as truth. The purpose of indoctrination is, therefore, to present a body of ideas in an appealing way such that the ideas are accepted. The distinction between indoctrination and education is therefore fundamental.

Health education, voluntarism and choices for health

For many health educators, voluntarism is an ideological sine qua non. Note, for instance, Green and Kreuter’s influential definition:

Health education is any combination of learning experiences designed to facilitate voluntary actions conducive to health … Voluntary means without coercion and with the full understanding and acceptance of the purposes of the action. (1999: 27) [our emphasis]

Faden and Faden (1978) made the point even more forcibly in their discussion of the ethics of health education. They cited the Society of Public Health Educators’ (SOPHE) Code of Ethics (1976), noting its affirmation of the importance of voluntary consumer participation:

Health educators value privacy, dignity, and the worth of the individual, and use skills consistent with these values. Health educators observe the principle of informed consent with respect to individuals and groups served. Health educators support change by choice, not by coercion.

According to the educational model of health education, coercive strategies and techniques are, therefore, unacceptable. Coercion occurs when an individual’s or group’s freedom of action is constrained. Faden and Faden (1978) cite Warwick and Kelman (1973), who defined coercion as a process forcing individuals to act or refrain from acting under the threat of severe deprivation – and clearly involving the application of power to reward or punish. It frequently results from externally imposed sanctions or other barriers.
It is important, then, to recognize the existence of two varieties of coercion. The first of these is externally imposed. For instance, it involves the implementation of policy measures imposing a potentially wide range of restrictive regulations, in the form of legislation, fiscal measures and environmental engineering. Examples of such ‘healthy public policies’ would include banning smoking in public areas; redesigning roadways and traffic calming measures; the inclusion of vitamins in popular food products; regulation of the food industry to reduce the fat content of products; increase in the price of alcohol; and so on. An interesting example of Japanese health legislation was the banning of the Pill in order to promote the use of condoms as a device to control the spread of HIV (Jitsukawa and Djerassi, 1994). The attraction of these various coercive strategies is doubtless self-evident, but McKinlay summarized it succinctly as follows:

One stroke of effective health legislation is equal to many separate health intervention endeavours and the cumulative efforts of innumerable health workers over long periods of time. (1975: 13, in Guttman, 2000: 85)

The second form of coercion is perhaps less obvious and may be designated as psychological rather than environmental manipulation. It involves the use of certain techniques to create a particular kind of learning that lacks the element of genuine informed choice that characterizes the principle of voluntarism. Figure 1.2 locates these techniques on a continuum ranging from high degrees of coercion to maximal potential for facilitating ‘free’ choice. Accordingly, ‘brainwashing’ is seen as highly coercive while ‘facilitation’ is, by definition, seeking to assist learners to achieve their own goals. ‘Persuasion’ is generally viewed as an intervention concerned with achieving the goals of the persuader rather than helping the persuadees to make up their own minds.
In the case of psychological coercion or 'persuasion', personal choice is modified in some way without the knowledge of the person in question. In proposing this latter description, Faden and Faden (1978) had in mind Warwick and Kelman’s (1973) definition of persuasion as a ‘form of interpersonal influence, in which one person tries to change the attitudes or behaviour of another by means of argument, reasoning, or, in certain cases, structured listening’. In fact, it is somewhat misleading to define coercion of this kind solely in terms of the persuadee’s lack of knowledge of what is going on. ‘Insight’ might be a better term as it is clear that, in many instances, individuals are well aware that someone is trying to influence them. Indeed, the most blatant form of psychological coercion, brainwashing, leaves the unfortunate recipient under no illusion that some fairly dramatic coercive techniques are being applied!

It may at first glance seem surprising that brainwashing has been partnered with primary socialization. This represents both an expression of doubt about the power of brainwashing to fundamentally affect firmly grounded values and, at the same time, seeks to acknowledge the potentially greater power of the processes of ‘shaping’, conditioning and modelling that are part and parcel of the childrearing experience.

At a more mundane level, people exposed to persuasive advertising also know that the advertiser is seeking to influence them. They may, however, lack insight into the influence process – for instance, why the advertiser is manipulating certain images or using certain presenters. This lack of insight into the psychodynamics of the attempt to influence militates against the principle of voluntarism, albeit in a rather more subtle way than the deliberate presentation of misleading information or the partial presentation of evidence supporting the attitude or behaviour change the persuader is seeking to induce.

Warwick and Kelman (1973) use the term ‘structured listening’ to refer to a type of interpersonal encounter that, at first glance, does not seem to involve coercion. It is particularly interesting as it serves as a reminder of the way in which a technique, that would be considered eminently educational – non-directive counselling – may, with a few apparently minor modifications, be employed as a persuasive tool. Effective counselling depends on the deployment of such social skills as active listening, empathy, appropriate self-disclosure and the constant supply of unconditional positive regard. Janis (1975) has noted how the replacement of the ethically unexceptionable unconditional positive regard with what he terms ‘quasi unconditional positive regard’ can be a compelling device for influencing attitude and behaviour change – in a nonvoluntaristic way. This technique involves implying that the highly rewarding positive strokes supplied by the health educator will be rationed and made contingent on the client adopting certain healthy practices. This apparently benevolent method will presumably be all the more powerful as it is difficult to detect the overt attempt to influence.

Rather like structured listening, the coined term ‘facipulation’ has been used for a persuasive method cosmetically concealed under a cloak of educational respectability (Constantino-David, 1982). Essentially, it refers to the subtle process whereby ‘leaders’ actually manage to manipulate their clients under the guise of ‘facilitation’ with the intention, conscious or otherwise, of promoting the leaders’ own political and ideological agenda.

Facilitation would usually be viewed as fundamentally voluntaristic and therefore ethical. After all, its concern is, by definition, to help people achieve the objectives
that they have set for themselves. However, voluntaristic choice is not necessarily consonant with the ethics of health promotion. For instance, the term ‘facilitation’ might reasonably describe any enabling process, irrespective of its goals. Training individuals to achieve their felt needs to become better terrorists might be appropriate to certain revolutionary ideologies, but is certainly inconsistent with the aims of health promotion! As we will note later, freedom to choose applies only to those objectives that do not militate against the key values of health promotion.

Limits to freedom of choice

One of the avowed aims of an empowerment model of health promotion is to remove obstacles to rational decision-making and freedom of choice. In some instances, overcoming such barriers is relatively simple – for example, the barrier created by ignorance. Others are more substantial – consider, for example, the case of addiction or other compulsive behaviours that sap freedom of choice. As McKeown pointed out:

it is said that the individual must be free to choose [whether he wishes to smoke]. But he is not free; with a drug of addiction the option is open only at the beginning. (1979: 125)

Environmental barriers to voluntaristic action have received considerable recognition in recent years and, in part, have contributed to the formulation of the contemporary ideology of health promotion. Indeed, probably the greatest progress in health promotion in recent years has been acknowledgement of the fact that material, social and cultural environments can both damage health and limit people’s capacity to take action to promote their own health and the health of their communities. It is quite apparent that various natural disasters, such as famine and war, may damage health both directly and indirectly by removing the possibility of making empowered health-related decisions. Climate change and environmental degradation also pose major challenges (WHO, 2007) and their effects are likely to be experienced disproportionately by the most disadvantaged in society.

Poverty and social inequality damage the individuals’ and communities’ capacity for action and are now recognized as being major determinants of public health. On a smaller scale, lack of access to affordable healthy food will largely nullify the effects of health education initiatives about the importance of a healthy diet. Less obviously, the complementary effects of culture and childrearing may effectively block choice and genuine decision-making. For instance, in the process of socialization, cultural values may result in certain foods being classified as ‘taboo’, thus creating a moral imperative against consumption, regardless of the nutritional value of the food in question.

In the face of these many and varied psychological and environmental obstacles to the achievement of health, the emphasis on ‘healthy public policy’ is hardly surprising. Policy measures typically involve fiscal, economic and legislative measures and associated environmental change. On the one hand, they can create the conditions that support health and individual health choices. On the other hand, as is apparent from Figure 1.2, other more draconian measures that have been proposed can militate against freedom of choice. The Nuffield Council on Bioethics suggests that individual consent may not
be required if measures are not ‘very intrusive’ or ‘prevent significant harm to others’. Further, collective approval through democratic processes can replace individual consent when there is only limited interference with individuals’ liberty (2007, paras 2.22–2.26). Although it is argued that healthy public policy makes the healthy choice the easy choice, it may effectively make the healthy choice the only choice! How can such attacks on freedom be reconciled with the discourse of voluntarism, which characterizes an ‘educational model’?

The fact is, of course, that unbridled freedom is only the prerogative of the despot and, possibly to a lesser extent, of certain privileged groups. There are inevitably and appropriately limitations on freedom of choice. It could well be argued that ‘true’ education should encourage people to think in a systematic way about what is of most importance to them in their lives so that they might consistently act in accordance with the values they have clarified. It is also important that educated individuals should be helped to make decisions rather than uncritically absorb dogma. There are, however, obvious limitations to freedom of choice. As noted elsewhere (Tones, 1987), all values are not equally acceptable in a given society: antisocial behaviour would not normally be considered acceptable.

Health promotion would certainly not subscribe to unfettered freedom of choice. It is avowedly committed to certain major values to which most nations subscribe (or to which they at least pay lip service) and that have been incorporated into the various doctrines and discourse propagated by the WHO. This position is, or should be, non-negotiable. While cultural sensitivity is part of a concern for people in general, where cultural practices are inconsistent with the overriding values of health promotion, they must be challenged – take, for example, the issue of female genital mutilation. In the context of the principles of voluntarism, we must therefore observe two major qualifying principles. People should have a right to self-fulfilment, provided that this does not impede others’ right to fulfilment and/or otherwise damage the well-being of the community at large. A good deal of consideration has, in fact, been given to the question of imposing limitations on liberty. The resulting ideological principles are most usefully expressed in terms of utilitarianism and paternalism. These principles provide support for the occasional overriding of personal liberty, either for the greater good or because some people seem incapable of exercising choice.

Utilitarianism, paternalism and the justification of coercion

There are two broad approaches to defining the ethics of interventions. One of these supports the principle that the integrity of a moral principle should be of prime consideration, whatever the consequences. For example, it is always wrong deliberately to provide inaccurate information, even if this might seem to be in the interests of the recipient of that information. The alternative view is that it is the results of actions that are most important (Guttman, 2000). This latter moral principle is generally described as utilitarianism.

There is an obvious and generally acceptable rationale underpinning actions based on the principle of utilitarianism. In short, people’s freedom of action should be
respected, so long as it does not interfere with the general good (for example, Mappes and Zembary, 1991). Indeed, it provides a simple baseline value for health education that legitimately espouses the imperative of self-actualization. However, personal gratification should not limit others’ equal right to self-actualization.

It follows logically, therefore, that it is quite legitimate to use many of the varieties of coercion identified in Figure 1.2 where individuals’ actions can be shown to damage others. The restriction on smoking in public places, for example, is therefore entirely justifiable in that smoking is not merely a public nuisance, but puts non-smokers at risk as a result of passive smoking.

Less clear-cut perhaps is the argument that seeks to restrain self-destructive behaviour on the grounds that the prudent in society should not have to pay for the excesses of the imprudent. More generally, economic arguments have indicated how self-inflicted illness damages the economy in terms of reduced productivity due to working days lost and increases the burden on already hard-pressed health services. Legislation can, therefore, be justified. For instance, in the UK, legislation enforcing seatbelt use and the wearing of protective headgear by motorcyclists has been in place for some time and is demonstrably effective. The situation regarding smoking is more equivocal. Certainly, many arguments have been used to demonstrate that smokers cover the cost of their morbidity and early mortality as a result of the finances levied by taxation and should actually be treated as social benefactors.

The cost–benefit analysis of smoking is a matter for health economics and so will not be debated here. However, a serious point is frequently made that those indulging in high-risk activities should be allowed to do so, providing that this does not damage the well-being of others and that possible social and medical costs are covered by insurance. The financial argument would not, of course, apply to those who impose a financial burden on the state because of illness for which they cannot be blamed.

The principle of utilitarianism, then, does not prove as unambiguous as it first appears. The question of limitations to free choice again proves problematic and leads us to consider the second principle, which may justify coercive methods. If people are not really responsible for their actions, then society must make decisions on their behalf, for their own good. These decisions will inevitably involve the restriction of liberties and involve some degree of coercion. This principle of paternalism (Nikku, 1997), though, proves even more difficult to justify than the appeal to utilitarianism. Beauchamp cites John Stuart Mill’s (1961) treatise on liberty and his assertion that utilitarianism is the only justification for coercion:

The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because in the opinion of others, to do so would be wise, or even right. These are good reasons for remonstrating with him, or reasoning with him or persuading him or entreating him, but not for compelling him. (1978: 244)
However, as Daniels indicates:

Even a view that holds the individual to be the best architect of his ends and judge of his interests rests on important assumptions about the information available to the agent, the competency of the agent to make these decisions rationally, and the voluntariness of the decisions he makes. It is because these assumptions are not always met that we require a theory of justifiable paternalism. (1985: 157, in Guttman, 2000: 52)

Pollard and Brennan (1978), in discussing the basis for governmental intervention in cases of self-regarding behaviour – that is, behaviour affecting only the individual but not others – cite Dworkin’s justification of paternalistic behaviour on the grounds that some adults may not be capable of rational thought because ‘at some point in the future the individual will see the wisdom of the paternalistic intervention, even though at present he or she is not aware of its value’ (1972: 71).

The intervention thus, in some way, protects the ‘real’ will of the individual. At first glance, such a proposition looks distinctly dubious. However, it is undoubtedly true that most societies routinely take responsibility for certain categories of individual. For instance, the very young and those having a substantial degree of mental impairment would routinely be protected in many societies. Again, the notion of protecting someone’s real will is not as Machiavellian as it might appear. For instance, it would seem fairly clear that a substantial majority of smokers would prefer not to smoke and it is appropriate to recall McKeown’s observation that ‘the critical decision to smoke is taken not by consenting adults but by children below the age of consent’ (1979: 125). Paternalistic intervention to limit people’s freedom to choose to smoke might make some sense ethically. Furthermore, even if suicide were legal, a depressed person might be legitimately prevented from taking his or her life on the reasonable supposition that, when no longer depressed, (s)he would not wish to do so.

Wikler poses the question, ‘Is there, then, a case for paternalist coercion for health?’ and answers it as follows:

It depends on whether the behaviour slated for change is involuntary or not, whether there exists a practical, non-intrusive way to find out if it is voluntary or not, whether actual policies and programmes can be made subtle enough to distinguish in practice between voluntary and involuntary behaviour; and whether pressure can be applied to specific behaviours without the need to take on whole cultures. It also depends on whether those making and executing policy in this area can distinguish between involuntary actions and actions which are merely different from their own; whether they can restrain themselves from enforcing their views in subjects on which they are not expert; whether the coercive methods they use inflict greater intrusions and privations than the behaviours they attempt to eradicate; and whether allowing health professionals to exercise paternalistic power within these strict limits will lead inexorably to abuses and unjustified restrictions on liberty. These questions are empirical, not philosophical, and those who would want to justify coercive lifestyle reform programmes on paternalist grounds would do well to engage in the research needed for answers. (1978: 232)
Notably the more recent notion of choice architecture positions itself as being ‘libertarian paternalism’ (Thaler and Sunstein, 2008). Whilst at first glance this combination appears to be a contradiction in terms, Thaler and Sunstein (2008) argue that the meaning of the word paternalism changes when preceded by the word ‘libertarianism’ in that the focus becomes about preserving liberty. Choice architecture and the concept of ‘nudge’ are discussed further in Chapter 10.

Beauchamp (1978) critically appraises the argument advanced by his namesake Dan Beauchamp (1976) that the state should adopt a paternalistic stance, then rejects it! The notion, however, merits some further consideration. It relates to the general concept of ‘distributive justice’. Distributive justice is about the ways in which both social goods and burdens are distributed – for example, healthcare and the taxation needed to pay for it. Dan Beauchamp advocates social justice, asserting that all people have an entitlement to health protection and minimum standards of income – a position equivalent to the WHO’s association of health with human rights. It is worth noting at this point the view expressed in the World Health Report (2000c) that it is ‘not sufficient to protect or improve the average health of the population, if – at the same time – inequality worsens or remains high because the gain accrues disproportionately to those already enjoying better health’ (2000c: 26).

The question of choice versus coercion in the interest of public health is very real. On the one hand, the principle of voluntarism urges freedom of choice unless good reason can be provided for coercive measures on the basis of utilitarianism, paternalism or ‘social justice’. On the other hand, it seems particularly difficult to reach consensus about when, where and to what extent these principles can be used to justify coercive interventions in the interest of public health. Those of a left-wing orientation might object to any infringement of liberty of disadvantaged people, but wholeheartedly support paternalistic (or should it be ‘maternalistic’?) measures by the nanny state on the grounds of social justice and equity. Equally, the more tough-minded advocates of market forces would vocally object to interventions that restricted their own freedom of action, but might well subscribe to the utilitarian restriction of the liberty of people of a different political persuasion! Public attitudes about individual versus government responsibility were explored by the Kings Fund (see box).

### Public attitudes to public health policy: individual responsibility and control

- Most of the people surveyed (89%) agree with the statement that individuals are responsible for their own health and 93% agree that parents have greater responsibility for their children’s health than anyone else. However, more than 60% think tackling poverty would be the most effective way of preventing illness.
- More than 40% agree with the statement that there are too many factors outside individual control to hold people responsible for their own health.

(Continued)
A higher proportion of those in socioeconomic group DE feel that health is beyond individual control than those in socioeconomic group AB and that tackling poverty is the best way of preventing illness. A large majority of those surveyed say the Government should intervene to prevent illness by:

- providing information and advice (86%);
- encouraging employers to promote health at work (82%);
- preventing actions that put others’ health at risk (77%); and
- actively discouraging people from putting their own health at risk (75%).

Source: Kings Fund (2004: 2)

Jochelson (2005) highlights the key arguments: ‘some people have argued that any government intervention is “nanny statist” – an unnecessary intrusion into people’s lives and what they do, eat and drink. Others argued that only the state can effectively reduce the poverty that is so often the root cause of ill-health’ (2005: 1). The debate about who is responsible for health continues and is inextricably tied up with ideological and political perspectives. In 2011, England saw the introduction of the ‘Responsibility Deal’, a voluntary agreement designed to encourage healthier lifestyles relating to four key areas – physical activity, food, alcohol and health at work. As of early 2012, over 400 companies, including manufacturers and supermarkets, had signed up. This light-touch approach contrasts somewhat with that taken in the USA, where a healthcare law was passed in 2010 requiring calorie counts to be put on menus and vending machines. Despite some cities having enforced this (led by New York City in 2010), there have been significant delays in its implementation in some sectors for a number of complex reasons.

The stewardship model described in the box on p. 18 provides a framework for considering the balance between individual freedom and state responsibility in relation to public health. We may be able to move some way towards resolving the dilemma by promoting self-empowerment. However, we should take account of Beauchamp’s noteworthy observation that ‘Public health should – at least ideally – be suspicious of behavioural paradigms for viewing public health problems since they tend to “blame the victim” and unfairly protect majorities and powerful interests from the burdens of prevention’ (Beauchamp, 1976, reprinted in Beauchamp and Steinbock, 1999: 106). Accordingly, our later analysis and discussion of empowerment will emphasize the importance of community participation and community empowerment.
Health promotion and the discourse of empowerment

The assertion that the main concern of health promotion should be that of empowerment is becoming increasingly acceptable, although this acceptance often takes the form of lip service rather than practice and policy! Certainly, as noted above, most of the key documents published by the WHO since the inception of ‘Health for All by the Year 2000’ have placed emphasis on individuals gaining control over their lives and their health and on the importance of active participating communities. In his Harveian Oration, Marmot (2006: 2081–2) recognized the central importance of the social environment and empowerment, asserting that: ‘Failing to meet the fundamental human needs of autonomy, empowerment and human freedom is a potent cause of ill health.’

It is axiomatic from our earlier discussion that empowerment is based on the principles of voluntarism. The key issue for health promotion is how people who lack power can become more powerful and actually gain a reasonable degree of control over their lives. How can they compete with, and resist coercion by, those who already have power?

Further reflections on power

Empowerment, by definition, has to do with people acquiring a degree of power and control. Self-empowerment describes the extent to which individuals have power and control over their interactions with their physical and social environment. Further, an empowered community is an identifiable group of people that also possesses power and control. It is a matter of some importance to understand the different circumstances under which people acquire power, wield it and yield to it.

Definitions of power and related concepts

The notion of power may manifest itself at macro, meso and micro levels. All three levels have some degree of relevance for health promotion. Studies of power at the micro level are concerned with influences on, and exerted by, individuals or small groups; meso-level power might refer to the power exerted by organizations or communities; the influence of national policy would be a macro-level influence – as would the kinds of ideological controls discussed above.

The classic Weberian analysis identifies three forms of power:

- **social power** based on such factors as prestige, family status, lifestyle and patterns of consumption
- **economic power** based on a group’s relationship to the mode of production, its position in the labour market and general life chances
- **political power** based on affiliation to parties, bureaucracy and legal structure.

Naturally, there are a number of different ideas associated with power. For instance, concepts such as ‘control’, ‘authority’ and ‘influence’ may be used almost interchangeably...
with power. Corwin (1978), for instance, defines ‘authority’ as legitimized institutionalized power (and uses the term ‘coercion’ to refer to the illegitimate use of power). He posits a continuum of control ranging from a situation in which there is a capacity for applying a high level of sanction through to an opposite in which control is limited to minimal sanction capability delivered in relatively informal circumstances. Corwin employs the term ‘influence’ to describe this latter circumstance. He also identifies a further kind of authority, which he calls ‘consensual authority’, which is when power and control depend on the outcome of negotiation based on the differential possession of resources. Corwin also refers to the notion of ‘social power’:

Social power is the probability that a person or group can realize its will against opposition. Since power pervades most social relationships, it can be observed when armies fight, corporations bribe politicians, employers direct their employees, a political candidate sways voters, teachers evaluate their students, prison guards shoot rebellious prisoners, parents set examples for their children, and unions negotiate with management. (1978: 65)

Bachrach and Baratz (1970) acknowledge the variations in the nomenclature and meaning of these various terms and offer a useful typology of influence (see box).

### A typology of influence

<table>
<thead>
<tr>
<th>Force</th>
<th>The individual or group is obliged to comply by removing all choice. Compliance is achieved by the threat of deprivation where conflict exists regarding values or courses of action.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coercion</td>
<td>Compliance results in the absence of recognition by those who comply or the source of nature of the demand made.</td>
</tr>
<tr>
<td>Manipulation</td>
<td>This term is used when an individual or organization succeeds in causing others to change their intended actions, but without overt or tacit threat of deprivation.</td>
</tr>
<tr>
<td>Influence</td>
<td>This form of power operates when people comply because they accept that commands are reasonable in terms of their own values or because an appropriate and acceptable procedure has been adopted.</td>
</tr>
</tbody>
</table>

**Source:** Bachrach and Baratz (1970: 28)

Lukes (2005) reminds us that dominant groups shape people’s needs and wants – by means of mass media, ‘indoctrination’ at school or, more powerfully, by socialization. Lukes’ analysis is clearly consistent with our earlier discussion of the often subtle means whereby dominant ideologies are perpetuated, including the creation of false consciousness. These observations are not only relevant to our discussion of ideologies in general, but, as we noted earlier in this chapter, more particularly to questions of utilitarianism and
paternalism. They also have an important bearing on our later examination of the
assessment of health needs. Moreover, these two notions underpin thinking about
empowerment, bearing in mind Kindervatter’s definition of empowerment as: ‘People
gaining an understanding of and control over social, economic and/or political forces
in order to improve their standing in society’ (1979: 62). A clear understanding of the
different constructions of power also has special significance in, for example, deter-
mining the success or failure of lobbying and advocacy for the implementation of
healthy public policy at macro and meso levels.

Notwithstanding the relevance of these macro- and meso-level influences on the
development of healthy public policy, at this juncture we will focus on the individual-
istic perspective and the micro-level exercise of power. After all, continuing pressure is
placed on individuals from a variety of sources, both explicitly and implicitly, to modify
their behaviours in ways that may – or equally may not – be healthy.

Five varieties of power: an individual perspective

One of the classic, and still valid, analyses of power at the micro level was provided
by French and Raven (1959), who distinguished five varieties of power. This scheme
(which has similarities to Weber’s analysis of charismatic, traditional and rational–
legal power) is frequently used to illuminate interactions when analysing small group
dynamics and discussing leadership functions. Their analysis comprises the following
five varieties of power:

- **Legitimate power**: authority is derived from legitimate status formally bestowed by
  a given social system.
- **Expert power**: authority derives from the actual and perceived expertise of the indi-
  vidual in question. It may or may not be associated with legitimate authority or be
  an informal adjunct of referent power (see below).
- **Reward power**: authority derives from the individual’s capacity for providing
  rewards.
- **Coercive power**: authority derives from the individual’s capacity to sanction.
- **Referent power**: authority derives from the referent’s individual characteristics,
  which, for some reason, are valued by the person who is influenced.

Stardom and charisma

Alberoni (1962, in McQuail, 1972) also discusses the characteristics of individuals who,
despite lacking legitimate authority, can nonetheless exert quite a powerful influence
over other people. He describes this ‘powerless “élite” as ‘stars’. Their ‘institutional
power is very limited or nonexistent, but [their] doings and way of life arouse a con-
siderable and sometimes even a maximum degree of interest’. He likens their personal
characteristics to Weber’s notion of charisma:

> By charisma we mean a quality regarded as extraordinary and attributed to a person …
> The latter is believed to be endowed with powers and properties which are supernatural
and superhuman, or at least exceptional even where accessible to others; or again as sent by God, or as if adorned with exemplary value and thus worthy to be a leader. (Weber, 1968: 241)

It is sometimes said, with a degree of acrimony, that many celebrities in contemporary society are ‘famous for being famous!’ It is certainly the case that these charismatic characters may well exert a quite dramatic degree of influence on people. They may influence taste and preferences and act as models. This phenomenon will be revisited in Chapter 7, when we consider the influence of source credibility and attractiveness in persuading individuals to adopt healthy or unhealthy courses of action.

The concept of referent power also merits some further comment. The individual’s influence is bestowed on him or her by ‘followers’ on account of that person’s perceived expertise or reward value. The concept has some points in common with the notion of charismatic leadership. It also relates to opinion leadership and the principle of ‘homophily’, both of which feature in the communication of innovations theory, which will be considered in Chapter 3. The source of a communication may play a significant part in determining the beliefs, attitudes and even behaviour of its recipients. Of more direct relevance to the study of empowerment are those investigations that have examined the effect of message source on an individual’s compliance and conformity. Perhaps the best known – and most alarming – of such studies is the work of Milgram, who demonstrated that, under the influence of an authority figure, 65 per cent of a group of ‘ordinary’ people were prepared to administer a 450-volt electric shock to an experimental subject. Many of them did this even while experiencing obvious concern and conflict (Milgram, 1963). As Higbee and Jensen point out:

people find it extremely difficult to refuse any request by an experimenter. In experimental settings people have tried to balance a marble on a steel ball and eat a large number of dry soda crackers, dump out cans of garbage and sort it into piles of similar material, add adjacent numbers on sheets containing random digits, tearing up each sheet after completing it, and continuing for five and a half hours until the experimenter gives up, and pick up a poisonous snake, put their hands into nitric acid, and throw acid into an assistant’s face (the people thought they were doing these things). (1978: 27)

We might legitimately conclude that empowered individuals would be more able and willing to resist pressure and not submit to unreasonable demands, particularly those that run counter to their existing values.

While analyses such as French and Raven’s are undoubtedly useful in designing health promotion programmes, it is essential to ask how someone comes to wield legitimate authority, how they are in a position to reward, how they acquire the power to coerce, how they acquire expert authority or come to be treated as referents by their communities. As we noted earlier, power does not rely only on the crude application of force and coercion, but can also be exerted by the ideological control of culture and the hegemony of political and state institutions.
Self-empowerment, community empowerment and reciprocal determinism

Earlier in this chapter, we emphasized the dramatic effects an oppressive environment can have on individuals’ health and their capacity to make choices. It is therefore self-evident that empowerment – people’s opportunities to make genuinely free choices – is not possible unless physical, socioeconomic and cultural circumstances are favourable. Thus, it is imperative that empowerment policy and the ensuing strategies must engage with the thorny question of environmental change. However, it is clear that individuals are, in many situations, capable in principle of making choices even when the environment is not especially conducive to individual action. Three different perspectives on human agency can be identified (see Figure 1.3).

In the first situation, the focus of attention is centred on individuals and those characteristics that explain their behaviour. The theorist may be interested only in psychological phenomena or even be effectively blind to the existence of the environment. Some forms of counselling may be characterized by this approach. In the second instance, individuals are viewed as being largely controlled by their circumstances – directly or indirectly.

The third formulation of human agency asserts that humans (and animals) interact with their environments. They are, on the one hand, affected by environmental forces but, on the other, typically capable of having at least some impact on the various physical, socioeconomic and cultural factors that influence them. The ideology and practice of empowerment ultimately derives from this last standpoint and has been a central feature of social learning theory. Its major exponent and advocate is Bandura (1986), who described the interactive process as ‘reciprocal determinism’ and contrasted it with the Skinnerian assertion that, ‘A person does not act upon the world, the world acts upon him’ (Skinner, 1971: 211). Bandura argues that a process of ‘triadic reciprocality’

![Figure 1.3](attachment://three_perspectives_on_human_agency.png)

**Figure 1.3** Three perspectives on human agency
operates when humans engage with life. In short, there is an often complicated system of interaction between psychological factors (such as beliefs and attitudes), behaviour and the environment. A more comprehensive account of this system is given and discussed in Chapter 3.

We should also note that this archetypal psychological analysis of human agency is by no means inconsistent with the broader perspectives of sociology. For instance, Giddens (1991: 204) observes that ‘actors are at the same time creators of social systems yet created by them’.

**Individual and community dimensions of empowerment**

The logic of reciprocal determinism for an empowerment model of health promotion is inescapable. If empowerment is about facilitating voluntaristic decision-making and achieving free choices (or those that are consistent with moral imperatives), then it

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**Figure 1.4** Reciprocal determinism and empowerment of communities and individuals
must operate at both the level of the environment and at the level of the individual. Furthermore, it is important to recognize that the environment itself has many levels – from macro to meso, from the level of national policy to the level of regional organizations and institutions, down to the level of the neighbourhood or village. At each level, individuals exist within a web of social systems. At the neighbourhood level, the community is a social system that has particular significance for health promotion. Figure 1.4 gives an indication of this complexity within the context of commenting on both individual and community empowerment. These, as South and Woodall (2010) argue, should be viewed as inextricably linked.

As may be seen from Figure 1.4, the community may mediate individual agency in relation to the general physical, socioeconomic and cultural environment. The community is an especially important social system within the lexicon of empowerment and health promotion. Following the doctrine of the Ottawa Charter, an active, empowered community is perhaps seen as the most important of the desirable empowerment outcomes of health promotion activities. In short, it enables people to take an active part in influencing policy. Three key features of an empowered community are also shown, namely: a sense of community – that is, a therapeutic feeling of identification with fellow community members; an active commitment to achieve community goals; and what is increasingly termed ‘social capital’ (see Chapter 2 for more about this).

Individual or self-empowerment, however, comprises a cluster of attributes related to a personal capacity for voluntaristic action:

Self-empowerment is a state in which an individual possesses a relatively high degree of actual power – that is, a genuine potential for making choices. Self-empowerment is associated with a number of beliefs about causality and the nature of control that are health promoting. It is also associated with a relatively high level of realistically based self-esteem together with a repertoire of life skills that contribute to the exercise of power over the individual’s life and health. (Tones and Tilford, 2001: 40)

Clearly, a community is composed of its membership – and it is arguable whether or not a community is more than the sum of the individuals making up this membership. In all events, a community is generally considered to be beneficial for its individual members, and the characteristics and capabilities of these individuals will contribute to the power of the community as a whole.

Figure 1.4 makes a distinction between ‘real’ and ‘virtual’ communities. The former represents a traditional idea of community as a group of people within a relatively small geographical area having a sense of identity and a network of relationships. A virtual community may lack the narrow geographical dimension of a real one, but otherwise has a shared identity. For instance, we can realistically talk about the gay community. What may be lacking, however, are interpersonal relationships. However, a virtual community may actually have more power at its disposal than a real community and, moreover, with the advent of technology such as the Internet, may benefit from different kinds of interaction.
Although often ignored in discussions of communities, Figure 1.4 reminds us that some individuals may not be part of any community – real or virtual. We have labelled as ‘non-members’ individuals who exist in relative isolation because no community exists. By contrast, and borrowing terminology from the domain of sociometry, we have used the term ‘loner’ to distinguish people who do not wish to belong to a community from those whose felt need is to belong, but who are not accepted or rejected – so-called ‘isolates’. Figure 1.4 also notes that individuals are affected by, and in turn affect, their environments at different levels without the mediation of community groups.

We might also note that environments do not exert their effects in a unidimensional way. It is more realistic to consider any given environment as exerting both facilitative and inhibitory influences of different strengths on communities and individuals. The sum total of both positive and negative pressures might be described in terms of these macro or meso influences ‘making the healthy choice the easy choice’ or, alternatively, being fundamentally oppressive. The specific, technical, detailed aspects of both community and individual empowerment will be explored at some length in Chapter 3.

One of the factors most closely associated with empowerment – with respect to both ideological and technical aspects – is that of participation. The WHO has frequently commented on the importance of an active, participating community and the desirability of individual involvement in decision-making is virtually taken for granted as a healthy development. We will also note in Chapter 5 the centrality of participation to the needs assessment process. How does participation actually contribute
to empowerment? It is almost a matter of common sense! A community that takes action – that is, participates in action to influence policy or practice at local or national level – feels that it has actually achieved something, even if the outcome is not dramatic. Similarly, individuals who are actively involved are likely to experience at least some degree of control. Obviously, there are many different degrees of involvement and Figure 1.5 indicates an assumed relationship between degrees of participation/involvement and empowerment. It draws on the classic analyses of Arnstein (1969) and Brager and Specht (1973).

It should be noted that Figure 1.5 applies equally not only to communities but also to settings such as health-promoting hospitals and health-promoting schools and, at the micro level, to interactions between individuals, such as doctor and patient.

Empowerment and health and well-being

An evidence review by Woodall et al. (2010) assessed the evidence in relation to empowerment and its effect on health and well-being. Based on the available literature, the review suggested that there are five key areas where empowerment strategies or interventions had improved individual health related outcomes. These areas were identified as:

- improved self-efficacy and self-esteem
- greater sense of control
- increased knowledge and awareness
- behaviour change
- a greater sense of community, broadened social networks and social support.

The review found fewer instances where empowerment approaches had made a difference to the actual health and well-being of communities, although there was good evidence showing that community engagement was beneficial for social cohesion, social capital and strengthening relationships and trust among participants. The authors suggested that further research is needed to establish the evidence for links between empowerment and improvements in the health status of communities.

An empowerment model of health promotion

We have considered the medical discourse associated with public health and a preventive model of health promotion or, rather, health education. We have also explored ideas related to the discourse of voluntarism, which might be said to give rise to an educational model of health promotion. Both of these models are limited in that they are inconsistent with the ideological thrust of health promotion. They are also technically limited in their capacity to explain what would be involved in achieving the empowerment goals of health promotion. Figure 1.6 sets out the main components of an empowerment model of health promotion and their interrelationships.
The central dynamic of the empowerment model is the interplay of education and healthy public policy. The development and implementation of policy is the essential precursor to the creation of health-promoting environmental influences. The relationship is multiplicative, as we noted earlier in the ‘formula’: health promotion = health education × healthy public policy. The empowering function of education not only strengthens individual capabilities for health-related action, but also makes a major contribution to the establishment of healthy public policy.

**Action to achieve healthy public policy**

We discussed the five action areas of the Ottawa Charter earlier in this chapter, including the imperative to reorientate health services. Accordingly, Figure 1.6 shows how policy initiatives are necessary to improve service provision to meet the health
needs of particular populations. More importantly, it identifies the significance of policy initiatives to address physical, socioeconomic and cultural circumstances. This position is reinforced in the Health in All Policies thrust of the more recent WHO international health promotion conferences (WHO, 2009, 2013). The focus is more on reframing than on reorientation. In tune with modern multidisciplinary public health, it recognizes the contribution to health of a range of services whose primary raison d’être may not be health in any formal sense, for example transport, housing, economic development. However, all of these have a major impact on health and, indeed, on disease.

Two major action strategies are included in the model. One is the traditional means of seeking to influence policy, such as lobbying. Advocacy is defined here as lobbying those who exercise power by those who have power but who are doing so on behalf of the relatively powerless. The term ‘mediation’, which was incorporated into the Ottawa Charter list of major actions, refers to the process of mediating between competing interests. By way of illustration, we might consider the different concerns of the owners and producers of mass media programmes and health professionals. On the one hand, the main goal of the former is to entertain the public and advertise products in order to make profits. On the other hand, the interests of the health promoters are to control advertising and any representation of health issues in ways that are considered to be damaging to the public health.

The second – and ultimately the most powerful – means of producing policy change is to create a sufficient level of public pressure so that decision-makers and politicians at the national or local level feel obliged to change. In a democracy, this might, in the final analysis, result in change by means of the ballot box.

The catalyst for change is health education, but emphatically not the variety of health education that has been tarred with the same brush of victim-blaming! Rather, following the precepts of critical theory, it might usefully be called ‘critical health education’ and its purpose is radical and political. Again, the nature of education and its technology will be reviewed in Chapters 7 and 8 and particular attention will be devoted to its radical and critical manifestations.

Health education and individual empowerment

Figure 1.6 includes an analysis of the essential contribution made by education to individual action. A training function has also been included in the model to demonstrate the continuing importance of providing skills – not only to communities, but also to the professionals who work in the various services to which reference was made above. This training would include awareness-raising of the health-promoting role of the organizations, as well as making available the competences needed to communicate with clients and the general public, providing appropriate education and analysing the impact of policy on health – and making appropriate adjustments in the interest of effectiveness and efficiency.

We earlier reviewed the traditional health education function. We noted that its purpose was to persuade individuals to adopt behaviours that would result in the
prevention of disease, both with regard to lifestyle and making proper use of medical services. The role of critical health education is not primarily that of persuasion (which is both ethically dubious and of limited effectiveness), but one of empowerment and support. Empowered individuals are more likely to make an effective contribution to community action, which, in turn, contributes to their empowerment, as we mentioned earlier. They are also more likely to engage with the various services contributing to health in an assertive and productive fashion. They are almost certainly more likely to adopt a lifestyle conducive to achieving the objectives of preventive medicine than if they were not empowered! Indeed, one of our more forceful assertions here is that the successful adoption of an empowerment model of health promotion is not only more likely to achieve positive health outcomes in an ethical fashion, but also to be more efficient in attaining the important outcomes associated with the prevention and management of disease and disability.

The empowerment model: critiques and reservations

The empowerment model of health promotion is not without its critics. For instance, some might reasonably argue that empowerment is a fashionable term, distinguished by its lack of clarity in conceptualization and use (the same criticism could, of course, be levelled at health promotion itself and even the notion of public health). A second objection derives from the assertion that empowerment lacks a theoretical base. This assertion is fundamentally incorrect, as we are in the process of demonstrating!

What is undoubtedly more problematic is translating the rhetoric into action. For instance, Mayo and Craig (1995: 2) cite the Bruntland Commission's conviction that the prerequisite for sustainable development is securing the effective participation of citizens, the World Bank's inclusion of empowerment as a main objective of community participation and the Human Development report definition of participation in terms of people having constant 'access to decision-making and power'. They also remind us that functionalist sociologists such as Parsons (1967) considered that power in society was a 'variable sum' and thus 'the powerless could be empowered, and could then share in the fruits of development, alongside those who had already achieved power'. Mayo and Craig argue that an alternative, and perhaps more convincing, viewpoint is that power is a 'zero sum'. Accordingly, the powerful will be reluctant to yield their power in the interest of empowering the powerless and will utilize the various ideological devices discussed earlier to keep the powerless in their place!

Unresolved challenges are also seen to exist in terms of the definition and operationalization of empowerment (Woodall et al., 2012a). In a paper that posits a critical stance on whether empowerment has, in fact, lost its power, Woodall et al. (2012) contend that the concept of empowerment has become diluted in contemporary health promotion and has somewhat lost touch with its radical social roots. Christens (2013) is in agreement with Woodall et al.’s (2012) conclusions that empowerment
needs to be defined more precisely, that multilevel approaches are needed and that research is required that links changes at structural levels to changes at individual levels. However, Christens (2013) also adds to the debate, pointing out some potential oversights in Woodall et al.’s arguments. He asserts the need to distinguish carefully between the use of the terms ‘individual’ and ‘psychological’ empowerment and argues that critical consciousness is crucial to bringing empowerment back to its radical, liberationist roots, noting that this first takes place at the individual level.

It should hopefully be clear from the observations made in this chapter that power and politics are central to health promotion. It would be a mistake to underestimate the difficulties of challenging power structures. Nonetheless, we believe that sophisticated analysis grounded in sound theory can result in the development of empowering strategies that can achieve results. The empowerment model of health promotion is advocated here on grounds of both ideological soundness and practical effectiveness. Moreover, it stands up well to ethical scrutiny.

PUBLIC HEALTH, HEALTH PROMOTION AND HEALTH EDUCATION

Health promotion and modern multidisciplinary public health

We have considered at some length the ideology of health promotion and have argued in favour of an empowerment model that recognizes the primacy of the broader social, cultural, economic and environmental determinants of health. To conclude this chapter, we will briefly examine the relationship between health promotion and modern multidisciplinary public health and the position of health promotion as a profession. We will also consider the future role of health education.

For some, there is no distinction between health promotion and public health. Kickbusch (2007) reminds us of the subtitle to the Ottawa Charter for Health Promotion – *the move towards a new public health*. Indeed, the Ottawa Charter has been hailed as heralding the third public health revolution. Potvin and McQueen (2007) have characterized revolutionary change as affecting three fundamental dimensions of systems:

- the direction or finality of the system – the target, objectives and goals
- knowledge base – including the conditions that support the production of knowledge as well as substantive knowledge itself
- actions – including design, implementation and evaluation.

However, for some authors, health promotion and public health, although related, are not synonymous. Raeburn and MacFarlane refer to some governments seeing public health as health protection plus health promotion, where health protection comprises ‘the more regulatory, centralized and reactive aspects of public health’ (2003: 245) and health promotion is more self-determined, community-based and developmental. In this interpretation, public health is the umbrella term and health promotion a defined sphere of activity within it.

The Bangkok Charter refers to health promotion as a ‘core function of public health’ (WHO, 2005). Potvin and McQueen see health promotion as ‘a strategy for public health that reflects modernity’ (2007: 14). They note that subsequent to its emergence in the 1970s and more formal adoption in the 1980s, health promotion rapidly spread through public health organizations and institutions internationally. However, latterly, while the principles and strategies remain relevant, the term ‘health promotion’ appears to be becoming ‘outmoded’ in some parts of the world. Here in England, for example, specialist health promotion has declined and attempts at professionalization have failed (Duncan, 2013). However, in other contexts, health promotion as a distinct entity thrives, as indicated by the newly established Department for Health Promotion in the Gambian Ministry of Health.

Potvin and McQueen argue that while some countries may have a cadre of health promotion professionals, health promotion activity involves a wide range of groups, including lay people, and that health promotion is ‘not a discipline, nor an institution, nor a profession’ (2007: 16). They see health promotion as embracing a ‘structured discourse and a set of practices’ and identify its two characteristic features as ‘a distinctive perspective on health; and a critical orientation towards action’ (2007: 16).

However, our position, set out earlier in this chapter, is that health promotion is a discipline with its own ideology and we will at later points in this book identify the theories, perspective and methods that characterize it as an ‘ordered field of study’. A study of the views of key informants in the UK by Tilford et al. (2003) found that they associated health promotion with a clear set of values as well as a set of activities. These included instrumental values associated with ways of working as well as terminal values, notably a holistic conceptualization of health, equity, empowerment, autonomy/self-determination and justice/fairness. While there was felt to be some degree of consensus between the values of public health and health promotion, there was a much stronger emphasis for health promotion on empowerment and autonomy with the associated instrumental values of involvement and participation. Prevention and protection featured more prominently in relation to public health, along with a clear population focus and greater attention to ‘ends’. In contrast, health promotion was more concerned about means and had a broader focus that included individuals as well as communities. Tilford et al. (2003) conclude that within the context of the move to multidisciplinary public health, health promotion makes a distinctive contribution through its core values (see box). By virtue of its more radical orientation, health promotion has in the past been described as the militant wing of public health. The emphasis on attention to process might also lead to it being seen as the critical conscience of public health.
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 goals.

Source: Tilford et al. (2003: 120)

As we noted above, the early emergence of health promotion was characterized by a struggle to distance itself from public health, held to be associated with the preventive medical model of health. Furthermore, it also sought a separate identity from health education – viewed as the ‘handmaiden of public health’ and tainted by association with approaches deemed to be victim-blaming in orientation. The move towards the ‘New Public Health’, which subscribed to a social model of health, brought about greater alignment with health promotion. The social model of health reflects, as we have seen, an attendant emphasis on issues such as inequality and sustainability (Duncan, 2013). Most of those who claim to be ‘health promoters’ would see commonalities with the broad statement of purpose used for public health:

- to improve health and well-being in the population
- to prevent disease and minimize its consequences
- to prolong valued life
- to reduce inequalities in health. (Skills for Health and Public Health Resource Unit, 2009)

Within England, the origins of modern multidisciplinary public health can be traced back to the Acheson Report, which defined public health as: ‘the science and art of preventing disease, prolonging life and promoting health through the organized efforts of society’ (Department of Health, 1988). The report also recognized that public health:

works through partnerships that cut across disciplinary, professional and organizational boundaries and exploits this diversity in collaboration, to bring evidence and research based policies to all areas which impact on the health and well being of populations. (1988)

The specialist health promotion workforce in the UK has depleted over the past two decades. Duncan (2013) argues three key reasons as to why this is the case. First, he points to a lack of a collective identity and a unified purpose among the health promotion workforce; second, the lack of a permanent organizational ‘place’ from which
health promotion could sustainably operate; and, finally, the powerful dominance of medicine, or more specifically public health medicine. The structure of public health in England has subsequently undergone rapid change in the last few years. At the beginning of April 2013, Public Health England came into being, established to ‘protect and improve the nation’s health and wellbeing, and to reduce inequalities’ (Department of Health, 2012). Nowhere in the structure is the term ‘health promotion’ actually used, rather ‘health protection’, ‘health improvement’ and ‘population health’. Nevertheless, the use of terms such as ‘reducing inequalities’, ‘advocacy’ and a commitment to working in partnership are perhaps indicative of a health promotion ethos.

Towards a competent health promotion workforce

Where does health promotion feature in this? Should health promotion have a separate identity and should there be distinct career pathways for those engaged in health promotion? As observed, towards the end of the old millennium, the term ‘health promotion’ started being used less frequently in both policy documents and job titles, despite the fact that the sphere of activity that had hitherto been described as health promotion was receiving more attention. Scott-Samuel and Springett (2007: 212) refer to this as the ‘semantic eclipse of health promotion’. Further, health promotion courses began to disappear from universities’ portfolios of provision to be replaced by a variety of titles, including Public Health and Public Health Promotion (Scriven, 2007). In many instances, this was merely a re-badging exercise rather than a significant change in content, but still generated concerns about the future of health promotion as a discipline and a profession. A review of specialist health promotion practice in England and Wales conducted by Griffiths and Dark concluded that: ‘Specialised health promotion is a discipline integral to public health’ but ‘has been eroded in recent years’ (2005: 6). They recommended that the specialist health promotion workforce requires recognition and advocacy along with systematic skills and competency development. A collaborative programme, ‘Shaping the Future of Health Promotion’, was set up in 2006 to implement these recommendations and:

- achieve recognition and identity for specialized health promotion
- develop an agreed career pathway for specialized health promotion staff.

Specification of core competencies and systems for professional registration can serve to define areas of professional practice and ensure standards. A statement on priorities for action issued by the International Union for Health Promotion and Education (IUHPE) and the Canadian Consortium for Health Promotion Research identified a specialist health promotion role as well as the need for a multisectoral response. It emphasized the importance of building a competent health promotion workforce. A number of countries have developed their own competency standards. In Australia there has been considerable work on the professionalization of the health promotion workforce (Shilton et al., 2008). The Australian Health Promotion Association has produced a national competencies framework aimed at a graduate level of competency. Five broad areas of competency are identified as follows:
1. Programme planning, implementation and evaluation.
2. Partnership building.
4. Technology.
5. Knowledge.

There is some debate about the use of a competency-based system. Naidoo and Wills (2005), for example, have argued that the narrow mechanistic focus of competencies is not an adequate basis for assessing professional practice because it overlooks not only the theoretical base but, importantly, the values which underpin critical reflective practice. An international review of the literature in this area pointed to the uneven progress that has been made in developing competency frameworks for health promotion and health education (Battel-Kirk et al., 2009). For example, in relation to the African context, Onya (2009) writes about the slow and inconsistent development of health promotion competencies and, with specific reference to South Africa, Wills and Rudolph (2010) point to a lack of occupational standards or competencies. In South East Asia, there has been more recent work around developing competencies in health promotion specifically in academic education programmes for health promotion and a call for a consistent approach across the region (Van der Putten et al., 2012).

There are also dissenting views about maintaining a separate identity for health promotion. Ashton, for example, is concerned that it is inconsistent with ‘an inclusive, holistic and integrated approach to public health practice’ and risks ‘health promotion apartheid’ (2007: 207). The alternative position is that ‘health promotion has been the subject of hegemonic absorption by an increasingly individualistic public health discourse’ (Scott-Samuel and Springett, 2007: 211). The consequence of not acknowledging the distinctive contribution of health promotion will be failure to nurture – and risk losing – the specific set of skills and values that it brings to modern multidisciplinary public health. It will also result in the suppression of what has long been regarded as the more radical and militant wing of public health. Responding to contemporary challenges to health, both nationally and internationally, has never before put so much emphasis on the importance of health promotion. For many, it is seen as an idea whose time has come (Scriven, 2007). Rising to this challenge requires recognition of the distinctive contribution of health promotion; the development of proper career pathways; and support for the professional development of a specialist cadre of health promotion staff – that is to say, those who see their role as entirely concerned with health promotion.

The IUHPE has proposed transnational agreements on core competencies ‘to further define the field and provide common direction for curriculum development’ (2007: 5). The Galway Consensus Conference (SOPHE, 2008) aimed to encourage ‘global exchange and understanding concerning domains of core competency in the professional preparation and practice of health promotion and health education specialists’. The identification of core competencies, standards and quality assurance systems was seen to be essential for
developing and strengthening the capacity to improve public health in the twenty-first century. Eight domains of core competency were identified:

- Catalyzing change
- Leadership
- Assessment
- Planning
- Implementation
- Evaluation
- Advocacy
- Partnerships

More recently, a European-wide project led by Professor Margaret Barry, has established a framework of core competencies for health promotion in Europe (Barry et al., 2012). The CompHP Core Competencies Framework for Health Promotion sets out the key requirements for effective health promotion practice and is intended as a resource for workforce development in health promotion in Europe. Reflecting a European commitment to health promotion, it identifies nine professional standards for health promotion underscored by ‘a core base of professional and ethical values integral to the practice of health promotion’ (Speller et al., 2012: 15). The nine standards are as follows:

Standard 1: Enable change
Standard 2: Advocate for health
Standard 3: Mediate through partnership
Standard 4: Communication
Standard 5: Leadership
Standard 6: Assessment
Standard 7: Planning
Standard 8: Implementation
Standard 9: Evaluation and Research

St Leger (2001) draws attention to the fact that we need to consider more than just the technical ability of practitioners, which is not necessarily matched by an understanding of the raison d'être of health promotion. Mittelmark’s discussion of Calderwood’s work on professional communities for social justice notes that professions are characterized by ‘specialised bodies of knowledge, a client base, self-regulated accountability and strict guidelines for membership’ (2008: 3). The notion of community adds the important element of shared values – in this instance, commitment to social justice. He argues that health promotion is a professional community for social justice. Sindall (2002) points out that health promotion should not take its own moral credentials for granted, but that a moral framework for practice is needed – an issue we will return
to throughout this book. It will be clear from our earlier discussion that defining a competent health promotion workforce should go beyond skills to include the values and ethical principles integral to health promotion – in short, it must be shaped by the discourse of health promotion and more specifically by an empowerment model of health promotion.

The ‘new’ critical health education

We have touched on health education at a number of points in this chapter. To bring the chapter to a close, we will briefly summarize our position on the role of health education vis-à-vis health promotion. The emergence of health promotion effectively marginalized health education by shifting attention towards the broader determinants of health and the need for a policy response. Yet this begs the question of how change is to be instigated and what processes should be put in place to improve the health of populations and, indeed, individuals. Our contention here is that the primary driver has to be health education. While it is acknowledged that health education requires a supportive environment to achieve its goals, the converse is all too often overlooked. The development of healthy public policy to create a supportive environment is dependent on health education. As Figure 1.6 makes clear, the development of healthy public policy requires some form of learning – and *ipso facto* education – be it among policy-makers themselves, advocates or communities seeking change.

Critiques of health education have centred on its individualistic, victim-blaming orientation. However, what the critics are actually attacking is the preventive medical model of health education. Alternative, coexisting models of health education – especially the more radical, empowering models – are overlooked, effectively discarding the health education baby with the victim-blaming bathwater. Health education has a key role in tackling the structural determinants of health. Even at the individual and community level, health education can have an empowering and emancipatory function. It can also facilitate the voluntary adoption of health-enhancing behaviour. The review by Tilford et al. of the values of health promotion supports the continued relevance of health education that is empowering and in tune with the precepts of critical theory:

> 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. (2003: 120)

Health education can thus be a major driver within an empowerment model of health promotion – shedding its behaviourist, victim-blaming associations. To emphasize the distinction, we refer to health education that incorporates this wider vision as the ‘New Health Education’. Subsequent chapters, which address planning and strategies for health promotion in more detail, will provide the opportunity to examine its potential more fully.
Key Points

- There are alternative conceptualizations of health. A working model is proposed that includes physical, mental, social and spiritual health and incorporates positive well-being as well as the absence of disease.
- Although health is influenced by human agency, structural factors have a major influence on health and health-related behaviour.
- Health promotion is a discipline with its own ideology and core values. These include equity and empowerment along with health as a right, social justice, voluntarism, autonomy, participation and partnerships.
- Ethical health promotion practice requires attention to these core principles along with the more general principles of beneficence, non-maleficence and the pursuit of the public good.
- Power is a key factor in relation to individuals’ health behaviour and health choices. Power also shapes discourse about health and health promotion.
- While different models of health promotion exist, the case is put forward for an empowerment model.
- Health promotion should generally uphold the principle of voluntarism, but the use of more coercive methods may exceptionally be justified on the grounds of utilitarianism, paternalism or social justice.
- Health promotion has a specialist role within a wider, multidisciplinary response to improving public health.
- Critical and empowering, the ‘New’ Health Education is a major driver within health promotion.

On the companion website


The following case studies on the companion website are relevant to the content of this chapter:

- Healthy University – Sharon Doherty and Prof Mark Dooris (United Kingdom)
- Community-Based Health Planning and Services Initiative – Grace Kafui Annan and Ebenezer Owusu-Addo (Ghana)
- Evaluation Circles – Dora Cardaci (El Salvador)
- Healthy Homes – R. Egan, K. Hicks and M. Dalziel (New Zealand)
- Knowledge-Based Strategies for Action – Monica Lillefjell and Ruca Maass (Norway)