

We need a comprehensive approach to health promotion

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Overview of the issue

Health promotion has been evolving since the pioneering work of Professor Lawrence Green and colleagues in the USA more than 35 years ago¹ and the Ottawa Charter in 1986.² This evolution has included shifts in philosophies based on the best available evidence. Early in the development of health promotion the recognition of individual health behaviour or lifestyle as a major cause of ill health led to a call for individuals to take responsibility for their own health (i.e. health promotion for self-responsibility or for behavioural perspectives). However, there is strong evidence that social, economic and environmental factors are significant determinants of behaviours and health status (structural perspectives or structural factors) and that addressing individual responsibility, without due consideration of the structural factors, can be viewed as a naive approach.

Some people use the evidence of ‘self-inflicted illness’ to recommend that individuals whose lifestyles cause their own ill-health should bear a substantial cost of the medical care they require. This may be in the form of imposing additional taxes, for example on cigarettes, alcohol, junk foods and other unhealthy products, to cover the cost of treating the health-related problems they cause or even charging those people who practise unhealthy lifestyles higher health insurance premiums or suggesting that those of a larger size pay more for plane flights.

On the other hand, there are criticisms of such recommendations as attempts to deny individuals a genuine freedom to choose their way of life. Although this argument can be easily countered, there is more substance to the claim that such approaches are part of an ethos of ‘victim blaming’ and that blaming victims allows for avoidance of dealing with the social and environmental impacts on health and lifestyle behaviours, which often affect those who are most vulnerable.

Health promotion and behavioural perspective

Health promotion for behavioural perspectives focuses on health education to encourage individuals to make lifestyle changes. It includes providing information related to health issues, such as

physical activity, nutrition, stress, safety, alcohol, tobacco and drug use and other risk factors that affect personal health.

This approach is based on epidemiological and medical evidence that links health-related behaviours with risk of chronic disease (cardiovascular disease, diabetes and some cancers). Such evidence indicates that those practising healthy lifestyle habits have a lower incidence of illness and live on average several years longer than those who practise fewer of these habits.^{3,4} The behaviours which require self-responsibility on the part of the individual include: elimination of cigarette smoking; minimising alcohol intake; maintaining a low-fat, low-refined-carbohydrate and low-salt diet; adequate fruit and vegetables intake; regular physical activity; adherence to traffic laws and use of seat belts; periodic screening for major disorders such as hypertension and some cancers; and refraining from illicit drug use.⁴

Recognition of this has encouraged numerous health behaviour change research studies. Some of the early classical community-based projects include the North Karelia Project in Finland, The Stanford Heart Disease Prevention Program and the Minnesota Heart Health Project of the 1980s.⁵ The main strategies of these programs involved individual and group education supported by some mass media and marketing promotions (behavioural perspectives) with relatively little attention given to other strategies (structural perspectives).

However, health promotion concentrating solely on individual behaviour change or lifestyles is no panacea, as human behaviour is regulated and determined by environmental, economic and social conditions, rather than being only due to individual initiative. Hence, to be truly effective and ethical, health promotion needs to consider both behavioural and structural perspectives.

Concept of health promotion

The comprehensive approach to health promotion was succinctly and clearly described by Peter Howat and colleagues and published in the *Health Promotion Journal of Australia* in 2003.⁶ Howat *et al.*'s definition reflected the combination of strategies commonly used in effective health promotion practice worldwide. It evolved over a period of almost two decades from reviews of definitions of health

promotion from the international literature, cross-referenced with the national health promotion competencies⁷ and current health promotion practice:

Health promotion can be regarded as a combination of educational, organisational, economic and political actions designed with consumer participation, to enable individuals, groups and whole communities to increase control over, and to improve their health through attitudinal, behavioural, social and environmental changes.⁶

The main components of this definition were consistent with the World Health Organisation's Ottawa Charter and the Jakarta Declaration and were influenced by the most eminent European and North American sources of that time.^{2,8,9} Rather than formulating a completely new definition, adapting universally accepted components of existing definitions was deemed more appropriate. Hence, the overall definition was based on Lawrence Green's definition,¹⁰ which was reworded and extended to ensure that consumer participation and their control over their own health were highlighted as intentions of the health promotion process, as emphasised by the World Health Organisation.^{2,9} Howat *et al.*'s definition⁷ clearly embedded both behavioural and structural perspectives and the influence of social determinants on health and reduced the risk of misinterpretation and confusion of what health promotion truly is.

Health promotion and the structural perspectives

Reviewing health promotion history, improvements in health have been achieved largely as a result of economic, environmental and legislative factors (i.e. laws or social policy) collectively referred to as structural variables. Free milk for school children, polio and other mass vaccinations, seat belts in motor vehicles, addition of folic acid to bread-making flour, iodised salt, tobacco plain packaging,³ improved housing insulation,¹¹ water fluoridation¹² and traffic safety laws¹³ are examples of structural variable change. Education has usually been an important precursor to these structural changes, which have resulted in improved health.

Excellent recent examples of such structural approaches to health promotion, which also simultaneously deal with social determinants of health as well as diffuse victim blaming, come from New Zealand. A study conducted in low-income communities found that insulating existing houses led to a significantly warmer and drier indoor environment resulting in improved self-rated health, self-reported wheezing, fewer days off school and work, fewer visits to general practitioners and a trend for fewer hospital admissions for respiratory conditions.¹⁴ An economic analysis of this program showed a 2:1 benefit to cost ratio with respect to health and environmental benefits.¹⁵

However, the funding levels for comprehensive health promotion initiatives at state and federal levels in Australia continue to be cyclical, often reflecting the philosophies of the political party that is in government.¹⁶ Available funding and funders' expectations

often result in practitioners and researchers being coerced into adopting a behavioural, rather than the more comprehensive structural approach, that is usually undertaken within a constrained timeframe, even though a structural approach is recognised as being the 'gold standard' and one that is taught in all comprehensive health promotion courses in Australian tertiary institutions.

Social determinants of health

Concerns are often raised whenever there is a mandate that the focus for health promotion be on a 'social determinants of health' approach, which is dominated by structural perspectives. Sometimes, critics see the health promotion that makes a strong commitment to the social determinants of health as supporting a 'nanny state' that negates individual responsibility and turns away from its primary mandate of prevention.¹⁷ This despite the science and practice of health promotion recognising that health status is significantly determined by social factors such as access to good quality food, housing, a healthy environment and public services.

Hence, tackling health inequities is a constant dilemma for health promotion with respect to what proportion of its very limited budgets (1.7% of the total Australian health expenditure)³ should be allocated to recognisable health-related programs on one hand, and on the other to social determinants that are often not seen as direct health issues. Governments generally allocate funds earmarked for health promotion to the former, with social determinants generally considered under budgets related to housing, transport, environment, education, social welfare and Indigenous health.

Some authorities assert that maximising the resources that eventually find their way to broader health promotion that encompasses social determinants is a key role of health promotion professionals.⁹ However, there is also a need for advocacy across government portfolios such as housing, transport, environment, and education to ensure funds from these areas are allocated to improve the social determinants that influence health. This will support the targeting of the limited health portfolio funds to specific, direct health issues (that perhaps politicians better understand).

There is a close relationship between social gradient and the risk factors of many health problems. Behavioural risk factors like smoking, unhealthy eating and insufficient physical activity are more prevalent in low-income, and lower educated groups. Environmental risk factors are also more influential on the health of such groups (i.e. social determinants of health), compared with those of a higher income and education level. According to the medical model perspective that focusses on treatment, individuals make informed choices about their personal health behaviours, such as the foods they eat and whether they will undertake regular physical activity. Failure to control such risk factors and the consequent development of obesity, cardiovascular disease and

some cancers is entirely the individuals 'choice' and they are at fault for their health problems.¹⁸

On the other hand, a health promotion perspective imbued with the public health model concentrates more on prevention, where it is recognised that harmful health behaviours are strongly influenced by the environment, thereby diluting the victim-blaming stance. Interventions for obesity, for example, address both the individual behaviours of food intake and physical activity (behavioural perspectives), but also set about to modify the obesogenic environment through policy and environmental changes (structural perspectives) such as controls over the location of fast food outlets, junk food advertising, availability of fresh fruit and vegetables, and taxes on junk foods. Such a comprehensive approach to health promotion incorporating both behavioural and structural interventions is the most effective way to achieve improvements for significant health issues. There are excellent Australian examples of this related to traffic safety, tobacco control and HIV/AIDS control.^{3,13} We encourage contributions to the *Health Promotion Journal of Australia* to build the evidence-base about program and policy interventions that combine both behavioural and structural approaches.

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