Health promotion’s record card: how principled are we 20 years on?

This year marks the 20th anniversary of the original paper on Health Promotion: Concepts and Principles, and the 10th anniversary of the International Union of Health Education including ‘health promotion’ in its title. Surely historians would rate the exponential growth of this new public health movement as extraordinary?

Across the world there are government health promotion strategies and reviews, statutory authorities and foundations, consumer interest groups, professional associations and journals. University departments and professors proudly bear the name, Masters and Bachelor degrees are in abundance and a new textbook seems to appear every few months. Millions of dollars are now increasingly being invested in health promotion programmes by governments and international organizations such as the World Bank, as well as through voluntary contributions from people themselves (Catford, 2003). It is quite remarkable that this has all happened in just two decades. But how true is the practice of health promotion to those principles developed in 1984?

The origins of health promotion are complex and no single driver is responsible. However, most commentators would agree that the shift in thinking began to occur around an important global meeting of the World Health Organization (WHO) at Alma Ata in the state of Kazak in the former Soviet Union in 1978. The declaration that resulted crucially recognized that health improvements would not occur just by developing and financing health services, which had been the focus for investment since the Second World War (WHO, 1978). It provided the seedbed for the development of health promotion in the following decade to reach out to other sectors.

Most notably, The Declaration of Alma Ata formally adopted primary health care (PHC) as the principle mechanism for health care delivery. This was a vital signal to developing countries that were increasingly investing in high-cost hospital systems, which were only available to a limited few, i.e. those in urban centres who could pay. Alma Ata heralded the shift in power, which is fundamental to health promotion, from the providers of health services (the doctors, nurses and health administrators) to the consumers of those health services and the wider community who ultimately pay for them. The consequence of the Alma Ata Declaration was that the majority of countries, particularly in the developing world, adopted PHC as their principle health response. This led the WHO to prepare a global strategy entitled ‘Health for All by the Year 2000’, with a series of measurable targets and goals (WHO, 1981). ‘Health for All’ fast became the driving force for comprehensive health development over the following two decades and provided an environment in which the concept of health promotion could be fostered and grow.

During this period the term ‘health promotion’ was becoming increasingly used by a new wave of public health activists who were dissatisfied with the rather traditional and top down approaches of ‘health education’ and ‘disease prevention’. It signalled a positive, creative and outcome-oriented approach. However, in some contexts and languages the term ‘promotion’ was considered synonymous with ‘marketing’ and ‘selling’ rather than ‘enhancement’ and ‘empowerment’.

This led to the WHO, through the leadership of Dr Ilona Kickbusch and Dr Jö Asvall, calling a special meeting in 1984 at the WHO EURO headquarters in Copenhagen, Denmark, to provide some clarity and direction. David
McQueen and I had the privilege of attending and participating in the beginnings of this exciting new adventure. What emerged was the first substantive document on health promotion, *Concepts and Principles of Health Promotion* (WHO, 1986), which is also available through the WHO archiving service (WHO, 1984). In addition to proposing a series of principles (see below), a number of subject areas, priorities and dilemmas were also presented.

**THE PRINCIPLES OF HEALTH PROMOTION**

The principles of health promotion were first proposed by a WHO Working Group in 1984:

- *Health promotion involves the population as a whole in the context of their everyday life,* rather than focusing on people at risk for specific diseases. It enables people to take control over, and responsibility for, their health as an important component of everyday life; both as spontaneous and organized action for health. This requires full and continuing access to information about health and how it might be sought by all the population using all dissemination methods available.

- *Health promotion is directed towards action on the determinants or causes of health.* Health promotion, therefore, requires a close cooperation of sectors beyond health services, reflecting the diversity of conditions that influence health. Government, at both local and national levels, has a unique responsibility to act appropriately in a timely way to ensure that the ‘total’ environment, which is beyond the control of individuals and groups, is conducive to health.

- *Health promotion combines diverse, but complementary, methods or approaches,* including communication, education, legislation, fiscal measures, organizational change, community development and spontaneous local activities against health hazards.

- *Health promotion aims particularly at effective and concrete public participation.* This focus requires the further development of problem-defining and decision-making life skills, both individually and collectively.

- While health promotion is basically an activity in the health and social fields, and not a medical service, *health professionals—particularly in primary health care—have an important role in nurturing and enabling health promotion.* Health professionals should work outwards, developing their special contributions in education and health advocacy.

Many public health leaders saw these principles as quite radical. For example, epidemiological assessments needed to be balanced against what were felt to be the needs of populations. Individuals needed to be viewed not as health consumers, as if health services were the source of health, but rather as health creators, recognizing that health is ‘won’ by people themselves. There also needed to be a shift to an ecological, holistic view of health from a medical, reductionist one. Some health service workers found this loss of power and status threatening. One way to overcome this was to improve better understanding of the issues and to provide practical examples of successful initiatives. As a response, the WHO EURO set up *Health Promotion International* in 1986, a quarterly journal published by Oxford University Press to provide a vehicle for describing progress in health promotion and the positive benefits of such an approach.

Looking back over the 18 volumes, 72 issues and more than 750 papers, a unique historical record of the development of health promotion over the last two decades now exists [see, for example (Mahler, 1986; Draper, 1987; Nutbeam, 1990; Catford, 1993; Kickbusch, 1997; McQueen, 2000; Nyamwaya, 2003)]. Even a brief review indicates that the original health promotion principles are alive and well today. Take, for example, this issue: all 12 papers engage with at least one of the five principles of personal empowerment, action on determinants, complementary interventions, public participation and primary health care. The same can be said for papers in issues of *Health Promotion International* 5, 10 and 15 years ago. Of course the journal set up to champion health promotion would hardly be expected to publish papers inconsistent with its foundations, but even so the sustainability and continuity is impressive. However there lies a dilemma, which was not anticipated 20 years ago.

In broadening its base and becoming part of the mainstream, health promotion runs the risk of being less innovative and radical. Indeed to some it has now become part of ‘establishment speak’. Unfortunately this has resulted in the term sometimes being misused, its principles becoming distorted and its meaning being lost. Further dangers are that its cutting edge could
easily become blunted and its leadership compromised (St Leger, 2001). When faced with such challenges the best strategy is to look, and then move, forwards. Surely we need to rise to the new opportunities and threats of the next millennium, and in so doing inject new energy and passion. But how could we act differently and better? Where should we be spending our efforts? Is there a new dimension of thinking and action that we should be moving into?

One of the potential benefits of the IUHPE 18th World Conference on Health Promotion and Health Education in Melbourne is that it can both close a chapter on the last 20 years of health promotion and then open a new one as we adapt and move forwards. Health2004 (http://www.health2004.com.au) will present nearly 200 sessions in the main scientific programme, including keynotes, plenaries, ‘Meet the Experts’ sessions, and policy forums. Up to 1500 papers are expected and will be presented in oral abstract sessions, moderated oral poster sessions and by poster. The 4 days (27–30 April 2004) are structured into the synergistic themes of:

- **Global Changes and Challenges to Health**, with contributions from Minister Bronwyn Pike, Prof. Mason Durie, Dr Jeff Koplan and Datin Paduka Marina Mahathir;
- **Valuing Diversity**, with contributions from Pat Anderson, Dr David Satcher, Prof. Mary Kalantzis and Dr Moncef Marzouki;
- **Reshaping Power: Leadership, Participation, Governance**, with contributions from Dr Jay Wortman, Hon. Linda Burney, Mayor Antanas Mockus and Rev. Andrew Mawson; and
- **Creating the Conditions for Health: Vision, Purpose, Pathways**, with contributions from Anna Tibaijuka, Dr Nafis Sadik, Prof. Fiona Stanley and Prof. Maurice Mittelmark.

The main programme will be presented in approximately 20 streams, and will also include skills building workshops, special streams on-site, and two satellite streams immediately before and after the conference. These comprise: Cancer, Donors, Environment and Urbanization, Evidence/Effectiveness, Food and Nutrition, Health Futures, Health Promoting Schools, Health Promoting Health Care Services, Health Promotion Theory, Healthy Ageing, HIV/AIDS and other Blood-Borne Viruses, Globalization and Governance, Indigenous Health, Injury Prevention, Local Government Role, Mental Health, Multicultural Health, Partnerships, Peace and Health, Physical Activity, Rural Health, Tobacco, Workforce Development, Workplace Health, and Youth.

Gateway conferences have also been organized in Singapore, Aotearoa New Zealand, Country Victoria, and Brisbane Queensland. The 2004 International Harm Reduction Conference will take place in Melbourne immediately before Health2004, as will a 2-day forum on Health Promoting Changes in Emergency Departments. In addition, the WHO’s Mega Country Health Promotion Network, a high level roundtable from the world’s 11 most populous nations, will meet in Melbourne in conjunction with Health2004.

A mass of information, experience and insights will be revealed in probably the largest and most diverse health promotion conference ever. This is very exciting and is a further demonstration of the pace and breadth of health promotion; but the danger is that we may not see the wood for the trees. If we look at the development of health promotion over the last few decades we see some interesting themes emerging. In the 1970s we started by tackling preventable diseases and risk behaviours, primarily through information and simple education (e.g. heart disease, cancer, tobacco, nutrition). We could call this the first dimension of health promotion. Then, in the 1980s, we emphasized the importance of complementary intervention approaches (e.g. Ottawa’s healthy public policy, personal skills, supportive environments, community action, health services); this was the second dimension of health promotion. Finally, in the third dimension of health promotion in the 1990s we learnt the value of reaching people through the settings and sectors in which they live and meet (e.g. schools, cities, health care settings, workplaces).

In the 2000s we need to sustain the momentum and add a fourth dimension of health promotion. But what is this? Does it exist? The answer is that it has always been there but we have been neither sufficiently confident nor skilled to respond to it. We need to move on, not only in our words but also in our actions, from the narrow entry point of disease prevention and control to the wider agenda of social determinants. The challenge now is to respond to the global trends of massive social change that impact on health, welfare and the environment. This fourth dimension is the most demanding but it may be mastered if we use the tried and tested tool-kits derived from the first three dimensions together with new concepts, approaches and theories.
As we look over the horizon into the next century, the picture is getting bigger and the terrain more hazardous. Although we have much to celebrate concerning the development of health promotion knowledge and practice over the last two decades, we dare not be complacent; as Mark Twain said: ‘Even if you are on the right track, you will get run over if you just sit there’. Leadership development coupled with a focus on the social determinants of health seem to be key ingredients for the continued growth and well-being of health promotion. So participate and connect with Health2004, both for your own sake and for the sake of safeguarding the principles of health promotion.

Finally, may I record my appreciation of all contributors to, and supporters of Health Promotion International during 2002–2003. I would particularly like to thank the referees who give so much of their time in providing excellent feedback to authors. This is often an unacknowledged task but of great importance in ensuring the high standards and quality of the journal. Their names are listed later in this issue. A number of changes have also been made to the Editorial Board and the Editors so that we have opportunities to renew and refresh. I am therefore very grateful to retiring, continuing and new members for their support in making ‘HPI’ the international leadership journal of the health promotion movement.

John Catford
Editor in Chief

REFERENCES