THE SETTINGS APPROACH TO HEALTH PROMOTION

The World Health Report 2002 (WHO, 2002) reiterated the influence of cultural, economic and social factors on the health of individuals and populations and the need to address the settings within which they live in order to have a meaningful impact. From a health promotion perspective, ‘settings’ have been defined as ‘a place or social context in which people engage in daily activities in which environmental, organizational and personal factors interact to affect health and well-being’ (Nutbeam, 1998: 362). Recognizing that human beings exist in complex social, cultural, economic and political environs, various aspects of which (individually or through interaction) can enhance or damage health, is at the heart of the settings approach to health promotion. Consequently such an approach should utilize interventions geared towards modifying the context within which individuals exist rather than solely attempting to change the individuals themselves. This signifies a shift in focus from reductionist strategies that emphasize individual action to a more salutogenic philosophy, with programmes that acknowledge the impact of wider environmental determinants, i.e. a social ecological model of health promotion (Green et al., 2000). Critically, such an approach should involve more than merely aiming a variety of concurrent yet separate health promotion techniques at those who interact in a particular environment: theoretically sound settings-based activities are those that emphasize the integration of sustained organization development (Johnson and Baum, 2001). The workplace, along with the school, the hospital, the city and the island, has been established as one of the most important settings for health promotion (Chu et al., 2000). Although health promotion programmes have
been embraced to varying degrees within all of these settings, the question is how congruent are these activities with the organizational theories and management models that distinguish being a ‘health promoting’ setting from merely undertaking health promotion within a setting (Baric, 1993).

### SETTING AND ORGANIZATION DEVELOPMENT

Organizations are more than the bricks and mortar that house them, or the groups of individuals who happen to work together to accomplish tasks: they are a ‘dynamic, complex set of relationships among individuals and groups’ (Adkins, 1999: 131). Indeed, the essence of an organization has been painted as ‘an ongoing conversation’ between everyone and anyone who interacts the organization in any way (Stacey, 2000). Similarly Wenzel (Wenzel, 1997) has described settings as ‘a concept referring to interaction that takes place’. Organization development (or organizational development, as it is more commonly referred to within health promotion publications) is arguably the management discipline of most importance to the settings approach, particularly to those that are workplaces (Grossman and Scala, 1993). Despite being an established field, organization development (OD) lacks a commonly agreed definition that is accepted as capturing its nature, purpose and scope (although many authors have tried). Beckhard (Beckhard, 1969: 9) described OD as “an effort, planned, organization wide and managed from the top, to increase organization effectiveness and health through planned interventions in the organization’s ‘processes’, using behavioural science knowledge”. More recently Cummings and Worley (Cummings and Worley, 1993: 2) suggested that it is ‘a systematic application of behavioural science knowledge to the planned development and reinforcement of organizational strategies, structures and processes for improving an organization’s effectiveness’. However, semantics aside, it is possible to identify a number of core characteristics:

- OD applies behavioural science to achieve planned organizational change.
- The goals of OD ‘interventions’ are usually improved organizational effectiveness, increasing the capacity of organizations to manage change and improving organizational capability for learning, improvement and innovation.
- The target of OD activity is the organizational system.
- OD commonly uses systems theory to analyse organizational issues, plan and implement organizational improvements.

It is the fourth of the above core characteristics that it is of particular relevance to the settings approach to health promotion (Dooris et al., 1998).

### Settings and systems

Hall and Fagen (Hall and Fagen, 1956: 18) define a system as ‘a set of objects together with relationships between the objects and between their attributes’. The articulation of systems theory owes much to the early work of Ludwig von Bertalanffy, a theoretical biologist, and particularly his General Systems Theory (von Bertalanffy, 1968). In essence, systems theory equates organizations as being comparable with living organisms; and builds on the axiom that like organisms, organizations “are ‘open’ to their environment and must achieve appropriate relations with that environment if they are to survive” (Morgan, 1997: 39). In a similar manner, the system itself is seen to be made up of an arrangement of sub-systems, all of which are characterized by individual patterns of interaction; both within their sub-systems and with other parts of the system. The nature of such open systems is often described with reference to the following key concepts (French and Bell, 1999):

- Open systems are input–throughput–output mechanisms. They take inputs (e.g. people, resources, information), change them in some way, and then return the processed input to the environment as an output.
- Open systems have permeable boundaries, which separate the organization from the environment.
- Open systems have goals and exist for a purpose. These purposes must be compatible with environmental needs otherwise the system will cease to exist.
- Open systems are homeostatic—they seek to achieve a state of equilibrium and minimise the impact of disruptive forces, whether internal or external.
- Open systems are predisposed to becoming increasingly differentiated, getting more
elaborated, complex and specialized over time. Thus increased co-ordination and integration are needed to manage systems as they develop.

Essentially systems theory emphasizes the importance of seeing any organization in its totality, and of understanding the inter-relationships and inter-dependencies between significant ‘components’ or ‘subsystems’ of the organization. It has consequently stimulated the conception of a number of influential OD frameworks to analyse and understand how organizations function, e.g. the Porras and Robertson Model of Organizational Change (Porras and Robertson, 1992), which proposes that changes to individual behaviour can be stimulated through the use of OD interventions to modify features of the work setting, thereby leading to both individual and organizational improvements. Considering an organization in this manner would appear to be eminently compatible with the intent of the settings approach to modify the context (or systems) within which people exist. While a growing number of academics have sought to emphasize the centrality of systems thinking to the settings approach to health promotion (Dooris, 2003), the implications and opportunities of pursuing this in practice arguably remain relatively under-developed.

In order to engender the type of sustained improvement promised by the settings approach, promoting health and well-being within organizations necessitates a comprehension of health that is not unduly fixated on individual responsibility (Cooper and Williams, 1994) and an acceptance of the influence that organizations have on those who interact within and with them (Suchman, 2001). While the health promotion programmes within large companies of recent years are admittedly more comprehensive than those of the past, disappointingly the predominant target for interventions remains the individual rather than the organization (Dugdill and Springett, 2001). Crucially Chu et al. (Chu et al., 2000) suggest that the lack of conceptual clarity evident in many programmes represents a fundamental barrier to the development of the settings approach within workplaces. Clearly the focus should be on the sophisticated task of addressing the underlying determinants of health, developing programmes akin to what Polyni et al. (Polyni et al., 2000) have characterized as ‘Promoting Workplace Determinants’ approaches that centre on organization-level interventions. And in doing so, such programmes should avoid the pitfall of attempting to deploy the settings approach as merely a vehicle for gaining access to populations within a particular setting (Whitelaw et al., 2001). The challenge then is to devise theoretically robust models that reinforce key principles and can actually be readily applied to the realities that organizations operate within, and in a manner that delivers benefits not only to them and their staff, but also to their clients and the wider community that they belong to.

THE HEALTHY LIVING AND WORKING MODEL: FROM SCHEMA TO STRATEGY

In order to promote and facilitate the utilization of systems theory-based settings approaches, we have developed the Healthy Living and Working (HLW) Model. Essentially, the HLW Model proposes following a process of OD in order to generate and implement system-specific strategies that are underpinned by and that exhibit a number of defined characteristics. The Model is intended to be accessible (but not exclusive) to organizations unfamiliar with the ideas and concepts of health promotion and the settings approach in particular (and consequently may very well include many of the people and places that would benefit most from such interventions). It comprises three generic components:

- the HLW Schema.
- the HLW Framework.
- the OD Process.

When combined and integrated accordingly, these three generic components yield a fourth component, an organization-specific HLW strategy. Figure 1 illustrates the relationships between these constituent components of the HLW Model.

The HLW Schema

A set of five settings-based principles that should function to govern and permeate all components and applications of the HLW Model

The notion of a schema was first articulated by Bartlett (Bartlett, 1932), and within cognitive psychology can be viewed as referring to a cognitive structure that emerges as a result of learning and which functions as a representation of generic knowledge in long-term memory. As Rumelhart (Rumelhart, 1981: 33) elaborates,
schemata are ‘the building blocks of cognition. They are the fundamental elements upon which all information processing depend’. From this perspective, individuals develop and maintain schemata to help them make sense (consciously or otherwise) of the world around them and guide their perceptions of what happens within it. Schemata are constructed around combinations of values—fixed compulsory and/or variable optional—that relate them to particular persons, objects, actions or concepts (Cohen, 1993). Cohen (Cohen, 1989: 71) explains: ‘A schema has slots which may be filled with fixed compulsory values, or with variable optional values. A schema for a boat would have floats as fixed value, but has oars and engine as variable values’.

In the context of the HLW Model, the purpose of the HLW Schema is to govern all applications of the model by identifying what activity is acceptable through the use of its own particular fixed compulsory values, which we have referred to as its essential features. It is our intention that these should represent an embodiment of the core principles of the approach we are advocating in its purest state. If our ‘distillation’ has been successful, those familiar with health promotion and the settings approach should not find any of these inclusions in themselves surprising; whilst those unfamiliar with the finer points of either (as many decision-makers and opinion leaders within organizations invariably may be) should appreciate our endeavour: to succinctly convey the essence of this approach in a precise yet functional manner. The following constitute the essential features of the HLW Schema:

- A view of the organization as the primary unit for change.
- A focus on addressing the determinants, rather than just the symptoms, of diminished health.
- An integration of approaches across the community of stakeholders.
- A preference for common actions to address multiple situations.
- A holistic view of health, acknowledging that health is more than the absence of disease.

The real significance of articulating the essential features of the HLW Model in the form of a Schema is that it requires them to be organized meaningfully, highlighting the nature of their inter-relatedness (Anderson, 1977). Therefore, it is important to recognize that the HLW Schema’s combination of essential features have been chosen with attention to their mutual compatibility (in line with systems thinking). Schemata have been described as existing in reticular formations or networks, consisting of nodes and links (Bruning et al., 1995). Figure 2 illustrates the HLW Schema in this manner, demonstrating how when interconnected via a network of links the five essential features can form a three-dimensional structure. Notably, schemata are not intended to be static constructs: as new information emerges and the knowledge-base develops, so they too should evolve (Piaget, 1973). Hence, it is envisaged that applications of and reflections on the HLW Model would,
over time, encourage the maturation of the HLW Schema.

The HLW Framework

_A generic framework underpinned by the HLW Schema, which can be developed into a comprehensive organization-specific HLW strategy through an appropriate process of OD_

The HLW Framework is the template within which any HLW strategy would be devised and structured. Currently being refined in practice (Sengupta and Parker-Smith, 2003), the Framework is intended to provide a means for organizations to coherently organize and direct all the data, information and decisions identified as relevant to their devising a HLW strategy that is tailored to their needs, pressures and priorities.

Congruent with the HLW Schema, the Framework will be constructed so as to emphasize the underlying determinants of health (Dahlgren and Whitehead, 1996), i.e.:

- Age, sex and hereditary factors;
- Individual lifestyle factors;
- Social and community influences;
- Living and working conditions;
- General socio-economic, cultural and environmental conditions.

Such an arrangement would also recognize and aim to advance the contribution of the organization to broader population health improvement. Thus, the Framework would arrange organizational activities and priorities in relation to all aspects of health and well-being, whilst also identifying broader opportunities that they may have hitherto given limited thought (e.g. their scope for supporting local community development). Indeed, such an approach to encompassing a wider range of issues than is traditionally addressed by workplace health promotion strategies would hopefully function to build awareness of the diversity of influences that impact on health and well-being.

In this way the Framework would prompt a systematic consideration of how the organizational setting could be modified so as to facilitate the process of integrating comprehensive health promotion activity within the organization. Utilization of an appropriate OD process would generate the organization-specific content required to populate the Framework and develop a bespoke HLW Strategy. In this way, while HLW Strategies generated by different organizations would demonstrate the same essential features, their specific concerns and activities would differ to reflect their individual needs and circumstances.

The OD Process

_A systematic process underpinned by the HLW Schema through which an organization can use the HLW Framework to develop and then implement a HLW Strategy tailored to its specific circumstances and priorities_

In the interests of empowering organizations to utilize whichever approach it is they are most comfortable with, we have resisted the temptation to limit the HLW Model to any one model of OD. However, irrespective of which specific model is used within a given organization, sustaining engendered change will be more likely if it is utilized in a manner congruent with the behaviour the process aims to foster. Conventional OD processes have some innate qualities that will resonate with those familiar to health promotion, e.g. an emphasis on empowerment and participation (French and Bell, 1999). In order to devise and action a HLW Strategy though, it is proposed that these properties ought to be augmented through the integration of the essential features of the HLW Schema within whatever OD process is adopted. The practical impact of such an incorporation would mean that the HLW Schema was essentially providing organizations with decision rules to streamline their decision-making within their chosen OD process. Figure 3 illustrates how this could affect the types of choices made in practice.

According to French and Bell (French and Bell, 1999: 121) all ‘OD programs follow a logical progression of events—a series of phases that unfolds over time’. Burke (Burke, 1994) describes the phases of OD as:

- Entry.
- Contracting.
- Diagnosis.
- Feedback.
- Planning change.
- Intervention.
- Evaluation.

For the purposes of this article, we are going to use Burke’s phases to briefly elaborate on the use of OD to develop and implement the HLW Strategy.
Entry and contracting
The first milestone would be for the executive management of the organization to agree to the adoption of the HLW Model, and publicly commit the organization to positively addressing health and well-being (in essence, becoming a health promoting setting). Key considerations at this stage would include:

- Clearly establishing the relevance of the HLW Model to wider strategic issues and plans within the organization.
- Deciding how the HLW Model would be implemented (e.g. timescales, resources and scope).

At this stage one or more appropriately responsible and skilled individuals (depending on the size of the organization) ought to be identified to lead the HLW Strategy development and implementation process. It is important that these individuals have sufficient influence (with their authority proportionate to their responsibility), as a lack of this is can easily undermine the efforts of all involved (Kotter, 1995); and a mandate to operate throughout the organization, in order to build awareness and broad ownership for the overall direction of travel (Cummings and Worley, 1993).

Diagnosis and feedback
The development of any strategy aimed at organizational improvement demands an assessment of the present situation (Beckhard, 1969). Using the HLW Framework, the critical variables and factors that affect health and well-being in relation to the organization would have to be identified, with data then gathered and analysed.

It is probable that a combination of quantitative data (e.g. incidence of sickness absence) and qualitative data (e.g. staff perceptions of management relationships) would be needed, some of which may be readily available while others may need to be specially collected. In line with the HLW Schema, this should be a positive process focused on the determinants of health and well-being. Comments and suggestions should be actively sought from all stakeholders throughout, to mitigate against the HLW Strategy developed being unduly skewed by the preconceptions or particular priorities of any one group.

Planning change, intervention and evaluation
Having developed a HLW Strategy, the focus should seamlessly transfer to making sure that it delivers on the improvements intended for the organization.
and expected. Given the settings approach to health, the Porras and Robertson Model of Organizational Change (Porras and Robertson, 1992) could provide a particularly compatible guide for action planning, as it describes the work setting as consisting of four factors:

- Organizing arrangements (e.g. policies and procedures);
- Physical setting (e.g. spatial configuration);
- Technology (e.g. job design);
- Social factors (e.g. management style).

Given the diversity of changes that the Strategy and the overall OD process itself would be seeking to effect, a multi-methodological approach to evaluation would almost certainly be required, coupled with systematic efforts to identify unintended consequences (both positive and negative). Such a comprehensive approach to monitoring and evaluation is especially important to the HLW Model, because while Burke’s phases are set out in a linear manner, within the context of the HLW Model the various sets of activities would in practice be both on-going and inter-linked. So the sequence as described here reflects a shift of emphasis from one set of parallel, often overlapping activities to the next, rather than definitive end-points for each stage; with each set of activities being continually subject to and refined in light of new data and information generated by all of the others. In this manner, each HLW Strategy would evolve through a series of iterations, with its actions being critically reflected upon and revised in light of that Strategy’s consequences and to respond to its organization’s inevitably changing circumstances over time.

In this way, just as for the HLW Schema, applications of and reflections on the HLW Model would encourage the maturation of its other three components. Not only would this engender a process of continuous quality improvement within those organizations that adopted the Model, but also encourage the evolution of the Model itself.

**TURNING RHETORIC INTO REALITY: INITIAL CHALLENGES**

Many of the difficulties associated with turning the HLW Model into a working reality are similar to those associated with other models of organizational change and indeed other attempts at applying the settings approach in practice, e.g. achieving widespread commitment, building short-term ‘wins’ into long-term plans (St Leger, 1997). However, there are a number of noteworthy potential challenges specifically in regards to the HLW Model.

Firstly, while this article supports the view that OD is the management discipline of most importance to the settings approach, it also recognizes that there are potential compatibility issues that merit consideration, particularly the challenge of coherently introducing values associated with health promotion to the efficiency-focused discipline of OD. Indeed, given the importance attached to values within the settings approach to health promotion it has been proposed that a strong case exists for establishing a distinct sub-type of OD that specifically reflects and reinforces those values (Sengupta and Paton, 2003). Secondly, given the focus on organizational-level change and the particular perspective on health and well-being that is central to the HLW Model, convincing organizations (especially small and medium sized enterprises) to try it is likely to be taxing. Thirdly, while those familiar with health promotion will probably not find any of the essential features that constitute the HLW Schema surprising in themselves, the ambition of simultaneously fulfilling this particular combination of criteria should not be underestimated. In particular, those health promotion practitioners involved would need to avoid complacency and ensure that the work was informed by the distinct analytical and intervention expertise necessary to support organizational-level change, as failure to do so has been highlighted as a barrier to the adoption and sustainability of settings-based activity (Polyani et al., 2000; Noblet, 2003). Finally, given the continuing need to build the evidence-base for health promotion (McQueen, 2001) and particularly the need for more critical analysis of settings-based activity (St Leger, 1997; Wenzel, 1997), it would be crucial to undertake and report comprehensive and rigorous assessments of applications of the HLW Model. Indeed, it would be fitting for such assessments to follow the suggestion of Goodstadt et al. (Goodstadt et al., 2001) and not only be appropriate to the sophistication of the approach being implemented but also contribute to the essential features underpinning it.

**CONCLUSION**

For all of the promise that the settings approach to health promotion holds for health improvement,
its rhetoric has been more readily adopted than its practice. And unfortunately this has been a temptation to which those working within health promotion have themselves not been immune. Lack of conceptual clarity, insufficient learning from other relevant disciplines and inadequate consideration of the realities within which diverse organizations actually operate has conspired to limit its impact in the real world.

Fundamentally facilitating improvement at the organizational level should be the defining characteristic of the settings approach to health promotion. Moving forward demands more practical interventions that clearly, coherently and critically draw from a range of theories and evidence. They also need to be presented in a manner that resonates with those from other disciplines and in other fields of work. Being able to articulate the thinking behind them in a manner that is clear and accessible to others should not be mistaken as synonymous with either a lack of theoretical rigour or intellectual sophistication.

Developing a fuller appreciation and understanding of management theories presents exciting opportunities for developing progressive health promotion interventions within organizational contexts. Having elaborated on the relationship between the settings approach to health promotion, OD and systems thinking, the Healthy Living and Working Model proposed herein is presented as one means of taking this admittedly ambitious yet undoubtedly ever-more pertinent agenda forward.

ACKNOWLEDGEMENTS

We would like to express especial thanks to Robin Bunton, Ros Crawley, Barbara Griffin, David Shilton and Clive Thacker. However, all views expressed here are solely attributable to the authors. The Intellectual Property Rights in relation to the HLW Model and all of its applications are held by the University of Sunderland on behalf of itself, the University of Teesside and South Tyneside Health Care NHS Trust. Aspects of this work were presented at both the 10th and 11th International Conferences on Health Promoting Hospitals.

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