



**Runanga Whakapiki Ake i te Hauora o Aotearoa**  
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## **Health Promotion: a Unique Discipline?**

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Health promotion's contribution as a unifying concept to wider public health developments over the past thirty years has been unique and substantial. This discussion paper makes an initial review to assess whether health promotion is an umbrella term that covers a wide range of disciplines or whether it is a discipline in its own right. It raises some key issues related to the ways it is being mainstreamed and the danger that this might have by marginalising specialist health promotion.

It recommends that more in depth scoping work is needed by global region, language and country to help to ascertain its current disciplinary status.

Efforts should be made to enable health promotion to continue its development independently as a specialist discipline but also as part of the on-going development of public health itself by seeking to form new disciplinary alliances.

## **The Rise of Health Promotion**

Health promotion in the modern era was used for the first time in the mid 1970s (Lalonde Report 1974), although its underlying concepts have been traced back to ancient Greece (Tountas 2009). It formally developed largely as a reaction against, and challenge to, the dominant bio-medical, pathogenic model of health, which perceived health as absence of illness. In the late 1970s it was perceived as a form of education for health persuading individuals to live more healthily. During the 1980s this approach broadened as individual health behaviour was recognised as being influenced by the contexts and settings in which people live. It was seen as a process that is enabling and empowering which seeks to change health status and improve the health of populations. It combined individual lifestyle/behavioural approaches with macro-social/structuralist approaches. The former developed mainly from health education to transfer knowledge, change attitudes/behaviour and improve self-esteem. Examples include stop-smoking groups, school health education curricula and peer education. Structuralist approaches can include legislative or fiscal measures, relate to taxation of cigarettes and alcohol, environmental protection, and other strategies to build healthy public policy. Health promotion was seen to offer a distinct perspective on health, which facilitated a 'third revolution in public health' (Breslow 1999). The essential elements of health promotion relate to its core values, which are based on the Health for All principles of social justice, equity, empowerment and self-determination.

A specific health promotion programme was initiated in the European Office of the World Health Organisation (WHO) in 1982, which defined the concepts and principles of health promotion for the first time (WHO 1984). A series of major international conferences followed, led by the WHO, each producing their own bespoke statement to advance health promotion in more detail, reflecting its global vision and strategies (WHO 2009). The inaugural WHO conference produced the Ottawa Charter, which set out the conceptual framework for health promotion and highlighted its key action areas (WHO 1986). Expanding beyond the health sector and from individual behaviour to a wide range of social and environmental actions, the Charter defined health promotion as a "process of enabling people to increase control over, and to improve, their health". During the 1980s and 1990s health promotion rapidly developed and became institutionalised in the departments of many local, national and international governmental agencies and public health bodies. In the UK for example, departments/specialists in health education changed their designations overnight to health promotion; many graduate and postgraduate courses in health promotion appeared, many having changed their names from health education to health promotion. In the late

1990's there were over 30 university courses in health promotion in the UK. At global level, the International Union for Health Education, which had existed under that title since 1951, changed its name to the International Union for Health Promotion and Education.

From the late 1990s, some countries began to adopt alternative terms for health promotion. For example in England, the term 'health development' came and went; more recently the term 'health improvement' is in vogue throughout the countries of the UK (Wills and Douglas 2008). There have also been attempts at national level to integrate health promotion with social marketing (Griffiths, Blair-Stevens and Thorpe 2008). In Canada, the term 'population health' often replaced health promotion (Raphael 2008). In the USA, health promotion as a term was used (eg American Journal of Health Promotion) but in practice never replaced public and school health education as the dominant terminology in general use. In these neo-liberal countries there was a conscious shift to focus on changing individual behavioural risk factors and reduce health promotion to health education and social marketing. The rapid process of institutionalisation of health promotion has therefore slowed down in the last decade and the term 'health promotion' dropped from many titles of jobs and organisations. On the other hand, a number of new innovative organisations entitled health promotion foundations appeared in various diverse parts of the world – Australia (Victoria, Western Australia), Thailand, Austria, Canada, Malaysia, Switzerland, and created their own global network. These organisations are mainly funded from ring-fenced sources and do not have to compete directly with health service funding, which is often the case in many other countries. In recent years health promotion has maintained its presence in practice, and is on the ascendancy in many parts of the world. For example, in its latest strategy for the European Region over the next decade, WHO highlights the contemporary importance of health promotion:

“Health promotion programmes based on principles of engagement and empowerment offer real benefits. These include: creating better conditions for health, improving health literacy, supporting independent living and making the healthier choice the easier choice” (WHO 2013 p 16).

### **What is Health Promotion?**

Debates over the actual meaning and scope of health promotion have continued over the past three decades. At its simplest, it can be regarded as a strategy for promoting the health of populations, yet the term “...has variously been used to refer to a social movement, an ideology, a discipline, a profession and a strategy or field of practice delineated by commitment to key values” (Green and Tones 2010 p 4). Health promotion has different meanings to different stakeholders:

“Different definitions can represent different options or types of health promotion available to the health promoter according to the task or programme in hand, reflecting the variety of health promotion goals, target populations, as well as the focus and type of intervention” (Macdonald and Bunton 2002 p11).

Tension exists between different types of health promotion; that which focuses on disease prevention using models of behaviour change linked to biomedical positivist methods and measures of effectiveness and that which focuses on tackling social/wider determinants of health (the causes of the causes) linked to a moral and political approach with its own structuralist methods and measures. The latter reflects the radical roots of health promotion

which continue to offer a challenge to the individual-focussed medical model and its related health care delivery systems.

These tensions highlight the socio-political nature of health promotion:

“Definitions of health promotion, like health itself, are subject to social and political influence and are, therefore, likely to vary across organisations and social contexts, making universal definition almost impossible”.(Macdonald and Bunton 2002 p10).

The changes in terminology discussed earlier do not reflect that health promotion has stopped developing and is no longer relevant but arise from changes in the policy rhetoric related to the health sectors of certain countries. For example, in the UK there has been a broader emphasis on public health as opposed to health promotion. The rivalry that exists between the medical and non-medical power base in the health sector has been an underlying cause; health promotion being replaced by the term ‘health improvement’ as one of the three domains of public health (the others being health protection and health service improvement) (Wills & Douglas 2008). It has been suggested that this is a result of “hegemonic absorption by an increasingly individualistic public health discourse” (Scott-Samuel and Springett 2007). In New Zealand health promotion is seen by the Public Health Clinical Network as one of the 5 core public health functions (Public Health Clinical Network 2011). The changes in terminology have been based on the epidemiological approach and a bio-medical positivist model that depoliticises health issues. As a result health promotion internationally has suffered from a lack of investment in its infrastructure, research and organisational capacity; its funding coming in most cases from the health sector where investment has been prioritised into delivering health care and treatment services. As a result, although there is often political rhetoric in its favour, health promotion in practice has not therefore been a national, and thereby often local, priority in terms of investment in many countries. Bunton (2008) points out that even in successful areas, such as tobacco control and raising issues related to health inequalities, health promotion has received no credit no acknowledgement.

Discussions regarding the nature of health promotion’s relationship to public health have continued since the late 1970s. It has been perceived as ‘the avant-garde of public health’ (McQueen and Kickbusch 2007) leading the shift from a pathogenic focus to a salutogenic focus on health. The Ottawa Charter is sub-titled “the move towards a new public health” (Kickbusch 2007). In this shift towards the new public health and a socio-ecological model, health promotion recognises health as a social phenomenon, as well as a physical/biological and psychological phenomenon, set within the on going processes of health development (Bauer, Davies and Pelikan 2006). It has often been regarded as the delivery mechanism for public health, being principally practice-driven. The Bangkok Charter for Health Promotion (WHO 2005) refers to health promotion as a ‘core function of public health’. This relationship with public health is important in considering whether health promotion is a discipline in its own right.

## What is a Discipline?

A discipline is an ordered field of study with its own ideology. Disciplines have been referred to as “...bounded groups or federations of theories, perspectives, and methods associated with an area of study” (Macdonald and Bunton 2002 p17). Disciplines have both epistemological and ethnographic aspects ie having different fields of knowledge and different cultural features respectively:

“We cannot and should not artificially separate the matter of substantive content from that of social behaviour” (Price cited by Becker 1994 p 152).

Becker (1989) has argued that different disciplinary groups consist of different ‘academic tribes’ each with their own sets of values and cognitive domains:

“Each tribe has a name and territory, settles its own affairs, goes to war with others, has a distinct language or at least a distinct dialect, and a variety of symbolic ways of demonstrating its apartness from others” (Becker 1994 p 151).

Several different factors need to be present before a subject can be defined as a discipline. It has to possess its own value base; specific knowledge domain; history, traditions and cultural codes of conduct; preferred research methods; and professional competency and capacity-building methods. It crosses geographical and national boundaries reflected by the organisation of international, regional and national conferences and symposia, establishment of active academic communication networks, mobility of staff and students, collaborative research and accreditation of teaching and learning. From a more cultural perspective, a discipline needs the ability to attract like-minded individuals and groups with similar beliefs, goals and visions.

### **Health Promotion as an Emerging Discipline**

Kuhn (1970) explored how scientific bodies of knowledge change over time by using the phenomenon of paradigm shift – when ideas, concepts and theories change as an outcome of collective effort. Yet such ‘revolutions’ are subject to cultural, social and perhaps political influence. Some disciplines are seen as multi-paradigmatic (Ritzle 1975). New ideas and schools of thought can run parallel to more established systems sometimes branching off and forming new disciplines (Macdonald and Bunton 2002). In this way the new public health and health promotion have emerged alongside the traditional fields of public health and preventive medicine.

The knowledge base and practice of contemporary health promotion reflects a paradigm shift in our understanding of health and this reflects its complex development as a field of study in its own right. It led the shift from an individualistic behavioural approach to one that perceives health as a holistic concept. Health promotion has been seen as a form of system science, which can deal with complex interactions between a range of determinants (Norman 2009). Longer established disciplines have provided the theoretical and disciplinary roots for the development of health promotion as a discipline. The “multidisciplinary roots of health promotion ...unified diverse disciplines and fields of study with a single focus” (Bunton and Macdonald 2002). Health promotion has attempted to define its own concepts and characteristics which are borrowed from its major contributing disciplines of sociology, psychology, education and epidemiology and those that have made an important if lesser contribution such as social policy, communications, marketing, politics, ethics, and genetics (Bunton and Macdonald 2002). Medicine, nursing, anthropology and social work have been suggested as additional contributing disciplines; various disciplines, from different academic traditions, can be added or omitted depending on which global region was under examination (Mittelmark 2005). This raises the question as to whether health promotion is a discipline or “just a collection of established disciplines brought together by the demands of this new approach to public health” (Edmondson & Kelleher 2001 p 1503).

In order to answer this key question, it is useful analytically to differentiate between health promotion as a scholarly or scientific body of knowledge and practice, with its own specialists at both academic and professional levels, and mainstreaming health promotion as a

social movement. This contrasts “a bureaucratic entity or formal domain of study and practice” with a new social movement - “a process concerned with empowering people to take control of their own health” (Pederson, Rootman and O’Neill 2005 p 255). In practice this raises an important distinction between the institutionalisation of health promotion by creating government departments of health promotion, courses in health promotion or research centres in health promotion, for example, with health promotion as a broader critical review process linked to building social capital, facilitating healthy public policy, building community partnerships, or reorienting health and social care services.

Health promotion as a specialism occupies a distinct niche in public health practice. It is perceived as “a (multi-disciplinary) specialist area of global public health activity” (Mittelmark 2005 p 51). Yet it is differentiated from public health as it is multi-disciplinary and cuts both horizontally as well as vertically across core disciplines. Over the last decade health promotion has grown more multi-disciplinary as it has attracted different alliances and partnerships. Health promotion is still developing and emerging as a distinctive academic discipline arising from these multidisciplinary roots. This has been contrasted on the one hand as a natural progression of learning from past experiences of traditional public health theory and practice and on the other hand as a radical challenge to it by offering a different and unique perspective based on an alternative value base and ideology. Nutbeam referred to ‘the tangled roots of contemporary health promotion’ making ‘a strong case for an emerging discipline’ (Nutbeam 2002). This emerging discipline is not yet based on a single paradigm with its own epistemological, theoretical and methodological foundations. Health promotion has been described as a set of practices (“field of action”) based on a “structured discourse’ (McQueen 2001). There are still on-going debates about the epistemological approach needed to further develop its specific knowledge base and methodology (Potvin and McQueen 2007). Complexity theory has been offered as a potential paradigm to enable health promotion to achieve this discipline status (Tremblay and Richard 2011). Some writers observe that health promotion has not yet achieved the status of a scientific discipline because it lacks a distinctive institutional structure which makes it vulnerable to changes made by others, it also is limited by lack of accreditation or oversight by a professional body ie anyone can call themselves a health promoter without censure (Potvin and McQueen 2007). Nevertheless this structured discourse and practice is developing and can potentially act as an interface between public health and social sciences to facilitate understanding of the significance of health in everyday life.

The health promotion community on a global level has its own dedicated NGO – the International Union for Health Promotion and Education (IUHPE) – this organisation has provided a unique stimulus to the development of health promotion as a discipline. Acting, often in formal partnership with WHO and other international agencies, it has built strong links with government, non-government agencies and the private sector world-wide to encourage development of health promotion. Some examples of its activities include – books (including McQueen and Jones 2007), journals (including Global Health Promotion) and internet based communications; a series of global conferences (its 21<sup>st</sup> World Conference on Health Promotion was held in Thailand in 2013 in conjunction with the Thai Health Promotion Foundation) and numerous regional conferences on health promotion in many parts of the world (eg Europe, Western Pacific, South America, etc). Its specific work on building the evidence base for health promotion and developing an accreditation strategy to advance health promotion as a discipline are detailed later in this paper.

### **Mainstream and Specialist Health Promotion**

Specialist health promotion engages both individuals and communities using participatory approaches to build social capital and advocate for positive health outcomes focussed on equity, empowerment and the broader determinants of health. The term specialist health promotion is used to differentiate the discipline from ‘mainstream health promotion’ which can be embedded into the work of many ‘health promoters’ both inside and outside the health

sector, for example in schools, sport and fitness settings, workplaces, prisons, etc. Mainstream health promoters are those who work to promote health as defined by the Ottawa Charter regardless of professional designation. In their review of specialist health promotion practice in England and Wales, Griffiths and Dark (2005) concluded that ‘specialist health promotion is a discipline integral to public health’. They recommended that the specialist health promotion workforce needed better recognition. As a result a programme on ‘Shaping the Future of Health Promotion’ was set up to develop appropriate recognition by highlighting a dedicated career pathway. In 2006 a defined specialist section was added, for the registration of health promotion specialists, to the UK Voluntary Register for Public Health (which had been set up in 2003). Yet health promotion managers did not readily identify with public health as a profession or with the Voluntary Register’s accreditation system for ‘defined health promotion specialists’ (Coen and Wills 2007). This accreditation system and the criteria involved were shaped by a traditional public health discourse and not by a health promotion discourse (Green and Tones 2010).

In other global regions health promotion specialists come from different backgrounds:

“Health promotion academics and professionals work in organisations dealing with various specific aspects of health, such as maternal and child health, health in schools and health behaviour change” (Mittelmark 2005 p 49).

For example, in Africa and South East Asia health promotion programmes are led by professionals trained in public health and implemented by health education and communication specialists; in North America health promoters come from nursing, social work, or education for example; in Europe health educators dominate in countries such as France and the Netherlands. In general terms “academic health promotion is dominated by the disciplines of public health, health education and health psychology” whereas health promotion in practical terms is shaped by public health and education professions (Mittelmark 2005 p 50). These examples reflect the complexity of differentiating health promotion specialists from general health promoters in different parts of the world. Nevertheless there are two areas that can be explored as examples to assess whether health promotion is reaching disciplinary status and attaining a separate professional entity – developing an evidence base/measuring health promotion effectiveness and the accreditation of health promotion as a professional activity.

### **Health Promotion Effectiveness**

Health promotion has always been uncomfortable with the empirical positivist research paradigm from natural science, which still largely dominates evidence-based practice. It has focussed its attention on developing a new toolbox and set of tools to measure quality, evidence and effectiveness (Davies and Macdonald 1998; WHO 1998; Rootman et al 2001; McQueen and Jones 2007). Debate about the theoretical roots of health promotion and the evidence base underlying its practice provides evidence of its emergence as a discipline in its own right. Since the early years of the 21<sup>st</sup> century health promotion has sought to justify its existence by attempting to establish such an evidence base. Being able to measure and demonstrate to funders its effectiveness is crucial to the future of health promotion. Numerous discussions have focussed on the theoretical challenges underlying attempts to relate effective health promotion into practice (Speller, Wimbush and Morgan 2005; Molleman and Bouwens 2005; Aro, van den Broucke and Raty 2005). Health promotion needs its own appropriate evaluation approaches and methods (Davies and Sherriff 2011). Often it is funded through the health sector and thereby finds difficulty when competing with treatment services and when bio-medical standards are applied:

“The standards of any single discipline are too narrow to provide a single framework for judging the quality of health promotion research and evidence” (Mittelmark 2007 xi).

This situation also applies to health promotion research funding. Funding for health promotion programmes and for research are even more challenging in the current era of austerity and cutback.

### **Health Promotion Accreditation**

At European and international level the IUHPE and the Society for Public Health Education in the USA have developed a global exchange on establishing an agreement on the domains of core competency for health promotion specialists through the Galway Consensus Statement, (Allegrante et al 2009; Barry et al 2009; IUHPE 2009). This work has included input from a wide range of countries including USA, New Zealand and Australia, for example. Arising from this, a Pan-European project (CompHP) was funded by the European Commission from 2009-2012, to establish a shared vision for health promotion workforce capacity-building in Europe based on core competencies, professional standards and accreditation mechanisms (Battel-Kirk et al 2011). Although this project was carried out among European countries, it had an international advisory committee and scoped relevant competencies work from different parts of the world.

Both the emerging work on evidence base and the agreement on accreditation of core competencies are major examples that support the development of health promotion as a discipline.

### **Conclusions**

Health promotion has a unique and specialised role within a wider multidisciplinary approach to maintaining and improving health. This is being achieved in two complementary ways; firstly by mainstreaming health promotion and/or by nurturing a core body of health promotion specialists. With regard to the former this has occurred in countries such as the UK and Canada and has resulted in the weakening of organisational capacity for health promotion with it being absorbed into a traditional individualised public health discourse and being dominated by other, usually medical, professions (Jackson 2011). This development can be attributed to the focus on individual lifestyle approaches favoured by neo-liberal governments (Green and Tones 2010). It has also occurred at international and global level where agencies such as WHO/Pan American Health Organisation (PAHO) have mainstreamed health promotion as a cross-cutting theme across the organisation. The alternative or complementary option is to build and maintain a core of health promotion specialists from both academic and policy/practice based organisations, especially at national and global levels, to maintain awareness of research and effective practice, and act as a resource to health promoters. The latter linked with specialist colleagues can strengthen health promotion as a discipline.

Health promotion is a discipline with its own ideology and ordered field of study. Its values relate to a holistic view of health that includes equity, autonomy/self-determination, social justice, participation and empowerment (Green & Tones 2010). Health promotion is continually striving to maintain this value base and ethos, enshrined in the Ottawa Charter, and its socio-ecological focus on tackling the wider determinants of health (Wills and Douglas 2008). Action needs to be grounded in the core values and principles of health promotion as it is “both a moral and political project, and is fundamentally values-based” (Smith, Kelleher and Fry 2008). It needs to keep advancing its disciplinary and alliance base. The danger of a move away from Ottawa Charter based health promotion and a return to traditional public health approaches (based on pathogenic individual risk-factor disease

prevention and lifestyles) will take the field backwards. Green and Tones (2010 p 4) stress that health promotion “needs to re-engage with its radical agenda and core values and maintain its distinct identity and purpose”. This allows freedom to experiment and try new approaches such as the healthy settings movement (cities, schools, workplaces, hospitals, prisons, for example), which demonstrates that health is produced and maintained in everyday life. Also these approaches have made substantive contribution to intersectoral action and healthy public policy approaches. Health promotion has in turn facilitated numerous policy statements and programmes in a variety of countries throughout the world.

Health promotion relates closely to public health yet differs from it by its much stronger emphasis on autonomy, participation and empowerment, among both individuals and their communities. Green and Tones (2010) see health promotion as ‘the critical conscience of public health’ (p 51). Health promotion makes a distinctive contribution to the development of multidisciplinary public health through its core values (Tilford, Green and Tones 2003). It is crucially important that health promotion maintain its own separate identity as a discipline. Yet it faces the paradox that by remaining a separate entity it becomes too insular and marginalised by not engaging with other professions; yet by mainstreaming it loses its radical value base and ethos and reverts back to traditional public health approaches with medical dominance and narrow lifestyle change strategies. It is recommended that further scoping research is needed to ascertain how different global regions and countries are tackling this paradox.

Health promotion needs to defend and uphold its position as a unique specialist discipline integral to public health:

“...some 30 years after its emergence onto the political and scholarly scene ‘health promotion’ continually seems to face a need to re-assess and re-assert its perspectives” (De Leeuw 2013 p 4).

Ideally health promotion needs to continue its development independently as a specialist discipline, but also as part of the on-going development of public health itself by seeking to form new disciplinary alliances within a complex of determining factors related to socio-political context and power distribution. In this way health promotion can continue to develop and offer both a force for social change as well as a process to maintain and improve health by facilitating an integrated approach targeting both individual and socio-ecological strategies in a variety of everyday settings in which people live.

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### **Biographical Note**

John Kenneth Davies is Professor of International Health Promotion at the University of Brighton, England, UK where he was Director of the International Health Development Research Centre in the Faculty of Health & Social Science from 2001-2011 and Course Leader of the MA European/International Health Promotion from 1995-2008. He has over 30 years experience as an academic and practitioner in health promotion and public health at local, national and international levels. He has served as a consultant and adviser to the World Health Organization and the European Commission; and served as Vice-President of the European Region and Global Vice-President for Scientific and Technical Development of the International Union for Health Promotion and Education.