Perspectives on health promotion: theory, evidence, practice and the emergence of complexity

This issue contains four articles under the heading ‘perspectives’. Two of these provide an overview of health promotion in Canada and Europe, and two illustrate the role of settings in the practice of health promotion. What is noteworthy is how they reflect the gestation, development and maturity of health promotion as a field of action. It has been less than two decades since the watershed event of Ottawa, nonetheless we are now at a stage where it is useful and pertinent to take stock of where health promotion is today and what challenges lie ahead for the field.

At the time of the Ottawa Charter, health promotion was still consumed with defining its role. Hygiene and public health had been well established in the first three-quarters of the 20th century. The challenge for health promotion was to define its niche in public health. Was it the core of a new public health? If epidemiology had always been seen as the ‘science’ of public health, was health promotion the ‘practice’ of public health? Much effort went into defining and delimiting the concepts and principles of health promotion (WHO, 1984). This discussion has never been satisfactorily concluded, and the concepts and principles remain uncertain today. Variants of the discussion are seen in debates in terminology, whether health promotion is transformed into population health or wellness (the Canadian dialogue).

Despite the fragmented epistemological debate on health promotion, the term remains on solid ground. Health promotion as an idea has entered the lexicon of public health. Buildings, institutes, centres and professorships bear the terminology throughout the Western world. With the establishment of health promotion as an ideology and a field of action, the concerns of the field have moved on and reflect the current Zeitgeist. Key notions now are ‘effectiveness’, ‘investment’, ‘participatory’, ‘evidence’ and ‘best practice’. Any perusal of the literature finds a surfeit of these key words and they are readily applied to the pursuit of health promotion. The main question is, ‘How robust is the largely a-theoretical, loose confederation of health promotion practice, when faced with terms demanding rigour, consensus and accountability?’

It is not the intention in this brief editorial to take on the lofty task of answering the question just posed. Others have explored dimensions of the question. Recently the IUHPE (1999) prepared a carefully constructed two-part report to the European Commission on ‘The evidence of health promotion effectiveness’. In this Report the authors produced a strong case for effectiveness and grounded the story in the history of health promotion activities since the Ottawa Charter, relying heavily on the Canadian and European experience. Despite the upbeat character of this report, it is useful to introduce a cautionary note that health promotion faces considerable challenges if it chooses to pursue evaluation in strict scientific terms.

Consider the thorniest issue for health promotion, the notion of ‘evidence’. There are three critical and unresolved issues around ‘evidence’ and ‘rules of evidence’ in health promotion research and practice (cf. McQueen and Anderson, 2000). First, it is arguable that ‘rules of evidence’ are tied to disciplines, not the type of projects that make up most of health promotion practice. Over the years, scientific disciplines, e.g. physics, biology, epidemiology, have developed their standards for what constitutes proof of causation of an effect. Generally in these disciplines evidence is discovered through observation and experiment. The appropriate ‘scientific method’ is both a product of historical development and the characteristic ‘observables’ in the discipline. There are differences among the disciplines for
‘rules of evidence’. Some disciplines apply experimental designs. Others require long-term careful and systematic observation according to strict rules of data gathering. In contrast, most health promotion projects are not discipline based, but represent a ‘field of action’ encompassing a multi-disciplinary approach. Therefore, there is no discipline-based epistemological structure underlying the evaluation of effort. This results in the need to distinguish underlying rules of evidence for the main disciplines of public health that are basic to community-based research and intervention, specifically epidemiology, social psychology, sociology, anthropology and health education. Ultimately the model for evaluation resides in a single discipline, and the multi-disciplinary nature of the health promotion intervention is discounted.

Second, within the field of health promotion practice there seems to be no consensus on any ‘hierarchy’ of evidence. Within the general area of health promotion research, as reported in the pages of this and other professional journals, there is considerable debate about what constitutes knowledge in the field and what is evidence. Indeed, there is even debate as to whether the notion of evidence is applicable to the evaluation of interventions in communities. Further, there is no consensus on any ‘hierarchy of evidence’ between researchers and practitioners in the field. International groups have asserted (WHO, 1999) that it is premature to prioritize types of evidence in a linear hierarchy. There is a need to further consider pros and cons of a consensus in the context of community health promotion programmes and to suggest directions for the future.

Third, and most critical, there is a growing recognition that the complexity of multi-disciplinary, compound interventions makes simple, universal, rules of evidence untenable. Existing rules of evidence are often based on interventions that have relatively simple, demonstrable chains of causation where single factors are manipulated to produce single easily measured outcomes. Many community-based health interventions include a complex mixture of many disciplines, many variables of varying degrees of measurement difficulty, and dynamic changing settings. In short, understanding multivariate fields of action may require a mixture of complex evaluation methodologies and considerable time to unravel any causal relationships. New analyses may reveal some critical outcomes years following an intervention. Thus, there is a need to recognize complexity as it pertains to community interventions and suggest the development of more appropriate analytical approaches. What is worrisome now is how little appreciated the complexity issue is and how it relates to our concerns with evidence. Complexity has been discussed in depth in the excellent book by Norretranders (1998). A view of the notion of complexity on the Internet reveals a vast literature of concern with complexity. Indeed, the arts and sciences deal with the concept of complexity routinely. Perhaps a brief illustration with a thought experiment from another field will illustrate some of the issues involved with complexity.

Imagine a concert hall with two stages curtained off. Behind curtain one is the Berlin Philharmonic Orchestra, behind the second curtain is an excellent community orchestra composed of talented amateurs. Both orchestras are given the task to perform the same Beethoven symphony and do so. You as the listener are not a professional musician, but have spent many years attending concerts and listening to recordings of the Beethoven symphonies. You fashion yourself as a practised symphony goer and judge of classical music. The question is, can you correctly identify which stage contains the Berlin ensemble? My contention is that most readers would answer, ‘of course’. But what is the evidence base being used for this certainty. Surely it is not simply indicator based. One would presume that both orchestras have faithfully played the notes as laid out by Beethoven and marked by the editors of the score. Probably the tempo and rhythm of the piece have been faithfully followed by both. Yet, it would be a tough argument that one could not distinguish the Berlin ensemble from the community ensemble.

The reason one can recognize the Berlin ensemble has everything to do with complexity and the ability of one’s brain to process a very complicated set of decisions of evaluation. At the same time, one is processing many layers of meaning and interpretation, many of which are not well specified. Yes, the notations are well specified, but anyone who has played an instrument as complicated as a violin knows the tremendous subtleties of good performance. However, the orchestra is not simply the addition of a group of strings, brass, woodwinds and percussion, it is more analogous to an organism that has its own life; most would agree that there is something else going on. We can understand that something else, but often we cannot verbalize it, rationalize
it, or otherwise measure it. That is because the level of complexity is greater than our abilities to derive an explanatory algorithm. Nevertheless we know which orchestra is behind curtain one.

The music analogy is relevant for the evaluation of health promotion practice. Gathering evidence for the value of health promotion remains a challenging task. However, we need to have a broad vision of evidence that embraces the inherent complexity of health promotion as a field. Also we need to understand that the knowledge of what works and is successful is embedded in a complex neural network. Rather than retreating to limited rules for what constitutes evidence, there is a need to look toward analytical frameworks that recognize the complexity of the field. It is a challenge for health promotion to convince its enthusiasts and detractors that there are no easy answers to complex human phenomena.

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REFERENCES


