WHEN HEALTH PROMOTION WORKS, 
THE OPPOSITION BEGINS: A PERSONAL VIEW

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INTRODUCTION

We have all been there. Most of us have taken part in those endless debates about the theory of health education and health promotion; those debates on terminology; and the endless arguments about whether it is possible to change behaviour.

Many of the colleagues I had worked with had recognised that beyond those theories of health education and health promotion, were many other disciplines and activities which had no problem at all in motivating, changing and shaping human behaviour. Having increasing contact with politicians and others who had to implement policy in nations or regions it became clear that the theory meant nothing to them; and that even if interested in the subject they needed action and results.

A third question was growing in my mind. If health promotion did work . . . wouldn’t that produce some pretty big potential changes which may touch the raw nerve of the many and varied vested interest groups . . . what would it be like if that happened and could we learn something from it?

With this concern over the relevance of much theory, acceptance of the need for results, not thoughts or words, and an anticipation that if it worked then it may open up a whole new field of questions, I accepted the position of director of health promotion in a government committed to results, with a Minister and chairman supportive of the concept of health promotion.

The case study that follows is naturally a biased account, but a number of my colleagues believed that those parts which could be written up should be. The results quoted are not biased. Independent research reports exist which describe them.

The end came after a change in government and a new Minister, a new Chairman and reorganised Commission had taken over. The end, amidst a party political uproar, demonstrated all too clearly that health promotion is political. When it works, the opposition begins.

BACKGROUND

South Australia, the State being described, has its own parliamentary system of upper and lower Houses, its own Cabinet, its own health, education and social welfare systems. It has extensive media coverage through electronic and other media. It has a Health


Commission, answerable to the Minister of Health who is a member of a Parliamentary Cabinet. It also has over 100 local councils voted into power on a non-party basis. It has large blue-collar industrial areas, large white-collar areas and is spread over a geographical area over five times the size of the British Isles.

My experience of South Australia is that it is a microcosm of the powers, pressures, problems and opportunities which I had seen operating in much larger populations. The processes of government, the problems of the health and welfare systems, the influence of vested interest groups, the economic prognosis, the patterns of youth and other age group unemployment, and an ageing population are all comparable to other Western nations. The size of the community allows a closer insight into the decision-making processes and the pressures on government policy related to health. Naturally there are many subtle differences, but for the purpose of this study much is comparable with other Western nations.

The government, Minister and Chairman of the Health Commission who established the health promotion services wanted us to demonstrate either that health promotion worked or didn’t work. They were not interested in just words and hopes. While that government, with its emphasis on innovative programmes, remained in office, the mandate was there to develop a fast-moving results-orientated service. Without that support at the highest levels it soon became impossible to operate in the same way.

**INITIAL AIMS**

The initial aims were quite straightforward for the first three years:

- We needed to demonstrate that preventative programmes worked.
- We needed to get preventative programmes away from therapy and into normal life. The dominant social welfare ideology which reduced people to being recipients of a welfare state, with no self esteem and organised by the next wave of social idealists who always knew best, had to be challenged. The aim was to encourage people to be health consumers, making choices about how to remain healthy, rather than be subjugated by the popular welfare concepts of illness and dependence.
- We needed to influence the health system in such a way that it would accept health promotion as a legitimate long-term component of the system, and would eventually recognise the preventative component of many parts of its work.

It was clear that unless the first results demonstrating the success of health promotion were available within two years after its inception, there would be growing opposition to spending in that area while cuts were taking place elsewhere.

Myths abounded immediately about the amount of money being spent on this new approach, but the truth is that even today, the budget represents a minuscule section of the health budget.

It was obvious that a strong organisation had to be developed to carry out the task. An initial feasibility study was carried out, looking at the capabilities within various organisations for preventative programmes, and meeting a wide cross-section of people within the State to discuss needs in health promotion. To this was added the advice of an excellent epidemiology department, which was able to pinpoint major aspects of preventable ill health. Added to these perceptions were the policies of the government in such areas as drug abuse prevention, smoking reduction, immunisation and breast cancer reduction, as well as general dissemination of knowledge about health to the population.

The feasibility study identified clearly that many organisations and groups were involved in health promotion, but there was a need for:
• an organisation that could run large-scale media and community programmes;
• the availability of good quality materials and publications which people could choose to obtain, to help them with questions about their health;
• opportunities for more health professionals to learn health promotion skills;
• systems for information, collection and dissemination of both successful and unsuccessful programmes;
• facilities for the proper use of epidemiological and other data in planning programmes and to research the outcome of programmes; and,
• an advocacy group which could suggest policy in health promotion and who could initiate action leading to more attention to health rather than illness.

The existing unit was not operating in this way as much of the work had been “face to face” work within the community, or in schools, or in the training of professionals. As the new unit was to have a central function, new people were needed.

The initial staff brought to the organisation a broad range of experience from many fields unconnected to health education and promotion. The team which emerged included people who were experienced in putting together large-scale community and media programmes, a world-class creative director from New York, researchers, political scientists, publishers, an entrepreneur to run a city centre shop, journalists and others of similarly diverse backgrounds. Most had one common factor—they were used to being paid for results rather than talking about the possibility of getting results.

A team of more than 30 such people is dynamic, but also requires massive flexibility as the approaches of each discipline can be different. In the end I concluded that it was impossible for such a team to function properly within the public service. The distinct differences between modern management styles seen in business, which can nurture such a team, and the management styles encouraged in health departments are so far apart as to make it nearly impossible to maintain an innovative team.

The organisational structure that was developed is shown in Figure 1. The programmes were based on a very simple model which could be understood easily and communicated to anyone. The first stage was to define the problem from epidemiological, socio-psychological, environmental, marketing and other data. Once the problem was defined, a range of strategies was chosen to attempt to help to reduce the problem in the community. The model has been illustrated as in Figure 2.

The following summaries cover a number of the programmes which were established in
South Australia, and demonstrate that health promotion works.

It is crucial to recognise that the strength of the programmes lay in the massive involvement of many groups and organisations within the community, and was not due simply to only one organisation which was coordinating the programmes centrally.

The programmes are set out under the following sections:

1. Statement of problem
2. Major strategies
3. Results
4. Main vested interest opponents
5. Costs of programme per head of population, including staffing from the health promotion services but excluding community support costs

**Programme to Reduce Tobacco Smoking**

1. **Statement of Problem**

   About a third of the population was smoking tobacco. Marketing of tobacco is aggressive in Australia. Large-scale demographic research was carried out across the State to determine the nature and scope of the problem and to gain a variety of community opinions. The research showed substantial support for action in this area with over 80 per cent supporting government campaigns. Two programmes of market research were then commissioned which segmented smokers and provided insights into the motivations of smokers concerning giving up smoking (Steidl and Cowley, 1982; Bowden, 1984). Concept-testing market research was then carried out and a range of communications which would be successful was determined.

2. **Major Strategies**

   Media: A six-week mass-media programme was run using a commercial at the start of the commercial break, which raised emotional feelings over smoking, and one at the end of the break, which demonstrated conditions under which smokers were “tempted” to start smoking again. One of these commercials was the highly acclaimed one from Bernie McKay’s New South Wales North Coast project, as it was not worth cre-
ating a new product if one worked well already.

Six weeks of radio commercials were created, again based on market research, and written around testimonials of people trying to stop smoking. Six weeks of informal news cover was organised to generate massive community discussion.

A school programme was run by teachers simultaneously and a professional manual was written to bring all professionals up to date.

Doctors were given material for patients; hospitals were involved in giving out material; and numerous community groups were involved.

A small number of “stop smoking” groups were organised for the few people who needed group counselling to help them give up. Shopping centre displays were organised. Local communities organised barbecues and runners ran between the towns carrying a collection of signatures which thanked the government for its assistance in this area. These petitions were flown to the capital city and presented to the government by the State Australian Medical Association.

Work was carried out through industry to provide no-smoking working environments.

3. Results

Based on substantial advice from experimental researchers and the Australian Bureau of Statistics, a household survey was carried out three months after the programme was concluded. The experimental area experienced a drop of 11.4 per cent of smokers maintained over three months. The control area experienced a 4.9 per cent drop, but this was probably artificially higher than the normal, due to the intervening effects of another State’s campaign.

In one town 13.5 per cent of the population maintained cessation and, interestingly, it was this town where we received the most opposition to the programme from welfare workers, who did not feel the subject was really appropriate. The towns were predominantly blue-collar areas (McDonald, 1983).

4. Main Vested Interest Opposition

The major opponents were undoubtedly some health and welfare workers. They rated smoking as a low priority. They also objected to the use of mass media. Others believed that work should be done through stop smoking groups in face-to-face therapy. We found that only 2 per cent actually needed this type of help.

Luckily, the majority of community health workers were strongly supportive, and the programme benefitted considerably from their support, but the vocal minority were a constant presence.

Before the programme even started some academics opposed it on the grounds that it was ideologically unsound. One of the striking demonstrations of this bias was where the minutes of one committee proclaimed that “the quality of the research is to be doubted and the results inconclusive.” At that stage, the research report had not been finalised, had not reached the research manager, myself or the Minister and could not have been studied by anyone.

The industry naturally opposed schemes that would influence what it saw as a legitimate and legal right to sell a product. In South Australia generally, the industry took a low profile.

5. Cost of Programme

The cost of the programme was about $5 per head of population for the pilot scheme and 40 cents for the later State-wide scheme.

The programme was taken State-wide but failed to provide comparable measured results. The main reasons seemed to be:

- the funding was too low (40 cents compared with $5 per person, as the origi-
nal budget had been progressively re-
duced);  
• there was a repositioning of some to-
bacco brands about the time of the fol-
low-up survey which would have 
increased smoking in some segments 
and influenced the sample; and  
• the level of informal news cover was con-
siderably lower.

It was interesting to note that the failure of 
this one programme created more interest 
than the successes of all the rest put together. 
The others were diminished in the light of this 
one failure. In other fields of behavioural 
change such as advertising, it is well recog-
nised that there are as many failures as suc-
cesses, whereas the demands on prevention 
are both high and unrealistic.

Programme to Increase Breast 
Self-examination

1. Statement of Problem

Epidemiological research together with 
federal recommendations showed the need 
for action in the area of breast cancer. Baseline 
data on breast self-examination, biopsies and 
attitudes was established. Concept testing 
was carried out by female researchers 
(Bowden, 1982; Bowden, 1984).

2. Major Strategies

A television commercial, using a doctor as 
an authoritative figure (shown to be essential 
by the market research), demonstrated breast 
self-examination. Large-scale informal press 
cover was organised. Posters were developed 
for display in places frequented by women. 
Many women's groups were involved, and 
community health centres arranged meet-
ings. Demonstration breasts were available 
with teaching materials in the women's lin-
gerie departments of large stores.

Teaching packs were developed to train 
health professionals, and large numbers of 
community groups were involved. Seminars 
for health professionals were run.

3. Results

A 16 per cent self-reported increase oc-
curred in breast self-examination. In the three-
month follow-up period there was a 30 per 
cent increase in cancer detection rates. A 53 
per cent increase in cancer detection rates for 
women under 50 years of age and a 21 per cent 
increase for those over 50 years old occurred. 
The proportion of cases with four or more af-
fected nodes at diagnosis was substantially 
reduced. There was a decrease in tumour size 
(McDonald, 1982).

4. Main Vested Interest Opponents

There were few vested interest oppo-
nents—primarily a very small number of 
medical specialists who feared money may be 
diverted from treatment and a minority group 
in the women's movement.

5. Costs of Programme

The costs of the programme were 5 cents 
per person excluding manpower costs and 20 
cents per person in all.

Immunisation Programme

1. Statement of Problem

Only 50–55 per cent of children were receiv-
ing measles vaccine: 360 cases per year needed 
hospitalisation due to measles. Twenty-seven 
per cent of 21–30 year old females were not im-
une to rubella. Market research into concepts 
related to rubella was established and materi-
als tested (Bowden, 1981).
2. **Major Strategies**

Television commercials which had been market tested, radio commercials and a controversial poster on the rubella theme were developed. Informal news cover on the themes related to immunisation were developed to keep the story alive in the mind of the public.

Attention was given to community groups to encourage them to cover the subject and the knowledge of professionals on immunisation was updated. Services were made more readily available through local councils and schools to enable easy access to immunisation.

In a follow-up programme aimed at specific ethnic groups, substantial work was carried out through the ethnic community networks.

3. **Results**

   Main programme: Measles immunisation rates up 64 per cent; rubella rates up 57 per cent (SAHC, 1982).

   Follow-up programme: South-east Asian triple antigen rates increased 42 per cent, poliomyelitis rates increased 28 per cent. One of the major failures of the supplementary stages of the programme was in trying to aim at too many ethnic groups at once. While the rates in ethnic groups continued to keep pace with general immunisation rates due to the programme, the very high increases seen in the South-east Asian community did not occur across all groups. The evidence suggests that with restricted resources, only one ethnic group at a time should be worked with.

4. **Main Vested Interest Opponents**

   Some community health workers did not like the use of the media; some women’s movement members did not like the emphasis on women being immunised against rubella, although this was offset by a massive reaction from women in the community at large, with over 80 per cent of women approving of the programme.

5. **Costs of Programme**

   The costs of the programme were three cents per person excluding manpower costs and 15 cents per person in all.

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**Cardio-Pulmonary Resuscitation Programme**

1. **Statement of Problem**

   More people could survive accidents and heart attacks if more of the population were trained to carry out resuscitation.

2. **Major Strategies**

   This was a community generated scheme with the assistance of a hospital, St John’s, Red Cross and later Apex, Woolworths and an advertising agency. The Health Commission provided the initial finance and assistance with media promotion of the scheme, sponsorship seeking and publishing. The main strategies were mass publicity for the scheme, teaching small groups within the community and mass media encouragement of people to participate.

3. **Results**

   In the 18 months of operation, eight lives were saved directly due to the programme.

4. **Main Vested Interest Opponents**

   Very few.
5. Cost of Programme

Three cents per head of population. (Government money before sponsorships).

There were many other programmes, each with differing emphases, using different combinations of strategies, but there is not sufficient space to go into them all in detail. However, some are worth a brief mention:

A health promotion programme on the elderly to assist families in caring for elderly relatives with senile dementia. This consisted of supporting a voluntary group, assisting them in the use of the media and pretesting and publishing a booklet for families. The cost was one cent per head of population (Manfield, 1983).

A daily physical fitness programme in schools which led to significant measurable changes in physical health of children lifestyle, behaviour and body knowledge. Some of the initial opposition to this programme came from traditional health educators in schools, concerned that the emphasis of schools should be more related to self-esteem and relationships than to physical health. This project, as a by-product, raised children’s self-esteem. The cost was 12 cents per head of population.

Accidents in industry programme concentrating on uniting unions and management in implementing primarily environmental changes in factories. The pilot project showed a drop from 428.2 hours lost through accidents to 56 hours lost in a comparable eight-month period. This was a successful pilot programme run jointly with the National Safety Council (National Safety Council, 1982).

Alcohol, driving, and the 16–24 age group. A large-scale media and community involvement programme was run. Due to research parameters, death rates could not be compared, but accident rates in this age group dropped in the period of the research (McDonald, 1984).

City centre shop. A highly innovative project was developed to try to develop a central shop in the capital city centre where people could come as consumers of health information. Various shop displays were developed which had massive consumer appeal. Large numbers of people used the shop and many organisations used it as a way to contact the general public in a non-therapeutic context.

THE END OF THE EXPERIMENT

Following these short-term successes, considerable effort was put into developing a Health Commission policy on health promotion, initiating research work to retarget programmes over longer periods of time and starting to aim to create long-term maintained positive trends in health indices. (Cowley, 1982; Laurence, 1984)

The experiment had been based around the central tenet of showing results which could be measured. The methods we used were acclaimed by many international visitors and the style of management related to innovation and entrepreneurism with a team within the public sector, was seen by many as quite different from many traditional approaches to health education and the health services.

One of the great encouragements of the experiment was that other governments asked for reviews to be carried out on their own health promotion organisations and new ones were established based on the South Australian experience (Cowley and Rubinstein, 1982; Cowley, 1982, 1983, 1984).

The end of the experiment is now widely known. The Government changed, the Minister changed, the Chairman changed. Relationships became strained. A review of health promotion was instigated by the Office of the Minister. The results of the review were presented under Parliamentary privilege, a setting in Australia which allows no legal redress through the normal laws of defamation.
The final discussions ignored the results and the recognition of what had been achieved, but rather concentrated on the intangible and debatable issues of management styles, a certain winner because management styles of innovative groups and private enterprise managers are always different from those of the public sector.

The conclusion was drawn that radical changes were necessary and I resigned as director together with a number of other staff who moved on, amid a political uproar between the two parties. The trend has been back towards approaches not dissimilar to those when the whole experiment began.

**WHAT OPPOSITION STARTED WHEN HEALTH PROMOTION WORKED?**

There were a number of areas where the raw nerves of vested interests were touched:

**Health Care Professionals: Curative and Medical Technology**

We generally received considerable support from the medical profession. It showed a high commitment to health promotion and the major professional medical groups were exceptionally supportive. There were a number of issues, however, which were the basis of some opposition:

- An inability to understand what health is among some health planners. Generally health planners have to deal with balancing accounts and ensuring hospitals do not overspend. It is a huge step to move from this to more general thinking and long-term planning concerning how the actual nature of health experienced by the population can be improved. Some health officials could never get beyond seeing health promotion just as a short-term fad.

- An inability of health systems to look at effectiveness as much as efficiency. The systems concentrate on whether money adds up, not on whether expenditure in one area equals greater benefit than expenditure in another area.

- Health innovations usually have to be funded within standstill budgets.

- Much time is spent in health departments trying to survive the next political crisis rather than on long-term planning.

- Medical practice vested interests sometimes felt that it was their money being spent on health promotion. They thought that if one part of the system had been cut it must have been that money which was being spent on health promotion.

- A belief that health promotion is extremely expensive. One hundred thousand dollars spent on a campaign was seen as gross over-expenditure, while 10 times that amount being spent each day on equipment was seen as necessary.

**Health and Welfare Professionals in Preventative Work and Community Work**

While most welfare workers supported the programmes, sadly, a vocal minority group opposed them. The major problems they raised were that:

- Programmes needed to move at speed and be tuned into consumer needs rather than be put together by endless committees. Some workers rejected this.

- There has been a tendency for some of the intellectual left of the welfare movement to develop the "gobbledygook" and "rhetoric" of the journals with buzzwords like "community development" and "community involvement" while at the same time having little real-life involvement outside their jobs with the community in which they work. They are the modern day missionaries; they commute from England to Africa but
don't sleep there; they tour in from their comfortable intellectual leftist environments with their aim to correct communities' "problems"; they hurry out quickly if there is the suggestion that they should shop, drink or otherwise mix in normal ways within those communities.

In the end these were the most influential vested interest groups. Their response to everything was "but." They asked: "Is it appropriate?" or "Is it ideologically sound?" "Has there been enough consultation?" and many other questions which destroy and tear apart the possibility of action. The theorists have based their disciplines on a negativism that cripples innovation and real social caring in our society. It reduces everything to descriptions and never looks for results.

- Some workers had an opposition to media.
- Some workers argued always for more consultation with everyone who worked in or on the community. Rarely did they suggest actually asking members of the community themselves.
- Some always wanted more research to be done, as if repetitive research were a self-perpetuating amoeba, making the problem easier to define.
- Some always said more resources were necessary, while failing to realise the resources already provided by the State.
- Some always argued for face-to-face work, while failing to accept the cost of such approaches and the unwillingness of the majority of the population to be treated as "clients" who needed help and had to be treated in therapeutic ways.
- Most of those who opposed the programmes misrepresented the communities in which they worked. They saw the communities through their commuter eyes; they denigrated the working class culture by accusing them of being too consumption orientated; they criticised what they perceived as bad parenting; they accused them of being socialised into not understanding leftist or extreme feminist ideologies and they developed programmes aimed predominantly at producing the tranquilliser of identity-seeking, rather than helping people to take pride in the cultures to which they belonged.

POLITICAL VESTED INTERESTS

Health is political and health promotion is political. Issues which need to be recognised include:

- the development of the "media politician" figure across the world, who desires policies and programmes which reflect on his image;
- the increasing demand by governments for short-term rather than long-term results;
- the need to respond to popular crises like AIDS, drugs or glue-sniffing, the publicity of which may be out of proportion to the epidemiological realities; and
- the need for Ministers to survive politically.

INDUSTRIAL VESTED INTERESTS

Vested interests do oppose health promotion. There are numerous examples of the use of corporate power to lobby and influence decisions. The health promoter has to understand however, that interest groups see their actions as totally necessary and that they are trying to preserve jobs and economic stability.

Perhaps one of the most important areas for the future is for health and industry to get together more to look at whether it is possible to develop both health and economic pros-
The strongest commitment needs to be made to such negotiations.

**WAS IT ALL WORTHWHILE?**

The first five years of the experiment in South Australia showed many lessons for the development of health promotion.

It confirmed that:

- measurable results can be achieved;
- a problem-solving approach to health promotion can produce effective strategies;
- media, community development, training, and political action are not mutually exclusive but can all be used in parallel;
- if the emphasis is on doing rather than theory, results can be achieved; and
- health promotion can be linked closely to the medical profession.

It also showed that:

- health promotion is politically volatile;
- health promotion touched the raw nerve of many types of vested interests; and
- the need exists for a holistic ecological approach which links health development to other aspects of society, particularly economic and industrial development.

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