CONCEPTS OF HEALTH PROMOTION: DUALITIES IN PUBLIC HEALTH THEORY[1]

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There exists a great deal of confusion regarding the concept of health promotion. It is a broad concept, and the tendency has been for different groups to limit themselves to one or another aspect of the total formulation. In this paper, the attempt is made to develop a unified concept of health promotion based on examination of its historical background. The hypothesis offered is that the differing concepts of health promotion stem primarily from a duality in theories of disease causation, namely, specific causes on the one hand, and general causes on the other.

THE 19TH CENTURY BACKGROUND

Let us go back to Scotland in 1820, when William P. Alison, Professor of Medical Jurisprudence at Edinburgh University, described the close association between poverty and disease. His later experience with epidemic typhus and relapsing fever in 1827–1828, and the cholera epidemic of 1831–1832, confirmed his observations. In his report to the English Poor Law Commissioners in 1842, he sharply contradicted the miasma theory which they supported. He was convinced that in Edinburgh

> a great deal of money might be expended in removing various nuisances, such as irrigated meadows in the neighborhood, and dunghills in various parts of the town—all of which would be perfectly ineffectual in preventing the recurrence of epidemic fever, as long as the condition and habits of the poorest of the people, and their resources when reduced by any cause to destitution, in this city and the other parts of Scotland, continue as at present.

The other Scottish medical reports agreed with Alison's view; they urged the primary necessity for attack upon the causes of destitution *(1)*.

At a time when the germ theory of disease had not yet been established, the theoretical conflict described above was between a correct general cause, poverty and destitution, and an incorrect specific cause, miasma. That general cause was emphasized in other countries as well. In France, in 1826, Louis René Villermé wrote his report *On Mortality in the*

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Different Sections of Paris, Demonstrating the Relation between Poverty and Disease. In 1840, he published what he considered to be his magnum opus, his *Survey of the Physical and Moral Conditions of the Workers Employed in the Cotton, Wool, and Silk Factories,* which revealed incredible living conditions as the cause of premature death *(2, 3).* And in Germany, Rudolf Virchow, investigating an epidemic in the industrial districts of Silesia in 1847,

> came to the conclusion that the causes of the epidemic were as much social and economic as they were physical. The remedy he recommended was prosperity, education, and liberty, which can develop only on the basis of 'complete and unrestricted democracy' *(4).*

Epidemiologists, starting with John Snow in his classic studies of cholera *(5),* have since described the various ways in which the general causes, poverty and destitution, influence the relation of specific causative agents to the host and environment. It should be noted that there is no conflict here between general and specific causes; they operate together in a "web of causation."

THE ORIGINAL CONCEPT OF HEALTH PROMOTION

To my knowledge, the first use of the term "health promotion" occurred in 1945, when Henry E. Sigerist, the great medical historian, defined the four major tasks of medicine as: (1) the promotion of health, (2) the prevention of illness, (3) the restoration of the sick, and (4) rehabilitation. He stated that "Health is promoted by providing a decent standard of living, good labor conditions, education, physical culture, means of rest and recreation," and called for the coordinated efforts of statesmen, labor, industry, educators, and physicians to this end. This call was to be repeated 40 years later in the Ottawa Charter for Health Promotion.

Sigerist also noted that "the promotion of health obviously tends to prevent illness, yet effective prevention calls for special protective measures" such as sanitation and communicable disease control, maternal and child health, and occupational health *(6).* It is evident that while health promotion is defined by Sigerist in terms of the general factors in disease causation, he considers both the general and the specific causes to be significant in prevention. It is of particular interest that in 1941, in listing the main points that must be included in a national health program, he listed first, free education for all the people, including health education; second, the best possible working and living conditions; and third, the best possible means of rest and recreation. Medical care is fourth, and research and training, fifth. It should also be noted that Sigerist's formulation for medical care called for

> A system of health institutions and medical personnel, available to all, responsible for the people's health, ready and able to advise and help them in the maintenance of health and in its restoration when prevention has broken down *(7).*

THE SECOND EPIDEMIOLOGIC REVOLUTION

In the early decades of the 20th Century, concepts of social hygiene and social medicine were well developed in continental Europe. As early as 1909 in Vienna, for example, Ludwig Teleky declared the need

> to investigate the relations between the health status of a population group and its living conditions which are determined by its social position, as well as the relations between the noxious factors that act in a particular form or with special intensity in a social group and the health conditions of this social group or class *(8).*

The concern was clearly with both the general causes, i.e., living conditions, and specific

causes, the "noxious factors" in the physical and social environment that determine the health status of a social group or class. This dual concern was also evident among the British proponents of social medicine, but their main thrust was directed at elucidating specific causes. As John A. Ryle, the first Professor of Social Medicine in Great Britain, appointed in 1943 at Oxford University, stated:

> Public health . . . has been largely preoccupied with the communicable diseases, their causes, distribution, and prevention. Social medicine is concerned with all diseases of prevalence, including rheumatic heart disease, peptic ulcer, the chronic rheumatic diseases, cardiovascular disease, cancer, the psychoneuroses, and accidental injuries—which also have their epidemiologies and their correlations with social and occupational conditions and must eventually be considered to be in greater or less degree preventable *(9)*.

In Great Britain, the movement for social medicine was a major factor in the development of noninfectious disease epidemiology. In the United States, on the other hand, it flourished under the aegis of public health rather than social medicine. The U.S. Public Health Service and a number of state health departments played the most important roles in this burgeoning movement.

Epidemiologists have, during the past 50 years, given us powerful weapons to prevent major causes of death, disability, and illness, such as ischemic heart disease, some forms of cancer, cerebrovascular disease, injuries, chronic obstructive pulmonary disease, and cirrhosis of the liver. They have accomplished this by discovering a variety of specific causative factors in the physical environment—radiation, toxic chemicals, carcinogenic agents, etc.; and in the social environment—factors such as tobacco use, fatty diets, alcohol consumption, and lack of physical exercise. The latter are considered to be "lifestyle" factors in the sense that individuals can make decisions which affect their exposure to these agents.

THE LALONDE REPORT

The Lalonde Report *(10)*, issued by the Government of Canada in 1974, was the first comprehensive theoretical statement in public health resulting from the discoveries in noninfectious disease epidemiology. For the narrow traditional view "that the art or science of medicine has been the fount from which all improvements in health have flowed," it substituted a broad Health Field Concept, namely, that the health field consists of four broad elements: Human Biology, Environment, Lifestyle, and Health Care Organization. The preventive orientation is clear, for, as the Report states,

> Until now most of society's efforts to improve health, and the bulk of direct health expenditures, have been focused on the Health Care Organization. Yet, when we identify the present main causes of sickness and death in Canada, we find that they are rooted in the other three elements of the Concept: Human Biology, Environment and Lifestyle. It is apparent, therefore, that vast sums are being spent treating diseases that could have been prevented in the first place.

Based on the Health Field Concept, five strategies were proposed: (1) Health Promotion Strategy, (2) Regulatory Strategy, (3) Research Strategy, (4) Health Care Efficiency Strategy, and (5) Goal-Setting Strategy.

The Health Promotion Strategy was directed at changing lifestyles. A total of 23 possible courses of action were suggested. These were almost all concerned with specific lifestyle factors such as diet, tobacco, alcohol, drugs, and sexual behavior. The proposed actions included educational programs directed at both individuals and organizations, and the promotion of additional resources for physical recreation.

HEALTHY PEOPLE: THE SURGEON GENERAL'S REPORT

Although the Lalonde Report conceived health promotion to be one of several preventive strategies, the 1979 report by the U.S. Public Health Service caused confusion. The very title of the book, *Healthy People: The Surgeon-General's Report on Health Promotion and Disease Prevention (11)*, separated health promotion from disease prevention and gave it equal status. Health promotion was defined in terms of lifestyle changes, and prevention was defined as protection from environmental threats to health. Separating the two, and giving them apparently equal status, encouraged a variety of interpretations of the role of health promotion. Some conceived the term to cover all health services; others, as a synonym for prevention; and still others, as an area to which prevention is subordinate.

THE ROLE OF GENERAL FACTORS IN HEALTH

However, the major conceptual difference is between the definition of health promotion, in both the Lalonde and Surgeon-General's Reports, as concerned with specific lifestyle changes, and the original definition of health promotion in terms of general factors such as "a decent standard of living, good labor conditions, education, physical culture, means of rest and recreation." These general causative factors are of the utmost importance, and the failure to take them into account places serious limitations on the effectiveness of preventive programs.

The cholera epidemic in Latin America is a current example. The Director of the Pan American Health Organization, Dr. Carlyle Guerra de Macedo, has pointed out that "

> Cholera must be seen as a classic disease of poverty, with transmission characteristics directly associated with marginal communities: lack of clean water, contaminated foodstuffs, inadequate or non-existent sanitation, high population density, and inadequate personal hygiene. [Furthermore, he states] In Latin America there are 180 million people living in poverty, a number which has grown by an estimated 50 million over the past decade. . . . The increase of poverty and the lack of financial resources have led to deterioration of already inadequate health care, water, and sanitation systems. [Similar considerations hold for other diarrheal diseases which are] responsible for the deaths annually of more than 300,000 children under the age of five years in the Americas *(12)*.

It is significant that Henry Sigerist, as noted earlier in this paper, made free education for all the people the first item in a national health program. Inadequate education, resulting in both formal and functional illiteracy, is a serious obstacle to learning the use of preventive measures such as personal hygiene, immunization, and lifestyle changes. In Canada, for example, the prevalence of smoking among women declined by only 7% between 1977 and 1981, but among women with a post-secondary certificate or diploma it declined by 25%, and among women with a university degree it declined by 41% *(13)*. In the United States the prevalence of cigarette smoking declined from 1974 to 1987 by only 7% in persons with less than 12 years of education, 13% in those with 12 years, 24% in those with 13–15 years, and 39% in those with 16 or more years of education. In 1987, the prevalence of cigarette smoking was 41% in the first group, 32% in the second, 27% in the third, and only 17% in the last, most highly educated group *(14)*.

Social classes vary greatly in their living and working conditions as well as income, education, and other general factors related to health status. In England and Wales, the inequality in mortality of social classes has not only failed to narrow since the establishment of the National Health Service in 1948, but has actually widened. The Standardized Mortality Ratio (SMR) of the two highest classes

(professional and managerial) was 91 in 1951 and 80 in 1971. For the two lowest social classes (semi-skilled and unskilled workers) it was 110 in 1951 and 121 in 1971. The difference in SMRs more than doubled in 20 years, rising from 19 in 1951 to 41 in 1971 *(15)*.

In the United States, data on mortality by occupational class or income level are not available. The data on morbidity, however, indicate serious class differences in illness and disability. In 1989, the lowest income fifth of the population, with a family income of US$ 15,000 a year, in comparison with the highest fifth, with a family income of US$ 50,000 or more, had more than twice as many persons limited in activity due to chronic conditions, more than twice as many days of restricted activity, more than twice as many days in bed due to illness, injury or impairment, and four times as many persons reported to be in fair or poor health *(16)*.

Perhaps one of the most dramatic examples of the importance of social class as a determinant of health status is provided by Canada, a country with a universal medical care system and the highest expectation of life in the Americas. In the late 1970s, the difference in life expectancy between people in the lowest and highest income fifths of the populations was 4.4 years; for disability-free life expectancy, the difference was 11 years. Poor people in Canada have, on the average, only 55 years of healthy life, that is, life free from disability, as compared with 66 years of healthy life for rich Canadians *(17)*.

THE OTTAWA CHARTER FOR HEALTH PROMOTION

These examples of the importance of general causes provide the background for the decision by the World Health Organization, Health and Welfare Canada, and the Canadian Public Health Association to organize an International Conference on Health Promotion in 1986. The Ottawa Charter for Health Promotion *(18)*, adopted by the 212 participants from 38 countries, represents a synthesis of the general-cause oriented and the specific-cause oriented approaches to health promotion. Like Alison, Virchow, Villermé, Sigerist, and many others, the Charter declares unequivocally that

> The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in these basic prerequisites *(18)*.

On the other hand, the Charter also emphasizes the need to improve the opportunities for people to make healthy choices with regard to specific factors by providing information, education for health, and enhancement of life skills.

HEALTH PROMOTION STRATEGIES

The Ottawa Charter affirms that "Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change." In addition, because of its concern with general as well as specific causes, the Charter underscores the crucial role of multisectoral action for health promotion, stating that

> The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by non-governmental and voluntary organizations, by local authorities, by industry and by the media *(18)*.

There are two other significant ways in which the Ottawa Charter goes beyond traditional approaches to health strategy. These hark back to the intellectual predecessors of the current movement for health promotion: to Rudolf Virchow, whose remedy for epi-

demic disease in 1847 was "prosperity, education, and liberty, which can develop only on the basis of 'complete and unrestricted democracy' " (4); and to Henry Sigerist, who commented on the 1848 German health movement that

> The people were never consulted. They had no voice in all these deliberations. The people's health, however, is the concern of the people themselves. They must want health. They must struggle for it and plan for it *(19)*.

The Ottawa Charter is notable because it rejects the approach of traditional health education, in which the public plays merely a passive role as recipient of educational programs developed by health professionals and specialists in communication techniques. Instead, the Charter calls for an active role of the public, for a process which, by

> providing information, education for health and enhancing life skills . . . increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health. [The Charter emphasizes that] People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health *(18)*.

Another central feature of the Ottawa Charter's strategy is its call to strengthen community action:

> Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies *(18)*.

This community action strategy has since become operational through the rapidly developing movement for Healthy Cities sponsored by the European Regional Office of the World Health Organization. In the Americas, the lead has been taken by Canada through the Healthy Communities Project sponsored by the Canadian Public Health Association, the Canadian Institute of Planners, and the Association of Canadian Municipalities. Most recently, the Pan American Health Organization has decided to cosponsor, together with the European Regional Office of WHO and the Spanish Ministry of Health, a symposium in Seville in September 1992 on "Urban Challenges and Healthy Cities/Healthy Municipalities: Bridging Europe and the Americas."

CONCLUSION

The Ottawa Charter defines health promotion broadly, as "the process of enabling people to increase control over, and to improve, their health." It states clearly that health promotion "goes beyond healthy lifestyles" to the "fundamental conditions and resources for health: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity" *(18)*.

This orientation leads to three interlocking components of the health promotion strategy:

- Intersectoral action to achieve healthy public policy as well as public health policy.
- Affirmation of the active role of the public in using health knowledge to make choices conducive to health and to increase control over their own health and over their environments.
- Community action by people at the local level. Strengthening public participation and public direction of health matters is at the heart of the health promotion strategy.

The broad concept of health promotion in the Ottawa Charter is entirely consistent with the epidemiological concept of "the web of causation." By taking all causative factors, both general and specific, into consideration,

it leads us to reorient our strategies to become more effective in our work. Theory is the eye of practice; let us move ahead with clearer vision.

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