A perspective on changes in values in the profession of health promotion

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Underpinning health promotion theory and practice is a set of ideologies, values and principles that shape health promotion action. The major ideological influences on the development of health promotion have been the recognition of the influence of social and structural factors on health, increasing recognition of the importance of communities, and the growing popularity of ecological and holistic approaches. While scientific evidence has an important role in guiding health promotion, there is general agreement in the literature that health promotion is, to a large extent, values driven. The Macquarie Dictionary defines values as social ideals or customs towards which members of a society have “an affective regard” – in other words, towards which people feel an emotional attraction. Naidoo and Wills suggest values are acquired through the socialisation process and “are those emotionally charged beliefs which make up what a person thinks is important.”

The purpose of this editorial is to examine perspectives on contemporary Australasian health promotion values through addressing the following questions: Are ‘values’ perspectives considered adequately in health promotion? If these values are changing, how are they changing in contemporary health promotion? Members of the Health Promotion Journal of Australia Editorial Advisory Committee have been invited to contribute their personal views on health promotion values and, specifically, to consider whether these values have changed in recent years. A synthesis of this thinking appears below, although there remain differences in perspectives among the authors.

Health promotion evolved out of clinical and settings-based work in ‘health education’, disease prevention and patient education, and initially shared the individual-oriented values of those disciplines. Following the World Health Organization’s Declaration on Primary Health Care at Alma Ata and its immediate sequel, Health for All by the Year 2000, health promotion developed into a new discipline. Its values were made explicit through the 1986 Ottawa Charter for Health Promotion. Individually oriented health education strategies that simply adopted a victim-blaming approach to educating people about the biomedical and behavioural risk factors for diseases of the physical body were considered to have limited potential for population-level health changes. It was thought that the way forward lay with a broader ‘health promotion’ approach that would address holistic health and incorporate a new set of values from which to work. The World Health Organization’s definition of health as a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity was embraced as the foundation value of the new health promotion approach. People were to be treated as whole, and not just the sum of disease-prone body parts.

Some of the important values underpinning the new health promotion approach of the 1980s included social justice, empowerment and equity. Health promotion was described as a process that enabled people to have control over their health and, importantly, on the conditions – the social and physical and economic environments – that affected their health. The enabling strategies of advocacy for policies to promote health, a focus on the determinants of health, participation and empowerment distinguished health promotion from its more narrowly focused antecedent clinical and educational disciplines.

Generally, social justice refers to all members of society having the same basic rights and opportunities. In health promotion, social justice refers to an inclusive strategy that recognises that people should have the same opportunities for health irrespective of cultural background, status, income and education. Empowerment is both the process and the outcome of people gaining control over decisions and actions that affect their health. Participatory processes enable and empower people to gain control over their lives and the determinants of their health. In the new world of health promotion post-1986 Ottawa, this was seen as distinct from disempowering processes or interventions that targeted ‘at risk’ people and their ‘unhealthy’ behaviours. A focus on equity entails prioritising work with communities that are most marginalised, vulnerable, disadvantaged and often regarded as hard to reach based on considerations of equity or fairness. This value for equity-based health promotion was seen as distinct from the practice of working with more visible groups or whole populations, or more accessible but less vulnerable populations.

Initially, in Australia, health promotion efforts (following the Ottawa Charter) were seen as radical and risky strategies, without an evidence base for improving population health. For example, ‘creating supportive environments’ through influencing urban design was not seen as a mainstream role for health services at that time. Actions to address holistic health via changes to social justice, empowerment or social disadvantage were not part of the repertoire or training of most health professionals. Changes occurred in the 1990s, with health promotion becoming integrated into undergraduate and postgraduate health professionals’ tertiary degree programs and to some extent with health departments.

In New Zealand, there was a gradual acceptance of Ottawa Charter-based health promotion within health practice and training. For example, the Charter has frequently been used to
frame public health interventions at least since the mid 1990s. There is no sentinel event or defining moment, but one wonders if these health promotion values have declined or changed since the days of the Ottawa Charter. Has attention to holistic health, equity, social justice, participation and empowerment as espoused in the Ottawa Charter for Health Promotion slowly been reduced in today’s health promotion practice, in health curricula and in health department jurisdictions?

Changes to health promotion values

An awareness of the role that values play in shaping practice, and a willingness to critically reflect on this, has been one of the strengths of health promotion. A perusal of the themes addressed in journal editorials or at health promotion conferences suggests that at the expressed level, the core values of health promotion are as strong as ever. The values system underpinning contemporary health promotion is strongly evident in the health promotion ‘talk’, but not as evident in the health promotion ‘walk’.

At the enacted level in Australia, it is possible to reach the conclusion that the values system described above is becoming more peripheral to health promotion. To some extent there has been a swing back to the conventional forms of health promotion that were prevalent in the pre-Ottawa Charter days. Today’s versions of health promotion have returned to a more biomedical health paradigm, based on the values of individualism, and rely primarily on strategies focused on individual persuasion and behaviour change. Alternatively, a more pessimistic view could argue that there has not been any change at all in the practice of health promotion, and there has simply been a continued lack of success in the implementation of strategies addressing social determinants of health or community empowerment strategies.

While infrastructure and funding for health promotion has actually improved, funding and health promotion programs are increasingly skewed towards improvements in biomedical and behavioural risk factors to reduce illness and costs associated with chronic disease, rather than a population-wide primary prevention focus. It seems that the social and cultural aetiologies of ill-health are still recognised and investigated by researchers, but less manifest in the public sector solutions that are offered as part of system-wide prevention efforts. Is it because the political implications of a society fully adopting the philosophy and values of health promotion are unacceptable or that the outcomes of strategies addressing the social determinants of health and empowerment are not clear enough or take too long to achieve? Is it that health promotion workers, mostly based in the health system, are not in the position to make progress on addressing determinants?

The language of health promotion includes terms such as ‘target groups’ and ‘interventions’. These terms, perhaps simply used as convenient jargon within health promotion circles, are inconsistent with the philosophical health promotion values system that espouses working collaboratively with people, not on them, yet are prevalent in the health promotion literature today. Programs that address the social determinants of health or adopt participatory approaches are the exception and receive neither government nor peer-reviewed research funding. The rhetoric has returned to the assumption of individual responsibility for disease prevention rather than collective responsibility for health promotion.

In New Zealand, like Australia, the core values of health promotion as stated in the Ottawa Charter have been consistently expressed for many years. Here the enacted values have also failed to live up to the rhetoric but, unlike Australia, this has not changed significantly. Health promotion practice in New Zealand has been consistently dominated by a focus on biomedical and behavioural risk factors. One only needs to read the health priorities of recent governments to see this. However, there have been some efforts to address the broader determinants of health, equity and empowerment throughout the past two decades and these continue today. The many Maori health service providers that have emerged since the 1993 health reforms continue to make a significant contribution. Public health units have maintained this focus in parts of their contracts with government, for example, in improving social environments. Non-governmental organisations such as the National Heart Foundation and Te Hotu Manawa Maori have succeeded in taking a settings-based approach and supporting local communities.

In true health promotion style, we could use a socio-ecological approach to understand the social, political and economic determinants of these values. One of the reasons for the discordance between expressed and enacted values may be because health promoters need to operate within the present terms of legitimacy and within the bounds of agency that are provided by governments of the day, prevailing social norms and broader societal values. It could be that health promotion changes are just a reflection of larger social norms that are less collectivist, less focused on ‘community’, and more oriented to individual outcomes. Many core values of health promotion are not shared by funding bodies and policy makers, and perhaps not by younger generations in the broader society-at-large. If we are going to resolve this discordance, health promotion needs to find ways of translating its expressed values into actions and outcomes that are valued by contemporary decision makers and the wider society.

There can be significant differences between professional, personal and organisational values. There is a fair degree of agreement about the professional values for health promotion.
These have been mostly consistent over the past few decades. Second, there are the personal values that people working in health promotion hold. These can be very diverse, even conflicting, and might be 'individual responsibility', 'efficiency', 'environmentally friendly', 'rational evidence-based approaches', 'consensus agreements on decisions', 'proper processes; 'timeliness', or their opposites. Personal values can be influenced in the workplace by organisational pressures. Public sector organisations have at different times emphasised community consultation and involvement, and at other times emphasised performance targets and cost-effectiveness.

Because of the potential influence of workplace organisational values, the professional values of health promotion are essential. Individual values may influence how the processes of specific projects are implemented – for example, perhaps some will emphasise the community consultation aspect of a needs assessment or planning process, and others might focus on setting timelines and measuring objectives. All aspects may be equally necessary, and professional standards of practice can assist in achieving a balance.

Values conflicts in health promotion research and evaluation

Health promotion values influence the research and evaluation methods used to assess programs. Health promotion can give rise to differing, sometimes competing sets of values that underpin research. At one end of the spectrum is the biomedical scientific paradigm, valuing randomised designs, validated outcome measures, and methods to reduce biases in the interpretation of data. This leads to epidemiologically compatible definitions of 'evidence for health promotion effectiveness'. At the other end of the spectrum is a set of values borne of conventional community health promotion approaches, concerned with social justice, equity, participation and empowerment. This is derived from social change and structural views of health, and is sometimes more concerned with the processes of health promotion than proving program impact or outcomes. Clearly, there are a broad range of health promotion research and evaluation models and approaches, and each derives from a particular value base.

The two 'extreme' approaches to health promotion research and evaluation are usually adversarial. The flaw in the debate on both sides is that it is values-driven cat-calling across the fence, "ours in the only true [research] understanding, or way of evaluating programs". These values-laden perspectives and conflicts prevent optimal mixed-method evaluations. New methods of statistical and psychometric analyses, clustered study designs and better quantitative measurement could be combined with careful process evaluation, rigorous qualitative methods, and triangulation of information from different perspectives in assessing a program of health-promoting work. In concert, these could improve our understanding of health-promoting processes and outcomes at both individual and community levels.

Conclusions

Apart from knowledge and skills, health promotion practitioners ought to have values that are consistent with the philosophy of health promotion. If personal values differ from the philosophy of health promotion, then professional practice must understand the value conflict and select methods and approaches that maximise population health and minimise value bias.

While the underlying value base of health promotion has been generally consistent over the past few decades, recently in Australia new values have appeared, shifting the focus to some extent away from a community focus to a 'top down' approach. These changes have been driven partly by social norms and government agencies changing their values towards 'disease prevention'. It is possible that this shift is an inevitable consequence of the individualistic, macro-level societal values driven by the Australian Government. New Zealand has had successive governments with such values, at least since the introduction of Ottawa Charter-based health promotion in 1986. The experience there suggests that health promotion values can be operationalised within this context but only in a limited way. Reflecting on why should cause us to consider the constraints to change in any political democracy and the tactics needed to overcome them.

The change in values in Australia is not so much a deliberate or conscious change but a case of slippage over the years as Western democratic governments have become more conservative, individualistic and economic rationalist in outlook. At the same time, because we have taken our values system for granted, we have not actively responded to these trends by protesting about the conflict between the dominant political ideologies and the values of contemporary health promotion. As such, there is a whole new generation of health promotion practitioners who have only ever worked within the conventional paradigm and have no experience of practice during the post-Ottawa Charter days. Although we talk our empowerment and social justice health promotion talk at conferences and in editorials, our conference programs and journal pages are still full of disease prevention interventions. Likewise in New Zealand, it is difficult to practice the health promotion that is spoken about.

Part of the answer to reversing this trend requires us to open up the discussion within the field about values, the fact that we have them as a professional discipline, how and why they might be changing and how we can reduce the gap between the talk and the walk. We should debate these values and the changes in them at conferences and in journal articles, and keep doing
this until there is a very clear understanding of what the values are, where they came from and how to practice in a way that is consistent with them. You are encouraged to contribute!

References


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