

The 'New Public Health' and health promotion agendas

Ashton and Seymour (1988) introduce their book, which discusses the New Public Health movement, by retelling one of the most common parables of that movement in which the health worker is likened to a lifesaver on the bank:

Every so often a drowning person is swept alongside. The lifesaver dives in to the rescue, retrieves the 'patient' and resuscitates them. Just as they have finished another casualty appears alongside. So busy and involved are the lifesavers in all of this rescue work that they have no time to walk upstream and see why it is that so many people are falling into the river.

(Ashton and Seymour, 1988, p.vii)

...Health promotion within the speciality of public health is commonly defined as a 'process of enabling people to increase control over and improve their health'. This definition can be broken down into its component parts

<i>the what?</i>	'a process'
<i>the why?</i>	'increase control over and improve their health'
<i>the how?</i>	'enabling people'
<i>the who?</i> definition?	(not specified here, so who is the 'who' in this definition?)

It is important to distinguish between health promotion and health education. Health education is essential if the public are to be involved in public health as partners. There are three elements to health education (Joffe, 1996):

- 1 biological knowledge: knowledge about what makes us healthy or not
- 2 how to access services to help improve health
- 3 knowledge of the big issues that affect health; the social, environmental, and political factors.

Sometimes health education is thought of simply as being the first of these, but for people and communities to be partners in improving health they need information in all three areas. Health education is an important part of health promotion, but health promotion is more than health education.

At the 1986 Ottawa conference on health promotion a set of principles was developed, building on the principles of Health For All. The *Ottawa Charter for Health Promotion* (WHO, 1986) sets out the following framework:

1 *Build public policies which support health*

This means international, national and local organisations (governmental and non-governmental) identifying health as a key issue in determining policy in all areas of action.

2 *Create supportive environments*

This means that health promoting activities must be aimed at enhancing our living and working environment because health is so closely linked to the environment in which we live.

3 *Strengthen community action*

This means communities having the power to influence and control their activities and initiatives.

4 *Develop personal skills*

This means helping people to develop the skills they need to make healthy choices.

5 *Re-orient health services*

This means that all people involved in health service delivery must work together in a system that sees health improvement as a central goal. It may also lead to changes in practices and responsibilities, and to the need to adjust values.

Health For All 2000

The World Health Organisation took an important lead in the development of the role of public health through its strategy for Health For all by the year 2000 (WHO, 1981), officially adopted at the World Health Assembly in 1981. The goal was that by 2000:

All people in all countries should have at least such a level of health that they are capable of working productively and of participating actively in the social life of the community in which they live.

The cornerstones of Health For All 2000 were:

- community participation

- intersectoral collaboration
- equity
- affordability and appropriateness

The basis of achieving improved health was through a variety of inputs tailored to meet specific local needs. The European Region, which was considered to have in place reasonable sanitation, water supplies and health services, therefore, concentrated on the role of primary care (in Britain, GPs and primary care teams). Much current understanding about the benefits of the primary healthcare approach was spearheaded within the developing world where the medical infrastructure was sparse (Morley *et al.*, 1983).

International concern with the escalating costs of medical care, and a re-evaluation of health needs in the light of demographic changes, promoted research that led to the publication jointly by the WHO and the World Bank of a report *Investing in Health* (World Bank, 1993). This has been influential in informing the health policies of many countries. It gives particular emphasis to public health interventions for health again. The notion of health includes ameliorating the effects of a disability or chronic illness and also opens up ideas of promoting a sense of wellbeing as a legitimate goal for society. The contribution of social and cultural factors to promoting wellbeing lies beyond the traditional remit of the medical professions, but sits well with the idea that communities themselves are partners in health production.

A broad focus (for public health activity) easily leads to accusations of ‘woolly breadth’, but this breadth is exactly what public health should be about. The challenge for public health practitioners is to justify and promote global concerns and at the same time proceed with evidence based, public-health programmes that deal with disease-specific factors and more general issues such as health inequalities. (Beaglehole and Bonita, 1998, p.591)

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