PROMOTING HEALTH
The Primary Health Care Approach
6E

DR LYN TALBOT
Dr Public Health (La Trobe), MHlthSc, Grad. Dip. HlthSc, Grad. Cert.
Higher Education RN,
Corporate and Community Planner—Strategy
City of Greater Bendigo

DR GLENDA VERRINDER
PhD (La Trobe), MHlthSc, Grad. Dip. HlthSc, Grad. Cert.
Higher Education, Cert. CHN, RN, Midwife, Senior Lecturer
La Trobe Rural Health School,
School of Science, Health and Engineering
La Trobe University

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PREFACE

There are major disparities in health status around the world. There is now overwhelming evidence that diseases affecting physical, social and emotional health are experienced differently, unequally and inequitably. Some argue that peak global health may be here already. Evidence also suggests new challenges for health practitioners.

This is a time of significant change internationally. Political instability and social uncertainty are the result of an erosion of ‘public goods’, persistent poverty, energy and food insecurity. It is a time of increasing awareness of the impact of globalised economic activities on social and environmental health. It is a time of financial crises across nations which previously seemed impermeable to this threat and there is deep concern about global climate change, ecological sustainability and the implications for human health and survival.

Greater understanding of the socio-ecological determinants of health within and between countries could now form the basis for public health strategic priorities internationally. Increasing disparities in health continue to highlight how very important the principles of a comprehensive primary health care (CPHC) approach to health are and how vital it is that they continue to have a place in contemporary society. Comprehensive primary health care continues to be relevant to health practitioners from all disciplines, it underpins all health promotion activities. There is an even more urgent need for CPHC than previously existed.

We argue that the concepts and skills presented in this text provide an essential toolkit for health promotion action. We hope that this updated edition of Promoting Health: The Primary Health Care Approach will engage health practitioners from a broad range of disciplines and support them in their health promotion work as social and policy change agents and in their work in partnership with communities.

This edition builds on the sound philosophical approach of the previous five editions. The key principles of comprehensive primary health care, and of equity, social justice and community empowerment underpin each section of the book. Current policy and practice initiatives have been updated. Health promotion frameworks introduced in previous editions have been strengthened and new examples from practice have been introduced in the text and on the Evolve site. The Ottawa Charter for Health Promotion continues to provide a relevant and useful framework for promoting health internationally; we present this framework within a continuum of health promotion practice. In each chapter the relevant International Union for Health Promotion and Education Core Competencies for Health Promotion have been identified. There are nine domains of action and each domain has a series of core competency statements and a detailed outline of the knowledge and skills that contribute to competency in that domain. Each chapter also contains a series of critical-thinking questions which may be used to prompt personal reflection and broader reading about the issues raised in the chapter, or they could be used to guide group exploration. In Chapters 3 to 9, the reflective questions are supported by a series of rhetorical questions about practice issues, framed within the Ottawa Charter action areas. We have used the Ottawa Charter in this way to illustrate the argument we have made throughout the book—that the Charter remains a relevant multipurpose tool.

Lyn Talbot and Glenda Verrinder
INTRODUCTION

This new edition of Promoting Health affirms the universal applicability of using the comprehensive primary health care approach to addressing health issues in all settings internationally. Once again, the specific focus of this text is the use of this approach in health promotion. The philosophy underpinning comprehensive primary health care remains as relevant now as it was when first endorsed by the World Health Organization in 1978 and expressed within the Declaration of Alma-Ata.

Primary health care was seen as a solution to inadequate illness management systems. By providing a balanced system of treatment, disease prevention and health promotion through affordable, accessible and appropriate services, it was hoped that this approach would address some of the major inequalities in health observed both within countries and between countries. At the same time, there was recognition that health services alone were not the answer, and that a major reorientation was needed in the way in which we think about, and act on, issues which impact upon health. The same challenges remain before countries still, in reducing inequalities and providing equitable access to health and illness care for all members of their population. Since the Declaration of Alma-Ata, despite the rhetoric, the hard work and considerable expenditure, inequalities in health status within nations, even the most affluent ones, have increased; likewise, inequalities in life expectancy between affluent and poor nations has also increased.

Central to comprehensive primary health care are principles which should guide all action on health issues. The principles tell us how we should do what we do. The principles emphasise social justice, equity, community empowerment and ecological sustainability. They emphasise using approaches that are affordable, and therefore sustainable. They emphasise the need to work with people, in order to enable them to make decisions about which issues are the most important to them and which responses are most useful, and they emphasise the role of all sectors and groups in addressing the root causes of ill health.

Comprehensive primary health care is much more than the provision of new or first-contact health services. The socio-ecological determinants of illness and health are well recognised and they need to be the focus of concerted effort in health service provision. Addressing these determinants of health requires sound knowledge and skills of health promotion strategies to foster wellbeing and prevent ill health. Comprehensive primary health care principles need to be applied at all levels of the health system and in every interaction between health practitioners, community members and other sectors. Such a comprehensive approach is so much more than the delivery of primary-level services. The term ‘comprehensive primary health care’ is used throughout this book to reflect a comprehensive approach, not primary-level services.

The Ottawa Charter for Health Promotion (WHO, 1986) enshrines comprehensive primary health care principles set out in the Declaration of Alma-Ata (WHO, 1978) in a framework for health promotion practice. The Charter has been reaffirmed time and again by health promoters worldwide, and continues to provide a relevant and comprehensive guide for professional practice in health promotion. Health promotion action to promote wellbeing and prevent illness must work to change the environments that structure health chances, as well as to help individuals to change those things over which they have control.

To undertake this action, health promotion practitioners need a broad range of skills not traditionally regarded as central to the health system. This book focuses on assisting health promotion professionals, and those from a range of health disciplines and other sectors who are incorporating health promotion into their practice, or creating settings and environments that are health promoting or health protecting, to develop the competencies essential for health promotion practice using a comprehensive primary health care approach. It is designed to provide both a theoretical introduction and practical strategies for action.

Health promotion is not only the responsibility of any one discipline. Although health promotion is now recognised as a discipline of its own that can lead to professional accreditation, health promotion is also everyone’s
responsibility. Health promotion is a broad-ranging activity, which must be embraced by as many people as possible if it is to be effective. Much health promotion work occurs outside the health sector, and therefore requires the active involvement of people who would not regard themselves as health practitioners at all. Teachers, police, road safety workers, engineers, mediators, human rights investigators, local government workers and many more play a central role in health promotion action. Active participation by members of the community in all aspects of health promotion action is also essential. Community members have a central role to play in forming partnerships with practitioners and agencies in developing environments which are conducive to the health of that community.

Everyone has opportunities to promote wellbeing, whether it be to lobby for changes to improve the social ecological determinants of health, to work to make community settings more health-promoting, to assist individuals to learn about health-enhancing behaviour or to engage people meaningfully in the decision-making processes that affect their health. There is a full range of health promotion practice roles, from policy advocacy and building health-enhancing settings, through to providing communities with support in making changes in their communities to improve health, conducting health education, providing health information and conducting screening and surveillance activities on behalf of particular groups. Health practitioners in particular have roles as advocates for these communities and in advocating for consideration of the health perspective on issues outside the health sector which have an impact on health.

By virtue of these roles and challenges, health promotion practitioners can take up a leadership role in the promotion of health. Multidisciplinary health associations, such as the International Union for Health Promotion and Education (IUHPE), and public health associations, have an important role to play, both in advocating for the health of the community and in modelling the effectiveness of a true multidisciplinary approach. The professional associations of specific health disciplines have an important role to play too.

Many health practitioners find themselves taking on health promotion roles without thorough theoretical and practical preparation. This book will provide detailed practical guidance for students and practitioners new to the health promotion role, whether their role is specifically in health promotion or it involves incorporating health promotion into their work in another health discipline or wider field of practice. This book will encourage practitioners to take up the challenge to work as health activists, to promote health in ways which enable communities and individuals to live their lives to the full.

If countries continue to support a burgeoning illness management system, the costs to the health of the community will continue to rise. Inequalities in health status and in access to appropriate health services will become even worse. However, if a comprehensive primary health care challenge is taken up by all whose work impacts on health, as well as by community members who find their health jeopardised by the circumstances in which they live, then the positive effect could be quite profound.

Throughout this book different terms to describe the workforce who are promoting health are used. They may be termed ‘health workers’ — a term that first came to be extensively used in the women’s health movement, because it was regarded as a term which implied a more equal relationship between professionals and their patients or clients. The term ‘health promotion practitioner’ may be used to describe the workforce role where the primary purpose is to promote health. These practitioners would possess or develop a full range of health promotion competencies. The term ‘health practitioner’ is used in recognition of the reality in the workforce that health promotion activities are undertaken by workers whose primary qualification may be from a range of different disciplines, and who might be undertaking some health promotion activities within a wider field of practice. This term of address also recognises the blurring of inter-professional boundaries in community-based health practice, which has real benefits for clients and community members. Workers are also described as community development workers, educators or planners depending on the practice focus of the chapter and in recognition of the role of many in promoting health.

In this book, the terms ‘low-income countries’ and ‘high-income countries’ are used. Low-income countries characterise a common life experience for the majority of the world’s population—about 80% of people. Another commonly used term for these populations is ‘majority world’. This term emerged in the early 1990s in journals such as New Internationalist (http://www.newint.org), which regularly features articles and images from the perspective of the majority of humankind. This 80% of the population consumes about 20% of the world’s
resources. Alternative but less accurate terms sometimes include ‘third world’ or ‘developing nations’. High-income countries refers to the proportion of the world’s population (around 20%) who consume around 80% of its collective resources (often referred to ‘minority world’ or as the ‘developed’ or ‘first’ world). Nations of the high-income countries dominate international economic decision-making and trade, and determine the extent of the inequity between nations worldwide. An example of this can be seen in the way high-income nations’ world events and preoccupations dominate news items. The terms third world and developing nations often suggest that the low-income nations are deficient and convey parochialism on the part of a smaller number of more dominant nations.

The majority of the world’s people are not rich but there is a minority of people who are. The United States of America (USA), for example, is a very rich and powerful country and part of a small minority in the world. Bangladesh is very poor and part of the large majority in the world. There is increasing polarisation between the rich high-income and emerging low-income nations and poor countries and, further, within all of these countries there is increasing polarisation between those with secure high incomes and the people whose employment is insecure or their income is low. Brazil is an example of an emerging market economy where polarisation of financial and health inequalities persists.

Health promotion draws on many areas of expertise. This means that it is difficult to make the hard choices about what to examine, and in what depth, in a text of this size. In deciding which skills and issues need to be addressed in a book such as this, strong consideration has been given to the IUHPE Health Promotion Competencies and to which topics are usually examined in undergraduate education in health. For example, it is expected that readers will already have grounding in sociology, psychology and health and disease. Hence, a number of topics, including the structural basis of ill health, communication skills and health and disease processes, while referred to, are not examined in any great depth. Readers who are using this book without having previously examined these issues are encouraged to supplement their reading in these areas.

Similarly, dilemmas exist in deciding what examples from practice to use to illustrate important concepts. We have drawn ‘real-life’ examples from our own professional practice fields and often in our local geographic area. This has been done on purpose, to illustrate the diversity and wisdom all around in health promotion. Rather than being parochial, the examples we use should encourage practitioners to examine the practice around them and to draw on the wisdom and expertise of what’s working locally. We hope that these examples will encourage budding health promoters to become involved in showcasing their work thus demonstrating that health promotion is already a meaningful part of a great many health workers’ practice. Promoting Health is divided into nine chapters.

HOW TO USE THIS BOOK

The book has been structured in a precise sequence. There are two distinct, but strongly integrated sections.

• Part 1, consisting of the first three chapters, is clearly theoretical although practice examples are presented. The chapters present a brief overview of the origins of health promotion as a discipline of practice and the emergence of key principles. Concepts that are fundamental to health promotion practice, whether it makes up a part of one’s professional role, or it is as a specialist health promotion practitioner role, are discussed in some detail.

• Part 2 presents an introduction to all of the types or areas that can be a part of health promotion practice from whole-of-population action designed to improve opportunities for health to health promotion action that has a focus on individuals.

The chapters are interrelated, but they are also designed to stand alone. Rather than reading from the start, readers can dip into their focus area, and the chapter will direct them to the relevant theoretical concepts presented earlier in the book. This approach may suit readers with a strong practice background.

Each chapter commences with a summary table of contents of the chapter as a means of identifying key components and to assist the reader with navigation.
Critical reflection on health promotion study and professional practice

In each chapter, a number of questions for reflection have been included, drawing on some of the important dilemmas for practice and challenges for health systems that have been raised in the chapter. In the practice-based Chapters 4 to 9, these reflective questions are framed in the action areas of the Ottawa Charter. The use of the Charter in this way illustrates its direct applicability to health promotion practice, and assists the practitioner to think broadly but strategically about practice challenges, and to reflect on and critique their professional role and the health-promoting philosophy of their organisation. Critical reflection helps to keep comprehensive primary health care philosophy at the forefront, even when it may be more expedient to make decisions for a community.

Additional reflective questions, insights and relevant weblinks are available on the Evolve site accompanying the text. These have been designed to encourage the student’s active and self-directed learning and assist lecturers and tutors with in-class discussions. An answer guide to all in-text questions has also been provided to instructors on the site.

The purpose of texts such as Promoting Health is to set out the core principles to guide practitioners in health promotion. In doing this, an ‘ideal’ set of circumstances and ways of working is described, which are much more difficult to put into practice than they seem. A more global perspective is taken in the early chapters, and content of specific relevance to the health promotion workforce in New Zealand and Australia is included. You are encouraged to read widely and examine the great many other examples currently available, and to work with your colleagues to develop your own ways of practising.

Comprehensive primary health care philosophy has provided us with a strong framework for health promotion, within which health practitioners, policymakers and members of the wider community can work together. The opportunity exists for all those whose work impacts on health to take up the challenge of working in such a broad health promotion framework. This book reflects the spirit of comprehensive primary health care, and contributes to our growing understanding of how to work to promote the health of communities locally and globally.

Health promotion competencies

Considerable work has been done since the 1990s to develop and define a list of professional competencies that are core to professional health promotion professional practice. This development process is described in more detail in Chapter 1. This text enables health promotion practitioners to develop an introductory-level understanding of all of the core concepts essential for professional accreditation. The IUHPE health promotion competency statements highlighted at the end of each chapter relate to the content of that chapter.

Part 1: Health promotion history and concepts

Chapter 1

In Chapter 1 health promotion is examined in the context of the development of primary health care and the new public health movement. The organisational leadership of the World Health Organization in working towards achieving health for all of the world’s population is discussed and the development of this international policy process and the ‘drivers’ of current policy development is reviewed. The social, environmental, cultural and psychological determinants of health and illness and the role that primary health care, the new public health movement and health promotion have in addressing health inequalities is discussed. A rationale for the continuing relevance and usefulness of comprehensive primary health care and the Ottawa Charter for Health Promotion as key frameworks for health promotion practice is provided. Conceptual diagrams, including a continuum of health promotion practice for action, are also presented.

Chapter 2

The concepts and values that underpin health promotion are presented in Chapter 2. The centrality of equity, social justice and community empowerment in the promotion of health, and directly addressing the determinants
INTRODUCTION

of health, are identified as fundamental issues for contemplation and action in health promotion. Given the importance of these issues and some of the challenges they have presented, other key concepts and values are presented, including cultural competence, raising a number of important questions that practitioners will face as they grapple with the complexities of health promotion practice in a range of different settings.

Chapter 3
Chapter 3 highlights the growing risks to, and concerns about, human health in a rapidly changing biophysical environment. The chapter presents an introduction to ecological sustainability for practitioners by providing definitions and principles of ecological sustainability; a rationale for the engagement of the health sector; and strategies for supporting action for change.

Part 2: Introduction to health promotion practice

Chapter 4
Commencing in Chapter 4 and continuing through the subsequent chapters in the book, each chapter relates to one approach to health promotion practice along the health promotion continuum introduced in Chapter 1. The continuous cycle of program development, from community assessment through to program design and evaluation, is examined in detail. Research skills form the basis of the process, and the steps necessary to develop an effective program based on evidence are outlined. Using these skills facilitates the development of a research base for health promotion in a way that both strengthens the relevance of health promotion work and enables practitioners to be accountable for their practice. A broad range of approaches can be used which are grounded in comprehensive primary health care, and there are clear relationships between the philosophical approaches and the methods used. Community engagement is fundamental to the success of program development and evaluation.

Chapter 5
In Chapter 5, we examine health promotion action when developing healthy public policy to create health-promoting environments. Developing public policy lays the foundation for healthy living and offers scope for developing effective long-term change with wide-ranging impact on the determinants of health and illness. In this chapter, we explore the key issues in the development of healthy public policy at a broad social level, a local/community level and within organisations.

Chapter 6
In Chapter 6 we discuss community action for social and environmental change. The social environment is the focus for action, rather than the individual. The potential of community development approaches to address some of the structural issues that lead to poor health are discussed. We examine the potential of community development as a way of working with communities, on issues they identify with, to achieve changes to the environment and enable community empowerment. Social entrepreneurship is a more recent approach to bringing about sustained social change for a specific group or community that is initiated from a business perspective.

Chapter 7
Building health literacy plays a central role in health promotion approaches, and in Chapter 7 we review some of the principles of health education for health literacy and consider the particular approaches that sit most comfortably with primary health care. Strategies for safeguarding cultural safety and using indigenous pedagogy in health education have been included.

Chapter 8
In Chapter 8 we move further along the health promotion continuum and discuss ways of disseminating and using information for promoting health through social marketing. Social marketing skills are an essential
component of the health promotion worker’s toolkit when used to complement policy development, education and community development to enhance health. In this chapter, we also provide some critique of social marketing.

Chapter 9

In Chapter 9, we move to the far end of the health promotion continuum to the health promotions approaches based on medical and epidemiological evidence. The focus of immunisation, screening, individual risk assessment and surveillance is disease prevention, and control is maintained by health professionals. These approaches are an important part of health promotion action, but we also provide a critique of some screening and risk assessment programs.

Where to from here?

‘Where to from here’ synthesises the tenet of the text, which is that a socially just society is a healthier society and success in health promotion is dependent upon examining our values and challenging the inequitable distribution of power, resources and opportunities for health. Health practitioners must raise the consciousness of communities to the determinants of health and work inclusively, respectfully, collaboratively and flexibly with each other and communities. International agreements such as the Declaration of Alma-Ata, the Declaration of Human Rights, the Ottawa Charter for Health Promotion and the Earth Charter provide the foundation for successfully implementing the strategies outlined in the text to promote health for all.
REVIEWERS

Linda Portsmouth, PhD, MHlthComm, PGDipHlthProm, BA, BAppSci
Undergraduate Course Coordinator (Health Promotion) and Senior Lecturer (Undergraduate and Postgraduate Health Promotion), School of Public Health, Curtin University
Perth, WA
Australia
MAHPA, MAASM

Jane Taylor, PhD, MHP, Grad. IntHlth, BEd
Senior Lecturer and Discipline Leader, Public Health, University of the Sunshine Coast
Sunshine Coast, QLD
Australia
Queensland branch member, Australian Health Promotion Association

Stefania Velardo, PhD, BEd(Hons), BHSc
Lecturer, School of Education, Flinders University
Adelaide, SA
Australia
President (SA Branch), Australian Health Promotion Association

Nasreen Waheed, RN, BN, MScN, DrPH, Grad. Cert. Higher Ed
Lecturer, Nursing, and Research Supervisor, Charles Darwin University
Darwin, NT
Australia
Research Supervisor, Villa College
Maldives
Member of: ICCN, Maldives Nursing Association, Maldives Nursing Council, Pakistan Nursing Federation, Golden Key International Honour Society, Northern Territory Tertiary Education Union (NTTEU); Research supervisor (Villa College, Maldives)

Ruth Mackenzie-Stewart (Klein), BAppSc (Health Promotion), PhD Candidate
Lecturer and Course Facilitator, Short Course in Health Promotion, Monash University
Melbourne, VIC
Australia
Victorian branch member, Australian Health Promotion Association
# Health promotion in context: comprehensive primary health care, the new public health and health promotion

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INTRODUCTION

In this chapter, the baselines for understanding health promotion and health promotion practice will be established. Life expectancy and the socio-ecological determinants of health are discussed and the underlying causes of, and global responses to, health inequalities are reviewed. There are three main premises underpinning this discussion. The first premise is that health can be conceptualised as ‘a complete state of physical, mental and social wellbeing, and not merely the absence of disease or infirmity’ (World Health Organization [WHO], 1948) and further, that health is determined by social, economic and physical environments as well as a person’s individual characteristics and behaviour which in combination are described as the socio-ecological determinants of health. The second premise is that how long people live, and how healthy they are, varies a great deal within countries, and between countries, and health systems and policies can do a great deal to reduce the variation (CSDH, 2008; Duckett, 2016; ABC Radio National & Marmot, 2016). The third premise is that health and illness services predominantly focus on managing illness and treating conditions after they have arisen, when prioritising action to improve the socio-ecological determinants of health and health promotion action could do a great deal to improve health and prevent illness occurring in the first place. These three premises apply everywhere in the world.

The part that neoliberalism has played in increasing health inequalities will be discussed. Neoliberalism is a social policy model that transfers control of economic factors to the private sector from the public sector. We propose policy and practice options for health practitioners by discussing the role that comprehensive primary health care (CPHC), the new public health movement and health promotion have played in improving the health of populations. We describe CPHC as a developmental process where the principles of equity, social justice and empowerment underpin the work for socio-ecological changes necessary to improve health. The aim of CPHC is to address the conditions that generate health and ill health. We review the role of the WHO, and we present a revised continuum for health promotion practice (Talbot & Verrinder, 2005). In other words, we discuss what the situation is in relation to life expectancy and health status globally, why that is and how societies have responded.

LIFE EXPECTANCY AND GLOBAL HEALTH INEQUALITIES

Global life expectancy increased between 1990 and 2013 but the data does not reflect the differences between and within countries. Life expectancy at birth reflects that the overall mortality level of a population and global life expectancy for both sexes increased from 65.3 years in 1990 to 71.5 years in 2013 (The Lancet, 2015). However, global progress masked variation by age and sex—for children, average absolute differences between countries decreased but relative differences increased. For women aged 25–39 years and older than 75 years and for men aged 20–49 years and 65 years and older, both absolute and relative differences increased (The Lancet, 2015). Data is collected and projected for the globe and there are certain assumptions made in the calculations, the most important being that the standard life expectancy is set at 80 years for males and 82.5 years for females (People’s
CHAPTER 1  HEALTH PROMOTION IN CONTEXT

Health Movement [PHM] et al., 2014) and so while the average life expectancy at birth increased globally, the WHO reports a range from 79 years in high-income countries to 62 years in low-income countries (WHO, 2015a, Global Health Observatory, Life Expectancy [GHO, Life Expectancy]). Box 1.1 shows some major global trends.

In the introduction to this book we refer to high-income countries (referring to the smaller number of more affluent and technologically ‘developed’ nations) and low-income countries (referring to the majority of the world’s people in low-income or ‘developing’ nations who are relatively poor or very poor). There are also middle-income countries and within each there are inequalities. Age-specific and regional data reveal that diseases of poverty are the biggest causes of death in low-income countries. For example, the People’s Health Movement and other organisations report the following (PHM et al., 2014, p. 190).

1. Infectious and parasitic disease, maternal and perinatal conditions and nutritional diseases are the dominant causes of death in low-income countries.
2. Among children under 5 year so age, 73% of the 10.4 million deaths are caused by six infectious diseases.
3. More than 7 out of 10 child deaths globally occur in Africa and South-East Asia.
4. Forty-six per cent of all deaths in the African region were of children aged less than 15, whereas 20% were people aged 60 and over.
5. An estimated 35% of child deaths are due to undernutrition and 5% are associated with human immunodeficiency virus (HIV).

BOX 1.1  GHO Health in 2015: from Millennium Development Goals (MDGs) to Sustainable Development Goals (SDGs): a snapshot

Trends for 34 different health topics are summarised and explanations for success, challenges and strategic priorities for improving health in the different areas are made. Topics range from addressing air pollution to reducing hepatitis and road traffic injuries, and can be viewed/downloaded individually from http://www.who.int/gho/publications/mdgs-sdgs/en/. A ‘snapshot’ of global trends in the report include the following.

- Deaths among pregnant women, children and adolescents account for more than one-third of the global burden of premature mortality, despite the fact that the vast majority of these deaths are preventable. Rates of maternal mortality are 19 times higher in low-income or ‘developing’ countries than in high-income or ‘developed’, and children in low-income countries are eight times more likely to die before they reach 5 years of age.
- Globally, the number of deaths due to infectious diseases, including parasitic diseases and respiratory infections, fell from 12.1 million in 2000 to 9.5 million in 2012. The percentage of all deaths due to infectious diseases decreased from 23 to 17%.
- In 2012, an estimated 52% of all deaths under age 70 was due to non-communicable diseases (NCDs), and two-thirds of those deaths were caused by cardiovascular diseases, cancer, diabetes and chronic respiratory disease. Premature mortality rates due to NCDs declined globally by 15% between 2000 and 2012.
- Mental health and substance use disorders, together with neurological and developmental disorders, are responsible for over 10% of the global disease burden.
- Injuries and violence are associated with more than 5 million deaths, or one in 11 deaths.

Inequalities in life expectancy between countries

The inequalities in life expectancy between countries are due to wider social and environmental living conditions; these are the socio-ecological determinants of health. For example, life expectancy in Europe stagnated and in Africa it decreased between 1990 and 2013. The WHO (2015a) reports that the phenomenon in Europe is due mainly to adverse mortality trends in the former Soviet Union countries (political and economic change and instability) and the decrease in Africa is due mainly to HIV/AIDS. However, the WHO also reports key trends in world health statistics showing that public health measures have been successful in improving life expectancy and health in some areas. ‘Significant strides’ have been made in meeting some of the Millennium Development Goals overall. For example, targets for reducing the rate of HIV infections and reducing mortality from tuberculosis have been met. Child and maternal mortality has reduced although while more women have been assisted in childbirth worldwide, women in the poorest countries face 15 times the risk of dying during pregnancy or from complications of childbirth. There have been fewer HIV and tuberculosis (TB) infections and deaths overall but again, 10% of maternal deaths in Africa are due to the aggravating effect of HIV infections (WHO, 2012; WHO, 2015d).

Inequalities in life expectancy within countries

Inequalities in life expectancy within countries exist everywhere (Wilkinson & Pickett, 2009; WHO, n.d.). The WHO reports that infant mortality is much higher in babies born to women with no education compared to those who do; life expectancy at birth for men in the Carlton neighbourhood of Glasgow, Scotland is 28 years less than that of men in Lenzie, a few kilometres away; and life expectancy at birth among Indigenous Australians is substantially lower than that of non-Indigenous Australians (WHO, n.d.).

Life expectancy is reflected in the ways people live and work and in the quality of their health care. Although there have been gains in health, education and living conditions worldwide, people in affluent high-income nations currently show overall a longer life expectancy than in poorer low-income countries. While there have been gains in education and per capita income in life expectancy, not all countries are making progress quickly and some have reversed health gains. As noted earlier, these countries are in sub-Saharan Africa and countries within the former Soviet Union (WHO, 2015a).

Public health emergencies in particular nations often occur as a result of multiple factors. Piot (2014) describes the Ebola epidemic in West Africa, for example, as a ‘perfect storm’ where decades of war have resulted in dysfunctional health services and because of low public trust in government and Western medicine, and traditional beliefs and cultural practices, five West African countries are now affected. The dysfunctional health services have been abandoned by many staff, causing further problems because people with treatable disease are no longer able to receive any services.

The human development index and happiness indicators

Life expectancy is only one measure of the robustness of the health of a population over time. The latest long-term trends in the inequality-adjusted human development index (HDI) (United Nations Development Program [UNDP], 2015) showed that the top 10 countries for life expectancy in order from the highest are Norway, Australia, Switzerland, Denmark, Netherlands, Germany, Ireland, United States (USA), Canada and New Zealand. These are all relatively rich countries. At the bottom of the 188 countries and in order are Mali, Mozambique, Sierra Leone, Guinea, Burkina Faso, Burundi, Chad, Eritrea, Central African Republic and Niger (the lowest). These are all relatively poor countries (the low-income countries). The HDI combines a country’s average achievements in health, education and income with how those achievements are distributed among a country’s population by ‘discounting'
each dimension’s average value according to its level of inequality. However, it also simplifies and captures only part of what human development entails and data is not available on all indices for every country (UNDP, 2015).

Inequalities are demonstrated with other indicators. Happiness indicators are being used increasingly by governments to guide policy and assess overall wellbeing (Helliwell et al., 2016). Average life evaluations, where 0 represents the worst possible life and 10 the best possible, show a range in the geography of happiness. There are differences in six key variables: gross domestic product (GDP) per capita, healthy years of life expectancy, social support, trust, perceived freedom to make life decisions, and generosity. Differences in social support, incomes and healthy life expectancy are the three most important factors. The World Happiness Report 2016 (Helliwell et al., 2016) shows that Denmark is closely followed by Switzerland and Iceland with all having scores of slightly more than 7.5. The rest of the top 10 include Norway, Finland, Canada, Netherlands, New Zealand, Australia and Sweden. There has been a big turnover between 2012 and 2015 at the bottom end where average ladder scores are below three. Most of these countries are in sub-Saharan Africa, with the addition of Afghanistan and a further drop for Syria. The 2016 report focuses on the inequality of happiness within and among countries. Once again, these indicators are associated with socio-ecological factors and in particular, war in Syria and Afghanistan. The Happy Planet Index is another index where progressively higher scores are given to nations with lower ecological footprints as well as wellbeing, life expectancy and inequality of outcomes, and these are not always high-income countries (see http://happyplanetindex.org/about/).

Population health improvements: it’s not just about health systems

The affluent nations have benefited from the general improvements in human health that came about in the 20th century due to improved living conditions—particularly sanitation, water supply and nutrition—and investments in public infrastructure such as education and health services. In parallel, economic security was achieved by industrial growth, technological advancement, trade and the development of a skilled workforce to support it. Furthermore, advances in scientific knowledge and access to health care have been factors in prolonging life expectancy and quality of life for those who can afford to pay. Life expectancy for the populations of high-income nations increased by around 20 years during the 20th century (WHO, 2015d). During the latter part of the 20th century, a number of low- to middle-income countries (LMICs) were encouraged to embrace globalised trade. Many people within these nations emerged from poverty and the changes are reflected in improvements in their population health status and life expectancy overall. Like the health gains in affluent nations, population health improvements in these nations reflect the changing shape of their societies, their economic, public health and social policies, and the quality of their health care systems; however, there are still significant inequities within all societies. While economic growth has contributed to many improvements, it should also be noted that a focus on economic growth alone can be detrimental to the health of some within a population due to a country’s choices around taxation, wealth distribution and neoliberal-inspired policies including austerity measures that reduce spending overall on public services such as education and health.

Factors that influence comparisons of health status between nations include geography, climate, natural resources and culture, as well as influences such as the political philosophy. The philosophy of a democratically elected government will determine to what extent equity is a principle underpinning public policy. For example, wealth redistribution through taxation is very influential. Nations that tend to have a graded taxation system with higher taxation rates for the wealthy are able to fund more and better social services, such as universal health care, dental care, transport, child care and housing assistance for their poor. When democratically elected governments adopt a neoliberal or user-pays approach to health policy, health risks for vulnerable members of society increase (PHM et al., 2014).
HEALTH CARE SYSTEMS

In terms of strengthening health care systems, there is great inequity in global health care spending. Richer countries spend more on health resources than poorer countries (UNDP, 2011). Globally, health care spending has grown substantially due to growth of the medico-industrial complex, referring to the health system which has an important (if not primary) function of making profits and two secondary functions, research and education (Navarro, 1976; and Insight 1.1).

Non-demographic factors such as technology and administrative costs have been important drivers of health care costs (Bryant & Sonerson, 2006; Mooney, 2012). This growth has occurred primarily in affluent countries such as those that are members of the Organization for Economic Cooperation and Development (OECD). However, higher spending on health care does not necessarily reflect that the system is based on equity, nor does it mean that universal access to basic public health services, such as sanitation, water supply and immunisation, is available. Over the past decade some LMICs are moving closer to various forms of universal health coverage (UHC); for example, China, Mexico, Rwanda, Turkey, South Africa, Brazil, Mexico and Tunisia (PHM et al., 2014) and the Western Pacific Region of the WHO (WHO, 2016). UHC is one of the targets for the Sustainable Development Goals. However, these developments are not without challenges and it will be important to see how this coverage impact on human development and life expectancy indices within each country. In these countries, the People’s Health Movement et al. (2014, p. 2) suggest that the current ‘dominant interpretation of UHC today – weakening public health systems and the pursuit of private profit’ needs to be understood. Their analysis of some of the transformations in these countries and the challenges is instructive. Waitzkin and Hellander’s (2016) discussion on health care reform is also instructive (Insight 1.1).

It is important to reiterate that ‘universal healthcare, while critical, does not guarantee equal opportunity to be healthy. Universal solutions (aimed at the entire population) can be very effective in improving average health, but do not necessarily alter underlying health disparities’ (Turrell et al., 2006 in Duckett, 2016, p. 4).

The focus of health care spending in Australia

The focus of the Australian health care system’s spending overall has been largely on the provision of acute illness care services to individuals. This means that attention and resources are focused on treating the end result rather than the cause of health problems, and the scope for increasing activity to prevent health problems is great. This is reflected in how Australia spends its health budget.

INSIGHT 1.1 Neoliberal-inspired health care reform

Waitzkin and Hellander (2016) argue that the aim of reform of the Colombian health system, which began in 1994 and influenced Latin America, Europe and the Unites States, was to improve access for the uninsured and underinsured in collaboration with the private, for-profit insurance industry. However, the plans were built on ‘unproven claims about the efficiency of the private sector and enhanced quality of care under principles of competition and business management’ (p. 747). The reform was (understandably) ‘favored by international financial institutions and multinational insurance corporations [because under this scheme there was] enhanced access by corporations to public-sector trust funds’ (p. 747). Waitzkin and Hellander contend that the Affordable Care Act (Obamacare and its predecessors) ‘maintains this historical continuity by dealing with health care as a commodity bought and sold in a marketplace, rather than a fundamental human right to be guaranteed according to principles of social solidarity …’ (p. 747).
In 2013, Australia spent 10% on health as a share of its GDP (Australian Institute of Health and Welfare [AIHW], 2016). However, the AIHW (2016) reports that growth in the government contribution to health expenditure slowed and in some areas expenditure declined. The areas of expenditure that most affected the slowdown in growth included public health, benefit-paid pharmaceuticals, administration and patient transport expenditure. In 2011–12, only 1.7% of the total health expenditure in Australia was for prevention, protection and promotion services in Australia (AIHW, 2014b) which was less than 2010–11. An estimated $6639 was spent per person on health in 2013–14. In 2010–11, health expenditure for Aboriginal and Torres Strait Islander people was estimated at 3.7% of Australia’s total recurrent health expenditure. The Aboriginal and Torres Strait Islander population comprised 2.5% of the Australian population at this time. Expenditure equated to $7995 per Indigenous person, which was 1.47 times greater than the $5437 spent per non-Indigenous Australian in the same year (AIHW, 2013) and yet the life expectancy is lower for Indigenous Australians than for non-Indigenous Australians, although some gains have been made. This demonstrates that even within affluent nations with strong public health care systems, there are differences in health status and life expectancy between different groups of the population. Here, the impacts of the socio-ecological determinants of health within nations become apparent and there is abundant evidence to suggest that inequalities in health emerge in unequal societies (Wilkinson & Pickett, 2009; WHO, n.d.). Furthermore, access to health care services is influenced by the degree to which the national health system is underpinned by the principle of equity and clearly, there is scope for Australia to focus more of its health expenditure on the promotion and protection of health using a socio-ecological framework. Particular subpopulations or groups suffer the cumulative effects of a number of socio-ecological determinants of health. These groups are notably people living in poverty, those from cultural, ethnic and social minority groups, and people from isolated rural communities, who tend to have worse health. Additionally, they have less access to medical practitioners and specialist health professionals, and suffer more accidents and chronic illnesses. Poverty results in poorer health status, not necessarily because of lower differential access to funds, but because the poor are more exposed to discrimination, violence and dangerous workplaces, and often take more risks with their health.

**Life expectancy and health inequalities in Australia and New Zealand**

**Australia**

Differences in life expectancy between population groups and geographical regions can indicate underlying health inequalities (AIHW, 2016). Over the last two decades, Australia has consistently ranked in the top 10 of OECD countries for life expectancy at birth. In 2013 Australia ranked sixth (AIHW, 2014a). However, as we have noted earlier, although Australians have high average levels of health by world standards, significant health inequalities remain. Population groups with worse than average health include Australia’s Aboriginal and Torres Strait Islander (hereafter ‘ATSI’ or ‘Indigenous’) peoples, those with low socio-economic status (SES), people living in rural or remote areas, sole parents, and people living with disability or mental illness. The social disadvantages Indigenous Australians experience in relation to housing, education, income and employment have contributed to the differences in life expectancy and health outcomes between Indigenous and non-Indigenous people (AIHW, 2016). ‘Hotspots’ of health inequality have been identified in Victoria and Queensland (Duckett, 2016), and Vinson, Rawsthorne et al. (2015) report that a disproportionately high level of disadvantage is experienced in a small number of communities within Victoria. Vinson et al.’s *Dropping off the Edge 2015* shows that 11 postcodes accounted for a nine-fold overrepresentation in disadvantage for life opportunities in areas such as social wellbeing, health and community safety, and access to housing, education and employment. There were dominant features in these postcodes of high unemployment, interaction with the criminal justice system, low levels of education and significant levels of disability.
New Zealand

The New Zealand Health Survey (Ministry of Health, 2014) shows similar health indicators to Australia. In 2013, New Zealand ranked 13th in the world for life expectancy. Although this is relatively high by world standards and the majority of New Zealanders report being in good health, adults and children living in the most deprived areas and Māori and Pacific adults have higher rates of health conditions such as diabetes and asthma. Diagnosed mental health conditions are rising. These population groups have higher rates for all health risks as well, including smoking, hazardous drinking and obesity. Social disadvantage is experienced by these groups in particular.

SOCIO-ECOLOGICAL DETERMINANTS OF HEALTH AND ILLNESS

The data clearly indicates that there are many factors that influence health and illness. A range of evidence indicates that inequalities in socio-ecological factors will result in differences in health status and life expectancy within nations and between nations (e.g. AIHW, 2016; Craig et al., 2015; PHM et al., 2014; Wilkinson & Pickett, 2009). The conditions in which people are born, live, work and age have a powerful influence on their health. There is generally no single cause or single contributing factor to health or illness. Inequalities in these factors lead to unequal health outcomes, and the majority are avoidable and thus inequitable. Along with health care interventions, the interactions between human biology, lifestyle and the physical and social environments impact on health. These factors are called the socio-ecological determinants of health. Within these broad parameters, social factors that determine physical and mental health status include poverty, income, employment, education and access to community resources. These factors create the life experiences and opportunities that in turn make it easier or more difficult for people to make positive decisions about their health. Equity of access to social and health resources is an important factor in determining health outcomes (PHM et al., 2014; WHO, 2011; Wilkinson & Pickett, 2009).

While there are many actions that a person can take to protect their own or their family’s health, very often the socio-ecological context of their lives makes it impossible to take those actions. Perhaps they have been disempowered in some way, are alienated from society or perhaps are living in poverty.

Research highlights the relationship between lower socio-economic status and ill health, both within particular nations and when comparisons are made between nations (PHM et al., 2014; WHO, 2011; Wilkinson & Pickett, 2009). The WHO’s Civil Society Report on Commission of Social Determinants of Health (2007) explored the following determinants of health to provide guidance on social actions to tackle inequalities created by these factors.

1. Social gradient. The lower a person’s socio-economic position, the worse their health. Degrees of personal and social empowerment and freedom are significant for health outcomes at every level in society.
2. Health system factors. The degree to which the health system promotes equitable access to services, whether it actively perpetuates injustices, and the amount of out-of-pocket expenses all affect health outcomes. Comprehensive primary health care is a fundamental philosophy and approach to improving health.
3. Urban settings. Across the world a high proportion of urban dwellers live in slums, deprived of the basic public health services of housing, water, sanitation and food security.
4. Early development. Great variation in child mortality within and between nations is not explained by biological factors, and thus is preventable. Maternal education and nutrition are strategies that improve survival.
5. Employment conditions. Availability of work, the work environment and employment contract conditions reflect the social gradient; those at lower levels often have unsafe work conditions and lower levels of control.

6. Education and life course. The benefits of education accumulate across the life course for individuals and families, and across generations in society.

7. Priority public health conditions related to behaviour within the social context. Tobacco, alcohol and drug use and under- or over-nutrition are international issues of concern and are socially patterned, demanding social solutions.

8. Women and gender equity. Gender inequality gives an indication of wider inequalities across society. Gender bias particularly marginalises women in the workforce, in their property rights and in economic and social life.

9. The shape of society. Health inequities reflect the unequal distribution of power in a society and the opportunities for decision-making and accessing resources this brings. The degree to which household, workplace and national economic and social policies are underpinned by equity principles are key indicators.

10. Globalisation of trade, communications and transport influence conditions within nations and relations between them. There are potential benefits and risks, with clear evidence that the globalisation of trade has increased inequalities between nations.

Risk and protective factors for health and illness

The links between the socio-ecological determinants of health and health outcomes for individuals and populations are now well understood. Health outcomes are mediated through a number of risk and protective factors, relating to the context of people’s lives and their individual behaviours. Socio-ecological benefits or exposure to risks is unequally experienced across society (e.g. AIHW, 2016; FHM et al., 2014; Wilkinson & Pickett, 2009). The challenge now is to develop, implement and sustain appropriate strategies which will overcome inequalities. Figs 1.1 and 1.2 illustrate the ‘causal chain’ linking the socio-ecological context of people’s lives with health and illness.

Risk and protective factors at population or community level, including environmental risks, influence the physical and mental health of individuals. Risk factors increase the likelihood that an illness will develop or be exacerbated. Protective factors, including a healthy, sustainable environment, reduce the likelihood that a disorder will develop. Importantly, protective factors give people resilience. Risk factors associated with physical and mental illness include biological, behavioural, psychological, sociocultural, economic, environmental and demographic conditions and characteristics; the socio-ecological determinants of health.

Psychosocial risk factors have a significant influence on the decisions people are able to make about their health. These factors describe the individual cognitive or emotional states which are often reactions to the way people try to deal with the daily living situations and stressors in their lives. They also describe a person’s connection to others.

Behavioural risk factors describe the individual lifestyle behaviours that people engage in. These include decisions people make about their use of addictive substances, their food choices and to what degree they are physically active. These factors have been the primary foci of many government-initiated health education and behaviour-change strategies, because of their clear link with observable health status.

Physiological risk factors include factors such as genetic inheritances. The impact of these risk factors is clearly evident in measurable or observable states of health, such as in epidemiological measures of the incidence and prevalence of certain conditions in society and in outcome mortality and morbidity measures. Genes are often expressed differently in different environments.
PROMOTING HEALTH: THE PRIMARY HEALTH CARE APPROACH

FIGURE 1.1 Determinants of illness


FIGURE 1.2 Determinants of health

Why is it important to focus on all the determinants of health and the risk and protective factors? If we focus on these factors, we are able to improve the health of populations rather than focusing on individual gain alone. If we are to provide comprehensive and successful mental and physical health care, we need to apply a model of health care that includes a range of influences on health, including factors at the individual, family, community and societal levels.

Understanding the relationship between psycho–socio–enviro–cultural factors and common illnesses in society forms important knowledge for health practitioners. This knowledge informs the activities they undertake, the communities they choose to work with and the ways in which they work.

The health iceberg: a method for examining the determinants of health

The health iceberg model provides a useful way to examine the determinants of health, and the relationships between the determinants and health outcomes. The iceberg model can assist in planning activities using a variety of health promotion approaches (see Fig. 1.3). The health iceberg divides...
into three sections. The top section refers to what is apparent; the measurable states of health or health outcomes. Using the iceberg analogy, this refers to the small section that is visible above the waterline. These could be either positive or negative states of health. These observable states of health could include mortality and morbidity measures or the prevalence of known risk factors related to the physiological risk factors outlined in the previous section and the right-hand section in Fig. 1.1, such as high blood pressure. The section immediately below the iceberg waterline is connected to the visible state of health and can be identified and measured without too much difficulty. This section relates to individuals’ lifestyle choices and behavioural risk factors; for example, the link between smoking and lung cancer, poor nutrition and heart disease. Screening tools such as client history, biological indicators and screening tests are readily available to identify specific risks. Towards the bottom of the iceberg, well below the surface, are the psycho–socio–cultural determinants outlined previously and represented in the left-hand column in Fig. 1.1. Here the major factors that influence individual and population health are to be found. At the very bottom of the iceberg, underpinning the health of entire populations and future generations, are environmental factors. This diagrammatic representation is useful because it continues with the iceberg metaphor. Only a very small proportion is visible; there is far greater danger (to health status) hidden below.

It is interesting to do a simple exercise using the health iceberg model to examine heart disease. What are the factors that contribute to heart disease? (Risk factors that are not always observable but can be detected.) What are the structural issues? For example, a polluted environment contributing to poor living conditions, or the overarching economic imperative to make money and consume goods leading to overtime or a poor workplace environment that causes stress and which leads to these physiological symptoms. Perhaps fresh food is not available. This is very likely in remote areas. What are the lifestyle behaviours that contribute to heart disease? For example, a busy life with little physical activity, poor diet—takeaway food, frequenting ‘pubs’ and clubs with abuse of alcohol. What are the psycho–socio–cultural factors that contribute to heart disease via the factors above them in the iceberg? (What are the causes of the causes?) For example, grew up in a family where physical activity was not valued, lack of physical education at school, poor body image, no convenient, safe or affordable facility for activity, smoking is the normal behaviour valued among friends and family, low income so cannot afford a range of healthier foods, lack of knowledge of healthy diet, poor food preparation skills, poor use of health services to identify risk factors early. These stress factors will worsen for successive generations and for groups with the least power in society. We need to ask who are these people? Where do they live? Do they receive adequate social support?

Understanding the impact of the socio-ecological determinants of health within a nation is essential to guide health practitioners in choosing where they work, what they do, how they do it and with whom. While statistics can indicate morbidity and mortality in the population, indicators of progress in addressing the socio-ecological determinants of health are more difficult to capture. In Chapter 2 some indicators of wellbeing that can be used at family and community level as benchmarks for improvements are presented. Referring back to the iceberg analogy, these indicators refer to improvements in factors towards the bottom of the iceberg. Another indicator of the impact of the socio-ecological determinants of health is a burden of disease measure, such as the disability adjusted life year (DALY). This metric indicates the impact of early mortality and morbidity causing disability from chronic illnesses (PHM et al., 2014). In the iceberg analogy, DALYs are indicators of the impact of factors just below the waterline (e.g. high blood pressure, excess weight, smoking, high cholesterol and family history).

When we consider the multiple effects of the socio-ecological determinants of health, it is clear that they must assume the major priority in health promotion planning and activities. As indicated, there is generally more than one factor associated with each physical or mental illness. For instance, consider the impacts on the likely mental health status of an Indigenous Australian woman living in poverty who is isolated from mainstream Australian society and possibly from her Aboriginal
community. Similarly, what would be the likely mental health status of a middle-aged man who has recently arrived in Australia, who doesn’t speak English and has been granted refugee status? What would be their experience in accessing affordable, appropriate health care in Australia?

A comprehensive whole-of-government approach is needed if we are to fully protect and maximise the health of the community. Such an approach would need to consider the health consequences of public policy in all areas, including the health portfolio itself. This idea will be taken up further in the following chapters.

Understanding the global context is vital, and advocacy about global issues is a key role for health practitioners. Action on the socio-ecological determinants of health must be at all levels of society; national government policy must set the context for action on those factors which account for a significant proportion of health impacts and which are amenable to change. There is already sufficient evidence to inform action on the pathways or mechanisms to change these risk factors. The PHM et al. (2014) provide examples of countries in Latin America that have been subject to significant colonial and neoliberal exploitation and social and political change. They report that in Bolivia, the concept of ‘living well’ (vivir bien) ‘is contributing to the dismantling of these unhealthy legacies’ (p. 6) and in the health sector communitarian approaches to health care are being trialled (see Insight 1.2).

**INSIGHT 1.2 Vivir bien in Bolivia**

_**Vivir bien**_ is a grassroots movement of Indigenous Bolivians and wage earners and the self-employed. The aim is to ‘recover national identity and state sovereignty, build participatory democracy and restore natural resources’ (PHM et al., 2014, p. 334). This movement claims equal rights and opportunities for all cultural, ethnic and language groups and freedom from exploitation. Bolivia is described as a post-capitalist nation, which means finding alternatives to purely capitalist development (driven by neoliberalism). Essentially, the development in Bolivia is based on a socio-ecological approach, which is founded on two primary concepts. The first is based on Indigenous and agrarian realities and reaffirms the connection to, and importance of, nature. The second is based on wage earner and self-employed realities and the notions of equality and democracy. In the health sector, development is based on health as a right, a public good, understanding the socio-ecological determinants of health and in the Ministry of Health, developing a universal free health system in the framework of family, community and intercultural health policy (FCIH). These principles are excellent examples of the notion of comprehensive primary health care discussed later in the chapter in improving the social, environmental and cultural issues impacting on health (PHM et al., 2014).

**KEY FACTORS THAT INFLUENCE COMPARISONS OF HEALTH STATUS BETWEEN NATIONS**

**Economic globalisation and neoliberalism**

Neoliberalism is a policy model that transfers control of economic factors to the private sector from the public sector. This model has had a profound effect on health. The PHM et al. argue that:

_The [global] financial system is profoundly dysfunctional, triggering economic crises, increasing inequality, and generating potentially disastrous environmental impacts, while conspicuously failing to meet social goals such as poverty eradication, health_
for all’, access to education, and the fulfilment of basic needs for the majority of humanity. It is at least arguable that it is doing more harm than good.

(2011, p. 24)

This argument is emphasised by Oxfam (2015) (see Box 1.2).

The inequality gap is widening and probably ‘locking billions of people into a cycle of poverty and there aren’t the mechanisms there to pull them out of that’ (Szoke, 2016). This is a significant factor influencing health, education, living conditions, the functioning of the Earth’s ecosystem and thus quality of life and in some cases life expectancy. The quality of health care available to people within nations also influences health, as we have said, especially the degree to which equity underpins access to services (Wilkinson & Pickett, 2009; PHM et al., 2014). A major factor influencing access has been this rise of global neoliberalism and the adoption of economic policy decisions in line with that ideology (Labonté & Schrecker, 2007; Mooney, 2012; PHM et al., 2014). Neoliberalism is built around the belief that as much of national and international life as possible should be left to the effects of the market and that governments should minimise their involvement in public life. The beliefs support sovereign individuals and strong property rights (PHM et al., 2014). The 1970s commenced a significant period of social and political change internationally, which brought about changes in fiscal policies that continue to underpin international trade decisions and internal political policies. These policies include ‘public goods’ such as provision of universal health care, education and social welfare provisions (Labonté & Schrecker, 2007; PHM et al., 2014).

Internationally, liberalisation of trade proceeds, particularly within the development of regional arrangements, such as the European Community (EC), the trade agreement between the USA and Canada, similar agreements between Australia and New Zealand, and other agreements such as the ASEAN–Australia–New Zealand Free Trade Area (AANZFTA) and the Trans-Pacific Partnership Agreement (TPPA). Governments open up their economies to global markets and liberalised market processes, especially reducing export barriers and import taxes, which purportedly increases competition in global markets for all commodities. The two policy agendas of liberalisation of trade and privatisation of government assets have been adopted by many high-income nations and in some cases, imposed on low-income nations since the early 1980s. Using commercial principles for services that are not based on discretionary decisions contradicts the philosophical assumption that ‘public goods’ are distributed as a part of a national ethos of rights and fairness, and should not be purely profit-driven (Leeder, 2003). The negative health consequences of neoliberalism have arisen from a set of values fundamentally at odds with the comprehensive primary health care approach.

When a neoliberal ideology underpins national policy, economic exchange figures are almost the only criterion by which government policy success is measured (Hancock, 1999; Labonté & Schrecker, 2007). The socio-ecological impacts of these influences on national policy have been clearly articulated (e.g. Labonté & Schrecker, 2006; Mooney, 2012; PHM et al., 2014). Researchers and social

**BOX 1.2 Global wealth distribution**

Oxfam (2015) reports that 80 individuals own the same amount of wealth as the bottom half of the world’s population. In 2010, it was 388 people. In 2014, the richest 1% of people in the world owned 48% of global wealth, leaving just 52% to be shared between the other 99% of adults on the planet. Almost all of that 52% is owned by those included in the richest 20%, leaving just 5.5% for the remaining 80% of people in the world.

commentators have argued that globalised economic processes are having widespread and sustained social policy effects within nations, leading to the end of the many social welfare programs that are underpinned by taxation and wealth distribution policies, which support the philosophy of equality of opportunity (e.g., Beresford, 2000; Mooney, 2012; Oxfam, 2015; PHM et al., 2014). The TPPA is an example and a concern for many health practitioners in Australia. The TPPA includes investor-state dispute settlement mechanisms that will enable foreign corporations to bring claims against Australian governments over health and environment policies (Gleeson, 2015).

The adoption of neoliberalism within nations has supported the burgeoning development of globalised economic business. According to Labonté and Schrecker, globalisation ‘describes the ways in which nations, businesses and people are becoming more connected and interdependent across national borders through increased economic integration, communication, cultural diffusion and travel’ (2006, p. 3). Globalised neoliberal inspired policies have been the driving force of other dimensions of globalisation, such as developments in communications technologies and cultural homogenisation. Globalised economic changes have local, social, environmental and health impacts.

**Transnational corporations**

The influence of transnational corporations (TNCs) on the world economy is significant. Many have annual profits that exceed the GDPs of low- and middle-income countries and seek to exert a great deal of power in monetary regulations. TNCs use their profits and power to lobby governments to create a policy environment that protects and enhances their interests further (Oxfam, 2015). This in turn reflects the diminished relative power of individual nations to influence trade decisions made by global corporations. They are relatively powerless to achieve an equitable price when they must compete in price negotiations between the multinational corporations and powerful trading blocs, such as the USA, EC and TPPA which are able to directly subsidise producers, so market prices are artificially low but good producer returns are safeguarded (Institute for Agriculture and Trade Policy [IATP], 2004). When the small nations are unable to compete in trade, they go into debt and internal political systems become unstable.

**International organisations: the IMF, WTO and World Bank**

International organisations such as the WHO, the International Monetary Fund (IMF), the World Bank and the World Trade Organization (WTO) have also been substantially powerful in structuring the global marketplace, and the decisions they make are controlled to a significant extent by the rich and powerful countries. Within these organisations there is an ‘economically weighted’ voting system; that is, the high-income nations (amounting to 14% of the world population), dominate the global decision-making processes, and the USA alone has a veto on all major policy decisions (PHM et al., 2011).

Overall, economic globalisation has led to a number of developments that have had a grave impact on the health of people in the least powerful nations and on vulnerable groups within affluent nations. Inequality has risen, with marked growth in the concentration of wealth in the hands of a few. As a consequence, health inequalities between rich and poor have been exacerbated (Mooney, 2012; Oxfam, 2015; PHM et al., 2014).

Globalisation has negative impacts on socio-ecological determinants of health through both direct means (by influencing health system structures, funding and health policy) and indirect means (where the impacts of global trade competition on national economies have flow-on effects to the health sector). A series of guidelines for ‘making globalization work for the benefit of health’ (Woodward et al., 2001, p. 879) will require new economic policies with population wellbeing at their core (Oxfam, 2015; PHM et al., 2014). Oxfam has called on governments to adopt a seven-point plan to tackle inequality.
1. Clamp down on tax dodging by corporations and rich individuals.
2. Invest in universal, free public services such as health and education.
3. Share the tax burden fairly, shifting taxation from labour and consumption towards capital and wealth.
4. Introduce minimum wages and move towards a living wage for all workers.
5. Introduce equal pay legislation and promote economic policies to give women a fair deal.
6. Ensure adequate safety nets for the poorest, including a minimum income guarantee.
7. Agree on a global goal to tackle inequality.

**Neoliberalism: the impact of structural adjustment, financialisation and austerity programs on health**

There have been three major phases of neoliberalism globally—structural adjustment, financialisation and austerity—all of which have impacted negatively on population health (PHM et al., 2014). Throughout the 1970s, a number of nations accumulated severe trade deficits after having been encouraged to borrow large amounts of money from the major banks. With changes to the international financial situation, interest rates 'skyrocketed' in the 1980s, resulting in those countries owing huge debts that they could not pay (Labonté & Schrecker, 2006; PHM et al., 2014). Practically all of Latin America and sub-Saharan Africa, and a considerable number of Asian and Eastern European countries, faced acute debt problems by 1983 (PHM et al., 2014).

The banks were concerned that these countries would not be able to repay their loans, and their political systems would become unstable; as a result, the IMF and the World Bank stepped in. They offered to refinance the loans on the proviso that countries accepted 'structural adjustment programs', designed to ensure that countries serviced the debt owed. However, there were major consequences for their internal policies. There were four main tenets of the structural adjustment programs which debt-ridden countries agreed to in order to qualify for loans. These were, first, devaluation of the local currency, which immediately decreased the purchasing power of individuals; it made exports cheaper for the nations they sold to, and therefore more competitive, and imports more expensive, therefore less desirable. Second, governments were required to make drastic cuts to public spending, such as health, education and other social services. Third, exports were promoted through, for instance, a move away from domestic food production to production of export goods and putting a freeze on local wages to ensure low-cost tradable items. Fourth, countries were required to open up their economy for overseas goods and investment, such as through easing rules for foreign investment or bypassing environment legislation (Bello, et al., 1994; Labonté & Schrecker, 2006). These changes have increased socio-economic inequalities in and between nations and impacted seriously on the poorest of the poor. For example, the reduction in land for family food production and subsistence farming has meant that many of the poor can no longer get enough food to eat.

In the face of criticism that the impacts of structural adjustment packages benefited the loan agencies of the IMF and World Bank, but consigned the recipient nations to overwhelming debt, some reform of the programs and debt-forgiveness were implemented. In recent years, poverty reduction rhetoric has replaced structural adjustment in the language of the World Bank and IMF; however, the impacts on low-income countries is very similar. Vast quantities of money are being moved each year from poor countries to rich countries, in order to service debt repayments. The impact of this drain on resources is experienced most heavily by the poor, especially children (Stallings, 2003 cited in Labonté & Schrecker, 2006, p. 17; PHM et al., 2011).

Many affluent industrialised countries have undergone their own self-imposed structural adjustment programs, including Australia and New Zealand. The gap between rich and poor has increased, as it has globally. Structural adjustment, finalisation and austerity continue globally. Following the
global financial crisis (GFC) the PHM et al. (2014, p. 2) argue that public investment in education, health care and infrastructure was attacked. This highlights the inextricable link between the political philosophy of an elite and the social impacts felt worldwide.

Current crises and connections to health

According to the PHM et al., ‘neoliberal globalisation has produced a global health crisis’ (2014, p. 2). Currently, the world is facing five acute major crises: food, fuel, financial, development and environmental degradation leading to Earth system changes such as climate change (PHM et al., 2011). The five crises are each connected to the other and each impact on the health of populations. The causes of these crises are said to be:

• global economic inequality
• the dominant role of the financial sector
• unequal global economic integration, and
• ineffective and undemocratic global governance.

Structural adjustment, financialisation and austerity packages following the 2007–08 GFC have affected high- and low-income countries. Many are arguing that the austerity created by these packages is not only increasing inequalities within nations, but is also causing the nations to lose any sense of hope for the future (Mooney, 2012). The bank write-downs for the 2007–08 GFC alone are estimated as ‘broadly equivalent in purchasing power terms to the annual income of the poorer half of the world population’ (PHM et al., 2011, p. 9) and this approach to financial crises continues. The globalised trade processes described earlier are having a drastic effect on food availability and prices, for example, which is of particular concern to low-income countries. Producers often receive better returns for fuel oil crops, such as canola, than for food crops, such as grains. Grain shortages cause dramatic price rises over a short period and the number of starving people in poor nations increases proportionately (PHM et al., 2011; WHO, 2006). According to De Schutter (2010), after the GFC ‘the food price crisis arose because a deeply flawed global financial system exacerbated the impacts of supply and demand’ (cited in PHM et al., 2011, p. 12). Further, climate change contributed to the food crisis as major cereal producers such as Australia experienced drought and other exceptional weather patterns. Some ‘emerging market’ countries have been less affected by the food and fuel crises overall but are vulnerable to the financial crisis because of their reliance on commercial capital. As we have discussed earlier, the gap between rich countries and poor countries is widening, with very poor countries unable to provide the infrastructure and public goods for living conditions for health (PHM et al., 2011). Their capacity for adaptation to climate change is also compromised.

Evidence shows that more equal societies are healthier and so it is reasonable to suggest that reducing socio-ecological inequalities should be the primary aim of health systems and other sectors. The World Bank, however, favours ‘a health system model of mixed public/private service delivery and stratified multi-payer health insurance markets with minimal safety net for the poor’ (PHM et al., 2014, p. 255). These preferences reflect the power of neoliberalism and although there are sufficient resources worldwide to meet the challenges in health inequalities, ‘many national health systems are weak, unresponsive, inequitable—even unsafe’ (WHO, 2006). In Australia, Baum et al. concluded that ‘a focus on clinical service provision, while highly compatible with neoliberal reforms, will not on its own produce the shifts in population disease patterns that would be required to reduce demand for health services and promote health’ (2016, p. 43). They argue that comprehensive primary health care is much better suited to that task. It is worth noting that only 10 to 15% of gains in life expectancy are estimated to be attributable to health care (Leys, 2009, p. 6 in PHM et al., 2014) but international responses such as comprehensive primary health care have made important gains in the quality of life for many. The WHO provides international leadership in this sector but it faces many challenges.
GLOBAL RESPONSES TO HEALTH AND ILLNESS

The World Health Organization

The WHO is a global health organisation established in 1948 under the auspices of the United Nations to improve the health of the world’s people. It is currently made up of 194 member states. Landmark documents developed by the WHO such as the Declaration of Alma-Ata (WHO, 1978) (see Appendix 1), the Ottawa Charter for Health Promotion (WHO, 1986) (see Appendix 2) and affirming declarations such as the Rio Political Declaration on Social Determinants of Health (SDH) (WHO, 2011), demonstrate the evolution of the organisation’s response to emergent health issues. A progress report on activities summarises the current focus on the socio-ecological determinants of health as a result of the 2011 declaration and demonstrates that the principles and provisions set out in the constitution in 1948 have remained constant. In 2015 they include:

- Better governance for health and development—Health in All Policies Training
- Health sector reorientation towards social determinants of health and reducing health inequities
- Guidance on pro-equity linkages between environmental and social health determinants
- Monitoring progress on the SDH and health equity.

(WHO, 2015c)

The Declaration of Alma-Ata

In 1978, the WHO and United Nations Children’s Fund (UNICEF) held a major international conference on primary health care in Kazakhstan, attended by representatives from 134 nations. The outcome of the conference was the Declaration of Alma-Ata (WHO, 1978). Through this Declaration, the member states of the WHO outlined a way forward for health systems based on comprehensive primary health care following growing concern in the 1960s and 1970s that the health status of some populations had not improved as predicted, despite the investment in, and rapid growth of, health care systems. Globally, there had been the belief that medical knowledge and technology would solve health problems, but there was a growing scepticism of the role and power of medicine itself and the value of medical treatment (e.g. Illich, 1975). It became increasingly apparent that medical services alone had a limited effect on the health of populations and that it was public health in its broadest sense that was responsible for most population health improvement (McKeown, 1979). Despite wide-ranging evidence that social conditions such as poverty, living conditions and education have a great impact on health, few countries had acted specifically to improve these conditions.

There were differences between high-income and low-income countries. High-income countries had invested heavily in acute medical care systems; however, low-income countries could not afford this investment and people in these countries often lacked access to even basic health care services. Some countries, including high-income countries, began to review their health systems and the approach to health and illness care. In Australia, for example, the Labor Government began to invest in community-controlled and community-based multidisciplinary health services in 1973. The Lalonde Report (1974) had a significant impact in Canada and other high-income countries. In that report, health was represented as being dependent on biological, environmental and lifestyle factors and access to health systems. This was a dramatic shift away from the focus on the biological determinants of health and medical interventions that had dominated health sector thinking in high-income countries in the first part of the 20th century.

Inspiration for the Declaration of Alma-Ata was drawn from the Chinese model of barefoot doctors and the participation of Australia’s National Aboriginal and Islander Health Organisation representatives in drafting the declaration. Ever since, ‘Aboriginal community controlled health services have been the torch bearers for comprehensive primary health care in Australia’ (PHM et al.,...
This conference and declaration are now regarded as a critically important milestone in the promotion of health equalities. Since then, this philosophy has been reiterated internationally in numerous documents, including those in the appendices of this book.

The WHO defines health as ‘a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity’ (WHO, 1948). The tenets of the constitution are that:

- the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition
- the health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and states
- the achievement of any state in the promotion and protection of health is of value to all
- unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger
- healthy development of the child is of basic importance
- the ability to live harmoniously in a changing total environment is essential to such development
- the extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health
- informed opinion and active cooperation on the part of the public are of the utmost importance in the improvement of the health of the people, and, finally,
- governments have a responsibility for the health of their peoples, which can be fulfilled only by the provision of adequate health and social measures.


The prerequisites for health outlined in the declaration include peace, shelter, education, social security, social relations, food, income, empowerment of women, a stable ecosystem, sustainable resource use, social justice, respect for human rights and equity (WHO, 1978). The declaration set out a philosophy designed to ensure these prerequisites for health are met; that a strategy, a set of activities and a level of care for health improvement permeate through the entire health system (Vuori, 1986).

**Comprehensive primary health care: a philosophy**

Comprehensive primary health care (CPHC) is essential health care based on practical, scientifically sound and socially acceptable methods. CPHC is made universally accessible to the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

*(WHO, 1978)*

The CPHC philosophy enables societies to take action on the prerequisites for health and address the socio-ecological determinants of health. These are the causes of health and ill health.

The Declaration of Alma-Ata (WHO, 1978) provided the foundation for CPHC that was seen as the key to achieving a level of health that permitted people of the world to lead a socially and economically productive life. Three major principles stand out in the Declaration of Alma-Ata:

1. equity
2. social justice
3. empowerment.
Equity means fairness, while social justice implies a commitment to fairness. Empowerment is a process which enables people to participate in a way that improves their lives and achieves social justice. These three key principles underpin all CPHC activities, and are discussed in more detail in Chapter 2.

The WHO continues to affirm the philosophy of primary health care (WHO, 2011; WHO, 2015c). The WHO calls for a global commitment for the promotion of health equity by taking action on the socio-ecological determinants of health. The philosophy provides a foundation for improving daily living conditions, tackling inequitable distribution of power, money and resources, and measuring and understanding problems and assessing the impact of action (WHO, 2011; WHO, 2015c). However, challenges to this philosophy and action are unremitting (PHM et al., 2014). The absence of reference to CPHC in the Sustainable Development Goals (Chapter 3) is an obvious example.

Comprehensive and selective primary health care

The words ‘selective’ and ‘comprehensive’ are good descriptors of the different approaches to, or ways of doing, primary health care. Selective primary health care (SPHC) (Walsh & Warren, 1979, cited in Baum, 2008) is based on the illness system and a medical model of health care, while CPHC is based on health and is more consistent with the philosophy discussed in this book. CPHC is a developmental process where the principles of equity, social justice and empowerment underpin the work for socio-ecological changes necessary to improve health. The aim in CPHC is to address the determinants of health; that is, the conditions that generate health and ill health. Therefore, provision of medical care is only one aspect of CPHC. SPHC concentrates on treating illnesses. Thus, while CPHC focuses on the process of empowerment and increasing people’s control over all those influences that impact on their health, SPHC operates in a way that assumes that the health system alone creates health and ensures that control over health is maintained by health practitioners. In discussing the two perspectives, some have likened it to ‘the individual versus the system’ (Green & Raeburn, 1988, cited in Baum, 2008, p. 35).

Arguing for comprehensive over selective primary health care is not to argue against the importance of the health care system in addressing specific diseases. SPHC has produced important gains, such as reducing disease rates through surveillance, screening, immunisation and rehabilitation. Clearly, we must address those diseases that cause human suffering and premature death. However, by only addressing those diseases, we risk perpetually attempting to address the end result of the problem instead of addressing the root causes of the diseases themselves or the socio-ecological conditions that perpetuate disease and other suffering. CPHC addresses these diseases and other issues in their socio-ecological context, using a process where the expertise that ordinary people have and their right to exert control over their own lives is recognised.

CPHC has been the linchpin for Aboriginal community controlled health services (ACCHS) in Australia. It is essential in tackling the broad socio-ecological determinants of health and improving greater access to culturally acceptable, affordable health care. ACCHS have played a critical role in developing ‘better informed Aboriginal health policy development’ (PHM et al., 2014, p. 396) and have provided a CPHC strategy for organising health care. As noted by Ah Chee (2015), ‘Aboriginal community controlled health services are key to Closing the Gap by 2030 (Hoy, 2009) and they are needed now, more than ever’. There are differences in how primary health care is implemented. Box 1.3 provides key areas in which SPHC compares with CPHC.

Comprehensive primary health care: a strategy for organising health care

When the philosophy of CPHC is implemented, a particular strategy for the organisation of health care becomes apparent. A balanced system of health promotion, disease prevention, rehabilitation and illness treatment can be developed, with the entire system built to meet the goals of CPHC; equity, social justice and empowerment. Dealing with the increasing burden of disease worldwide
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requires ‘upstream’ health promotion and disease prevention in the community as well as ‘downstream’
disease management within health care services. Boxes 1.4 and 1.5 provide examples of comprehensive
primary health care as a strategy in Australia. A health system based on CPHC will:

• reduce exclusion and social disparities in health (universal coverage)
• organise health services around people’s needs and expectations (collaborative
service delivery)
• integrate health into all sectors (public policy)
• pursue collaborative models of policy dialogue (leadership), and
• increase stakeholder participation.

(WHO, 2008a)

**Comprehensive primary health care: a set of activities**

The Declaration of Alma-Ata (WHO, 1978) highlighted a minimum set of activities that need to occur if CPHC is to be implemented in a health care system. Box 1.6 provides an international example or CPHC activities, which include:

• education concerning prevailing health problems and the methods of preventing and
controlling them
BOX 1.4 CPHC as a strategy for organising health care: National Aboriginal Community Controlled Health Organisation (NACCHO)

NACCHO is 'a living embodiment of the aspirations of Aboriginal communities and their struggle for self-determination' (NACCHO, http://www.naccho.org.au/about). It represents over 150 Aboriginal Community Controlled Health Services (ACCHSs) in urban, regional and remote Australia. The organisation aims to increase the capacity of ACCHSs in health policy development and in controlling and delivering effective health care. These services are initiated and operated by the local Aboriginal communities to deliver ‘holistic, comprehensive and culturally appropriate health care to the community which controls it, through a locally elected Board of Management’. NACCHO’s work includes the following.

- Promoting, developing and expanding the provision of health and wellbeing services through local ACCHSs.
- Liaison with organisations and governments within both the Aboriginal and non-Aboriginal community on health and wellbeing policy and planning issues.
- Representation and advocacy relating to health service delivery, health information, research, public health, health financing and health programs.
- Fostering cooperative partnerships and working relationships with agencies that respect Aboriginal community control and holistic concepts of health and wellbeing. The National Aboriginal Community Controlled Health.


BOX 1.5 New Zealand Health Strategy: The future we want

- Acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi
- The best health and wellbeing possible for all New Zealanders throughout their lives
- An improvement in health status of those currently disadvantaged
- Collaborative health promotion, rehabilitation and disease and injury prevention by all sectors
- Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay
- A high-performing system in which people have confidence
- Active partnership with people and communities at all levels
- Thinking beyond narrow definitions of health and collaborating with others to achieve wellbeing


BOX 1.6 CPHC as a set of activities: Médecins Sans Frontières

Médecins Sans Frontières (MSF) dispenses essential drugs such as vaccines, and assists local communities with water and sanitation programs which, if used alone, would be described as SPHC. However, MSF also provides training of local personnel to work with disadvantaged groups in remote health care centres and slums. MSF works at both preventing illness and treating disease by providing essential medical care, and also assists with essential infrastructure support in a socially acceptable and empowering way to improve living conditions and health care. Other potential priorities are also acknowledged by the WHO; for example, priorities set by local communities themselves.

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- promotion of food supply and proper nutrition
- provision of an adequate supply of safe water and basic sanitation
- provision of maternal and child health care, including family planning
- immunisation against the major infectious diseases
- prevention and control of locally endemic diseases
- appropriate treatment of common diseases and injuries
- provision of essential drugs.

Comprehensive primary health care: a level of care

The term ‘primary health care’ is often used to refer to primary-level health services; that is, the first point of contact with the health system for people with health problems. In a CPHC system, this level of care needs to be the most comprehensive. In this way, problems can be dealt with where they begin. Primary-level health services include ACCHSs, community health centres, pharmacies and local governments. Non-government organisations (NGOs) and community groups are also an important part of CPHC services. However, these services can only be regarded as CPHC services if the CPHC philosophy underpins the way in which those first-level services are provided. That is, the work is guided by the principles of equity, social justice and empowerment. Community participation in decision-making, collaboration with other sectors within the community to deal effectively with health issues, and incorporation of health promotion and disease prevention, is essential to the work.

There are examples worldwide of successful CPHC organisations that have improved the health of populations (PHM et al., 2014), including ACCHSs (Box 1.4). Programs in India, South America and Asia have ‘shown consistent commitment to equitable, broad-based and multi-sectoral development’, with each reflecting their own histories (PHM et al., 2011, p. 51). For example, Reeve et al. (2015) evaluated primary care partnerships between ACCHSs, a hospital and a community health service in Western Australia between 2006 and 2012. The ‘intervention’ was the integration of health promotion, health assessments and chronic disease management with an acute primary care service. They found that occasions of service increased to very remote outlying communities in particular. Health assessment uptake increased which in turn led to people being placed on a care plan and quality-of-care indicators showed improvements. There was a downward trend in mortality.

Primary care

The term ‘primary care’ is often used interchangeably with CPHC. Very often, primary care denotes selective primary health care (described previously). However, primary care is not the same as CPHC, unless it is underpinned by the philosophy and meets all of the criteria set out in the section above. To be effective, CPHC principles need to be applied throughout the health system and beyond. To address socio-ecological determinants of health, the partnerships extend outside the health sector to organisations such as local governments, the departments of agriculture and sustainability, and universities. As we have said, given the recognition of the need for action outside the health sector to improve health, the CPHC philosophy has implications way beyond the health system.

Australia

The primary health networks (PHN) in Australia provide a good example of the loose use of the terminology. Thirty PHNs have been established with the aim of improving ‘primary health care’ in Australia. They are designed to be ‘clinically focused, with general practice at the heart of improving the delivery of primary health care’ (Australian Government, 2014). The PHNs were ‘established to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and to improve coordination of care … PHNs will achieve these objectives’
by working directly with general practitioners, other primary health care providers, secondary care providers and hospitals to facilitate improved outcomes for patients’ (Department of Health, n.d.). The six key priorities areas in PHNs are mental health, Aboriginal and Torres Strait Islander health, population health, health workforce, eHealth and aged care. These are important areas; however, the clinical leadership expected from medical practitioners and allied health professionals within the health sector may limit CPHC and the vision of NACCHO, for example, as described in Box 1.4. Examination of partnerships in population health planning between Medicare Locals (the precursor to PHNs) and local health networks (LHNs) in South Australia, and the factors that facilitated or constrained collaborative work (including data sharing and synthesis, program implementation and community consultation) found that the focus of LHNs on acute and intermediate care, the lack of system-level strategies to support collaboration, and constant policy and structural changes leading to uncertainty in the primary health care landscape were perceived as key barriers to collaboration (Javanparast et al., 2015). In Victoria and South Australia, the community health centres set up in the 1970s and 1980s had local boards of management but since then many have been amalgamated and found it more difficult to practise CPCHC. No ACCHSs have been established in Central Australia for 25 years (Ah Chee, 2015). However, evaluation of the Primary Care Partnerships (PCPs) strategy in Victoria has shown that integrated planning has improved; the organisational capacity for health promotion has improved; resource efficiencies have been achieved; and overall the strategy has contributed to healthier communities (Department of Health, Victoria, 2013). The PCPs were designed to prevent illness and reduce morbidity using integrated health promotion strategies, agency partnerships and better coordination of care, especially for the management of chronic conditions.

New Zealand

In New Zealand, 20 district health boards (DHBs) plan, manage, provide and purchase health services for the population of their district (local geographic area) to ensure services are arranged effectively according to the specific demography and needs of their population. DHBs manage funding for primary care, hospital services, public health services, aged care services and services provided by other non-government health providers including Māori and Pacific providers. DHB objectives seem to include the notion of CPHC; for example, ‘promoting the inclusion and participation in society and the independence of people with disabilities; reducing health disparities by improving health outcomes for Māori and other population groups; reducing—with a view toward elimination—health outcome disparities between various population groups’ (Ministry of Health, n.d.). Furthermore, DHBs are expected to ‘show a sense of social responsibility [and] to foster community participation in health improvement’ (Ministry of Health, n.d.).

Comprehensive primary health care and political will

Implementation of CPHC is clearly a massive task involving considerable political will and major changes in health systems dominated by neoliberal thinking. This is politically significant. Given the power of the medico-industrial complex with a focus on profit, and the urgent need for basic medical services in some parts of the world, it is not surprising that those already in power in the high-income world set priorities based on the medical model of health care (Mooney, 2012). CPHC threatens those with vested interests in the current system; in particular, those who have power in, and who make money from, a technologically dependent health system.

COMPREHENSIVE PRIMARY HEALTH CARE, THE OTTAWA CHARTER FOR HEALTH PROMOTION AND THE NEW PUBLIC HEALTH MOVEMENT

The Ottawa Charter for Health Promotion (Appendix 2) was built on the progress made through the Declaration of Alma-Ata and defines health promotion as ‘the process of enabling people to
increase control over, and to improve, their health’ (WHO, 1986). The Ottawa Charter for Health Promotion is regarded as the formal beginning of the ‘new public health’ movement, a term that has widespread recognition, despite having been used several times before (Beaglehole & Bonita, 2004, pp. 214–217). The Charter was the outcome of the first WHO International Conference on Health Promotion and was held in Ottawa, Canada, in 1986. The aim was to increase the relevance of the CPHC approach to high-income countries that had largely ignored the Declaration of Alma-Ata. Like the Declaration of Alma-Ata, the Ottawa Charter for Health Promotion was a landmark document, laying out a clear statement of action that continues to have resonance for health practitioners around the world to improve the health of populations.

The new public health movement arose out of the recognition that ill health arises from a combination of biological, social, economic, emotional and environmental factors. Actions to improve health and prevent ill health will likewise need to be directed at these broad determinants. The major improvements in health status are attributable to action to improve the socio-ecological determinants of health, rather than as a result of biomedical interventions. CPHC, health promotion and the new public health are based on the same philosophy, strategy and activities for achieving health. Addressing the determinants of health through social justice and providing a balanced system of health care are at the core of this approach. The Ottawa Charter provides further guidance about how this can be done.

**Putting health promotion into practice using the Ottawa Charter for Health Promotion**

The strength of the Ottawa Charter lies in the fact that it incorporates both selective and comprehensive perspectives of primary health care. The five action areas of the Charter, used collectively within any population and within any setting, have a far better chance of promoting health than when they are used singularly (Kickbusch, 1989). The Ottawa Charter for Health Promotion highlights the collective role of organisations, systems and communities, as well as individual behaviours and capacities in achieving positive wellbeing. The five action areas of the Charter (see Fig. 1.4) are designed to promote health in the following ways.

1. **Building healthy public policy.** It is not health policy alone that influences health—all public policy should be examined for its impact on health and, where policies have a negative impact on health, work to change them needs to be done. For example, if a local government has a policy of allowing industrial complexes near residential areas, this would need to change if it was having a negative impact on residents’ health.

2. **Creating environments which support healthy living.** The protection of both the natural and built environment is important for health. In the built environment, living, work and leisure environments need to be organised in ways that do not create or contribute to poor health. For example, affordable child care for working parents needs to be provided. The natural environment needs to be conserved for health. These will come through the establishment of healthy public policy.

3. **Strengthening community action.** Communities themselves are the experts in their own community and can determine what their needs are, and how they can best be met. Thus, greater power and control remain with the people themselves, rather than totally with the ‘experts’. Community development is one means by which this can be achieved.

4. **Developing personal skills.** If people are to feel more in control of their lives and have more power in decisions that affect them, they may need to develop more skills. This could include being provided with necessary information, training or other resources that would enable people to take action to promote or protect their health. Those who work in the health system must work towards enabling people to acquire the necessary knowledge and skills to make informed decisions.
5. Reorienting health care. Health promotion is everybody’s business and intersectoral collaboration is the key. Within the health system there needs to be a balance between health promotion and curative services. One prerequisite for this reorientation is a major change in the way in which health practitioners are educated.

The Ottawa Charter continues to provide a vehicle to understand the determinants of health and guide practice. As Ludovika Singh said:

*Time flows like a river*
*The Charter is a boulder in the stream*
*Its erosion forms a wide and fertile estuary*

*(cited in de Leeuw, 2011, p. ii159)*

**FIGURE 1.4 The Ottawa Charter for Health Promotion**


**Affirming the philosophy: international health promotion**

Each international health promotion conference, since the first in Ottawa, has reaffirmed the philosophy that underpins CPHC as outlined in the Declaration of Alma-Ata, and the action areas of the Ottawa Charter for Health Promotion have been celebrated and built upon each time. The benchmark
conferences were followed by international health promotion conferences in Adelaide (1988), Sundsvall (1991), Jakarta (1997), Mexico City (2000), Bangkok (2005), Nairobi (2009) and the 8th conference in Helsinki in 2013. At the eighth conference, Health in All Policies (HiAP) was revisited. The conference aimed to:

- facilitate the exchange of experiences and lessons learnt and give guidance on effective mechanisms for promoting intersectoral action
- review approaches to address barriers and build capacity for implementing Health in All Policies
- identify opportunities to implement the recommendations of the Commission on Social Determinants of Health through Health in All Policies
- establish and review economic, developmental and social case for investing in HiAP
- address the contribution of health promotion in the renewal and reform of primary health care
- review progress, impact and achievements of health promotion since the Ottawa Conference.

There are many challenges facing organisations and practitioners implementing the five action areas of the Ottawa Charter to fulfil the promise of the Charter locally and globally. At the core of the work is a commitment to empowerment, community engagement and political action, and there is a need to strengthen and validate the role of advocacy, mediation and enabling (de Leeuw, 2011). Health promotion experts have reflected on the Charter and highlight areas for vigilance. Many raise concerns about the impact of neoliberalism. (See the entire issue of Health Promotion International, 26 [S2]. Analysis of progress made in achieving the five action areas of the Ottawa Charter for Health Promotion and the continuing challenges facing practitioners, including the impact of neoliberalism, is made by international experts in health promotion.) The PHM et al. (2014, p. 1) argue that neoliberal globalisation has produced a global health crisis. Baum and Sanders (2011) argue that TNCs pose a major threat to improving health inequalities. They reason that to counteract this, a Health in All Policies approach should be used to monitor and enforce TNCs’ accountability for health (WHO, 2013b). They suggest that part of this process should include the use of a form of health impact assessment (see Chapters 3 and 9) and health equity impact assessment on their activities. Similarly, Wallerstein, Mendes, Minkler and Akerman (2011) are concerned about TNCs, and the accompanying social and environmental devastation which in their view has challenged the effectiveness of community action to create health. However, they propose that there are new mechanisms for community engagement (see Chapter 6) that continue to emerge and provide examples of a reorientation of health promotion through the growth of healthy city and healthy community initiatives and other current community organising strategies where ‘the principle of community is given greater value, and with it the ideas of agency, equality, autonomy and solidarity’ (Wallerstein et al., p. ii234). Poor health promotion literacy (see Chapter 7) within the health sector is raised by Whitehead and Irvine (2011). They argue that developing the literacy of health practitioners who remain unaware of, or unengaged with, health promotion practice is the main reform required for the future of developing personal skills, which is the fourth action area of the Ottawa Charter for Health Promotion.

The new public health movement and the socio-ecological model of health

The new public health movement builds on traditional public health approaches in three important ways. First, the broad nature of health promotion is recognised, and the need to work with other sectors of government and private institutions whose work impacts on health. This intersectoral collaboration has become recognised as a central feature of effective health promotion. Second, the need to work in partnership with communities to increase community control over issues affecting health is recognised (see Chapter 6). Third, the primacy of people’s environments (both physical and
social) in determining their health, and the need to work for change to the environment rather than focusing on change solely at the level of the individual is recognised (Tones et al., 1990, pp. 3–4; WHO, 2011; also see Chapters 5 to 9).

New public health is ‘based on a clear articulation of a social model of health’ (Baum, 2002, p. 311) that emerged from philosophical underpinnings of the Declaration of Alma-Ata and the action areas of the Ottawa Charter for Health Promotion discussed earlier. As we have said, a socio-ecological perspective of health implies that health promotion action is designed to intervene to change those aspects of the environment which are causing ill health, rather than continue to simply deal with illness after it appears, or continue to exhort individuals to change their attitudes and lifestyles when, in fact, the environment in which they live and work gives them little choice or support for making such changes (South Australian Health Commission, 1988, p. 3). A socio-ecological view of health implies that improvements in health are achieved by addressing the many cultural, environmental, biological, political and economic factors that determine illness and health. In the new public health, it is acknowledged that medical and behavioural interventions used alone have a limited role in improving health because of their failure to deliver more equitable health outcomes within and between population groups. A socio-ecological model of health sets very wide scope for health promotion practice and it resonates well with CPHC.

The socio-ecological model of health as a foundation for health promotion policy and practice

Lead by the WHO Commission for the Social Determinants of Health, and supported by national, regional and local research (e.g. see AIHW, 2016; Craig et al., 2015; and Fair Society Healthy Lives [The Marmot Review], 2010), the notion of the socio-ecological model of health is gradually being incorporated into the language of health care service provision, especially in the community sector, but much more slowly in the medical care sectors. The planning frameworks, funding application proformas and reporting documents used by agencies, such as state government health departments and associations (e.g. health promotion foundations such as VicHealth in Victoria and Healthway in South Australia) provide useful examples of how a socio-ecological perspective can be integrated into practice, which can be drawn on, or improved on, to guide the provision of collaborative local, community-based activities.

A CONTINUUM OF HEALTH PROMOTION PRACTICE

Health promotion practice extends beyond disease prevention to address broader social, environmental and cultural issues impacting on health. Health promotion activities or service delivery can be organised from a range of different but complementary approaches, depending on the key priorities identified by evidence.

Key requirements for health promotion practice

Key requirements for quality in health promotion practice are that it draws on CPHC philosophy and action areas of the Ottawa Charter (WHO, 1986) set out earlier.

1. It is done with and by the people, not for them—it encourages participation in decision-making at all levels;
2. It usually involves a range of different approaches that include structural and policy changes for people in the context of their everyday lives, not just a focus on individual behaviour-change approaches; and
3. It is directed at improving people’s control over the determinants of their health.
The International Union for Health Promotion and Education (IUHPE) competencies referred to later in this chapter identify the core skills and attributes which are essential for practice. A number of categories for health promotion activities can be envisaged. They form a continuum (see Fig. 1.5) which illustrates how they relate to each other; activities with a socio-ecological approach at one end, moving to a behavioural approach and then those with a medical focus at the other end. Each category on the continuum is outlined briefly below. Each will be discussed more fully in Chapters 4 to 9.

### FIGURE 1.5 Continuum of health promotion practice


#### Program planning and evaluation

Research skills form the basis of program development and evaluation and, in theory, all of the practice areas of the continuum encompass program planning and evaluation knowledge and skills. The process is a continuous cycle of assessment, development and evaluation (see Fig. 4.1 in Chapter 4). Throughout the cycle, we need to define the issue, work out what to do about it, act and then evaluate what effect this action has had.

#### Healthy public policy: creating environments and settings that support wellbeing and health promotion

Developing healthy public policy has been identified as central to effective health promotion practice since the development of the Ottawa Charter for Health Promotion (WHO, 1986). Healthy public policy describes the decisions enshrined in the legislation, policy, strategic plan or rules, or operations of a sector of government or an organisation, made on behalf of the relevant population or group designed to protect their health. Healthy public policy can be very broad and include national policy, state policy, local government policy, regulatory activities including executive orders, local laws, ordinances, organisational position statements, regulations, and formal and informal rules. Policies in particular settings provide structural and regulatory support that cannot be implemented so readily elsewhere. The aim is to ensure that regulations relating to that setting, service directions, priorities and practices integrate CPHC principles. Examples could include SunSmart schools, or access to a workplace mentorship program.

#### Community development action for social and environmental change

The aim here is for communities (both geographic localities and communities of common purpose or interest) to become empowered to build their capacity to develop and sustain improvements in their social and physical environments. Health promotion approaches at this end of the continuum are typically community development activities organised across whole communities or populations,
such as local community capacity-building plans and activities. Examples include the many creative and innovative projects presented in *Fairer Health: Case Studies on Improving Health for All* (VicHealth, 2009), the *Transitioning Towns Toolbox* (McKinna & Wall, 2013) and the *Cultural Diversity and Inclusion Plan (CDIP 2015–2018)* in the City of Greater Bendigo (2015).

Advocacy is an important aspect of community action. Advocacy involves a combination of individual, peer and social actions designed to gain political commitment, policy support, structural change, social acceptance and systems support for a particular goal. It includes direct political lobbying. Advocacy may be carried out on behalf of a vulnerable community, or by the community itself. Socio-ecological approaches relate to factors securing the quality of the social and ecological environment of people’s lives. They involve change being made by people in their own locality or change at policy or planning level by a budget-holder, on behalf of another group of constituents, workers or population groups. They are likely to be sustained over time if community members are directly involved in identifying the need and planning and implementing an approach. Once in place, policies and economic regulatory activities can be a powerful lever for individuals seeking to make that setting more health protective (see Chapter 6).

**Health education and health literacy**

Health education and skill development include the provision of education through discrete planned sessions to individuals or groups, and working with individuals as they develop self-awareness and personal skills with the aim of improving their knowledge, attitudes, self-efficacy and individual capacity to change. Activities may be organised around population groups with a learning need in common, such as adolescents, culturally and linguistically diverse groups, same-sex attracted youth, Indigenous people or groups affected by a specific condition. Such groups are singled out because of higher mortality or morbidity indicators, and they become the focus for specific health promotion messages and capacity-building strategies (see Chapter 7).

**Health information and social marketing**

Social marketing involves programs designed to advocate for change and influence the voluntary behaviour of target audiences to benefit this audience and society as a whole. The aim is to shift attitudes, change people’s view of themselves and their relationships with others, change lifelong habits, values or behaviours, and make a sustained change in their personal behaviour around a specific issue. Social marketing and health information typically use persuasive and cultural change processes (not just information). Health promotion activities are usually organised around lifestyle factors and behaviours, such as smoking, physical inactivity and ways to improve mental health, but are also now widely used in promotion of sustainable environment changes (French et al., 2009; McKenzie-Mohr, 2011).

The aim of health information programs is to create awareness of the causes of health and illness, the services and support available to help maintain or improve health, and personal responsibility for actions affecting their health. Examples could include any of the various health awareness weeks. These approaches can involve raising public awareness about a health issue through use of mass media for example, advertising in newspapers, magazines, pamphlets and fliers or on radio, television and so forth at local, state and national levels. It may also involve a mix of promotional strategies including public relations and face-to-face communications (French et al., 2009; McKenzie-Mohr, 2011). Health education and social marketing approaches to health promotion are considered to be behavioural approaches because they seek to engage individuals in making informed choices to change to more health-enhancing behaviours, such as quitting smoking or eating a healthy diet. Naturally, some people will find this more difficult than others because of the other determinants of a person’s life (described above) (see Chapter 8).
Immunisation, screening, individual risk assessment and surveillance

Activities at this end of the health promotion continuum are considered to be medical approaches to health promotion because they are based on prevention or early detection of diseases, based on medical and epidemiological knowledge. Each of these health promotion approaches will be discussed in more depth in Chapter 9. Immunisation programs are based on scientific knowledge of immunology and improve public health for minimal costs. Equity is enhanced by government strategies, such as providing free immunisation, and by improving access for vulnerable population groups. Screening involves the systematic use of a test or investigatory tool to detect individuals at risk of developing a specific disease that is amenable to prevention or treatment. Activities include medical and preventive approaches designed at improving physiological risk factors, such as heart disease or early detection of some cancers.

Screening and individual risk assessment activities are aimed at early detection of disease rather than disease prevention or health promotion. With early detection of a disease, however, complications that may further compromise the health of an individual may be prevented. Health promotion strategies in this area usually require individuals to initiate an activity to enhance their current or future health, such as attending screening, or to change an existing lifestyle or behavioural risk. The approaches do not alter the underlying life conditions for the individual. Individual risk factor assessment involves a more comprehensive process of detecting overall risk of a single disease or multiple diseases. These can include genetic, biological, psychological and behavioural risks. Surveillance activities are designed to inform potential whole-of-population responses to health risks that could have the capacity to affect large numbers of people. Potential risks posed by rapidly spread infectious diseases, such as influenza, involve global strategies to minimise spread (see Chapter 9).

Challenges facing the development of equitable health systems

Health systems are defined as ‘the ensemble of all public and private organisations, institutions and resources mandated to improve, maintain or restore health’ (The Tallinn Charter: health systems for health and wealth, cited in Kutzin & Sparkes, 2016). Health systems encompass both personal and population services, as well as activities to influence the policies and actions of other sectors to address the socio-ecological determinants of health. If the system is to be ‘universally accessible to the community through their full participation and at a cost that the community and country can afford’ (WHO, 1978) then universal health coverage (UHC) is essential and disease prevention and health promotion must be part of the suit of strategies to improve health. However, the interpretation of UHC varies from country to country (WHO, 2016) and is not necessarily ‘universal’ (PHM et al., 2014). Furthermore, reorientation of health systems to include disease prevention and health promotion development has been patchy (Ziglio et al., 2011).

In light of the global structures discussed in this chapter, it is clear that there are enormous challenges for the WHO, national governments and health practitioners to implement these fundamentally important strategies to improve population health. The WHO is under continuing pressure to implement SPHC and to ‘retreat to a purely technical role and withdraw from any effective engagement with the political and economic dynamics that characterise the global health crisis’ (PHM et al., 2014, p. 5). They are beholden to the financial contributions of member states and voluntary contributions which are tied funds by donors. The members from the rich and powerful dominate policy directions in their role as donors. Furthermore, non-government agencies are increasingly beholden to donor funding and also the agendas of donors (PHM et al., 2014). TNCs such as the pharmaceutical industry exert political influence through donations (Oxfam, 2015). Yet international organisations such as the WHO, UNICEF and the International Labour Organization do express concern about the impacts of the neoliberal agenda. Health practitioners working in CPHC need to inform themselves and join the discussion about ‘public goods’ and the negative health impacts of...
structural adjustments, global financing and austerity measures. Thinking globally means supporting
the need to re-regulate global finance, rejecting austerity measures and tax havens, and supporting
global tax systems, and everyone needs to confront the question of limits to growth if we are to
have a habitable planet (PHM et al., 2014). Acting locally means working towards and within a fair
(universally accessible) health system.

WHO reports provide expert information to guide government policy and funding decisions on
specific subjects—for example, health research (WHO, 2012), health system financing—universal
coverage (WHO, 2010a, 2013a), primary health care (WHO, 2008b), and health workforce (2006,
2010b). The reports highlight significant challenges for governments including implementing pro-
equity health policies worldwide, the lack of financial resources and the critical shortage of health
practitioners in many countries (WHO, 2006; Sheikh, 2012). Research in Australia demonstrates how
difficult it is to provide CPHC in a changing political environment (Freeman et al., 2015).

The health workforce

The global workforce crisis is an urgent issue facing health care systems. There is not only a shortage
of the number of people who make the systems work, but there is also a shortage of the right mix
of skills from acute care through to health promotion and rehabilitation. The shortage is most
severe in the poorest countries. Rural and isolated areas are most disadvantaged in countries such
as Australia (Humphreys, 2012) and across the world. Migration of health practitioners compounds
the problem. Affluent nations have actively recruited new health graduates, such as doctors and
nurses, from universities in overseas poorer nations in order to meet their workforce shortages
(Mooney, 2012). The promise of high wages is hard to resist for the new graduates, but the ‘brain
drain’ has a significant effect on the already poor health care systems of these nations. Affluent
nations have effectively transferred the cost of tertiary education for more professionals to the
economies of countries that can least afford it (WHO, 2006). There is an unequal distribution of
health practitioners within and between countries. Sheikh (2012, p. 233) reports that ‘there is an
undeniable correlation between countries facing the greatest burden of maternal and child deaths
and those with health workforce shortages’. Cost containment measures, changed priorities, weak
education and health management systems, and discrimination contribute to the problem (WHO, 2006;
Sheikh, 2012).

In an attempt to address the challenge of migration the WHO Global Code of Practice on the
International Recruitment of Health Personnel was adopted in 2010. The aim of the Code is to
establish and promote voluntary principles and practices for the ethical international recruitment
of health personnel and to facilitate the strengthening of health systems. Active recruitment of health
personnel from developing countries facing critical shortages of health practitioners is discouraged
between member states (WHO, 2010b).

Evidence suggests that offering workers good working conditions, adequate remuneration,
the chance to work in a supportive team, the opportunity for further education and being shown respect,
develops a healthy workforce. To achieve the goals associated with health care systems driven by
CPHC philosophy, renewed commitment and new options for education and employment of health
describes that ministries within governments of education, health, public services, labour, foreign affairs,
finance and international trade all have a role to play. Community health workers were an important
component of the original vision of a universal health system based on CPHC principles.

Identifying competencies for health promotion practice

A number of nations with well-developed health promotion policies and workforces have under-
taken projects to identify health promotion and public health competencies for practice, although
progress has been uneven among countries, with some providing competency frameworks and others
extending those to accreditation standards for practice and registration (Battel-Kirk et al., 2009; IUHPE, n.d.).

Health promotion competencies identify the core skills and attributes which are essential for practice, and a range of other competencies which are useful but not absolutely essential. The International Union for Health Promotion and Education (IUHPE) Core Competencies for Health Promotion comprise nine domains of action which are underpinned by explicit ethical values and a knowledge domain. Ethical values inform the context within which all the other competencies are practiced (Fig. 1.6). These sit well with the philosophy of CPHC.

\textit{The IUHPE Core Competencies and Professional Standards for Health Promotion are underpinned by an understanding that Health Promotion has been shown to be an ethical, principled, effective and evidence-based discipline and that there are well-developed theories, strategies, evidence and values that determine good practice in Health Promotion. The term ‘Health Promotion action’ is used in the context of these competencies and standards to describe programmes, policies and other organised Health Promotion interventions that are empowering, participatory, holistic, intersectoral, equitable, sustainable and multi-strategy in nature, which aim to improve health and reduce health inequities. (Barry et al., 2012 p. 4)}

The knowledge domain describes the core concepts and principles that make health promotion practice distinctive. The remaining nine domains—enable change, advocate for health, mediate through partnership, communication, leadership, assessment, planning, implementation, and evaluation and research—each deal with a specific area of health promotion practice with their associated

\begin{figure}[h]
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\caption{International Union for Health Promotion and Education’s Core Competencies and Professional Standards for Health Promotion}
\end{figure}
competency statements articulating the necessary skills needed for competent practice. It is the combined application of all the domains, the knowledge base and the ethical values which constitute the IUHPE Core Competencies Framework for Health Promotion (Barry et al., 2012, p. 7). Competencies for each nation vary according to the local context of practice, educational programs and health system environment.

There are different points of view about the usefulness of identifying health promotion competencies. Some have argued that there are clear advantages for the practitioners, their employers and their clients (Shilton et al., 2001; Howat et al., 2000; Talbot et al., 2007; IUHPE, n.d.). Others have suggested there are disadvantages (Dempsey et al., 2011). The positives include: defining and consolidating the discipline; a shared/agreed language for defining tasks, skills and knowledge; and usefulness in developing programs and curricula, and recruitment and selection of staff. The negatives include: limiting innovation; under valuing professional judgment and experience; and disregard of values and principles (Battel-Kirk et al., 2009). The challenge in developing competencies for international workforce development is to develop robust and meaningful competencies for use in a broad context.

The aim of Chapters 4 to 9 of this text is to describe health promotion practice and provide examples of health competencies drawing from ‘real-life’ examples. At the end of each chapter, a table of health promotion competencies relating to the chapter are presented.

**Health information systems**

The lack of appropriate timely evidence threatens health care systems. Health research is the focus of the *World Health Report 2013: Research for Universal Health Coverage* (WHO, 2013a). At the international level research initiatives and knowledge to action practices in public health have been encouraged by the WHO. The 2013 report highlights the significance of conducting and translating health research to improve the health of populations.

A health information system (HIS) based on CPHC principles can be defined as ‘an integrated effort to collect, process, report and use health information and knowledge to influence policy-making, program action and research’ (WHO, 2003, p. 110). The information can be used for strategic decision-making and also for program planning, implementation, monitoring and evaluation. Surveillance and monitoring will be discussed in Chapter 9 of this book. Robust health information systems are needed in health care systems oriented to CPHC principles so that the needs of the population, particularly those most in need, can be understood and addressed efficiently and effectively. The WHO’s *Components of a Strong Health Information System* (2008c) provides a framework for countries based on inputs, processes and outputs. The inputs include all health information system resources, the physical and structural prerequisites of an HIS including: the ability of those responsible to lead and coordinate the process; the existence of policies; financial resources; and people with the necessary skills to do the work. The processes used by a HIS include health indicators from a variety of data sources that produce an accessible, relevant management system that protects the privacy of an individual. The outputs need to be useful evidence for decision-making. Information should then be synthesised into usable statistics and widely disseminated. The aim of a HIS is to benefit to all those who participate in it.

**Stewardship**

Commitment to health equity is an essential part of effective stewardship. Health ministries are responsible for protecting citizens’ health and ensuring quality care is provided. Pro-equity health care strategies differ from country to country. Access to health care is one measure of equity. Globally this usually takes three forms. In the poorest countries, most of the population have equal but deficient access to health care. The elite class in these countries find ways to obtain care. In richer countries, general access is better but the middle and upper classes benefit most, and the lower class usually have to queue for care. In some countries, the majority of the population has adequate access
to health care but a small minority, often the poorest, are deprived (WHO, 2003, p. 123). A commitment to UHC needs to be tackled differently in high-income and low-income nations, but in every country co-payments for services prevent millions of people accessing services or essential medicine when they need them (WHO, 2010a; PHM et al., 2014). The goal of UHC needs to be a goal of equity and health. Further, an approach based on CPHC recognises the need to attack the roots of health disparities intersectorally, and supports the notion of the CPHC activities including community participation in defining and implementing health agendas. If governments are to perform their stewardship roles effectively they must engage the community through participation, empowerment and ownership strategies—when the right structures are in place, effective governance and vigorous community involvement support each other’ (WHO, 2003, p. 126).

**Health sector reforms for the future**

A global understanding of what public health services and functions consist of (World Federation Public Health Associations, 2016) along with a broadening of research into socio-ecological conditions and health equity is needed (Pedrano et al., 2015). The four sets of health sector reforms considered necessary by the WHO to improve health systems and health outcomes reiterate the messages of the past 35 years.

1. Universal coverage in health systems to improve access to health services and ensure health equity.
2. Reorientation of health service delivery to ensure socially acceptable services to improve access and health outcomes.
3. Policy reforms in sectors other than health to improve health outcomes.
4. Inclusive, participatory, negotiation-based leadership.

(WHO, 2008b, p. ix)

**IS COMPREHENSIVE PRIMARY HEALTH CARE STILL RELEVANT?**

A number of challenges emerged in the years following the Declaration of Alma-Ata that may provide lessons for implementing a CPHC approach in the future. The WHO continues to promote CPHC; however, its effect in practice has been described as limited (PHM et al., 2014). The adoption of SPHC, discussed earlier in the chapter, ensured the disproportionate spending on medical care, and this situation is largely unchanged in most nations. The rise of neoliberalism and its sequelae has brought about economic changes (including increased disparities between rich and poor), caused social and ecological degradation, and forced a reduction in spending on health care in some countries (Gillam, 2008; Labonté & Schrecker, 2006; PHM et al., 2014). Implementation of UHC is not truly universal in many countries. Inequities have been aggravated by health sector reform where local health services have been left unsupported and co-payments for health services introduced or increased (PHM et al., 2014). An increased dependency on donors has reinforced SPHC. While this approach has provided much-needed relief to address ‘downstream’ interventions such as antiviral treatment for HIV transmission, ‘upstream’ activities tackling the socio-ecological determinants of health have often been neglected. Furthermore, intersectoral collaboration and community participation in health care decisions has not necessarily been supported in these programs; instead, ‘vertically implemented and managed programs’ have been preferred (PHM et al., 2011, p. 48). Consequently, although life expectancy has risen overall globally, there are widening health inequalities within and between countries and some gains have been lost (WHO, 2015a).

For these reasons CPHC is more important than ever. CPHC has provided better knowledge and understanding of the socio-ecological determinants of health and equity has been at the core of
concerns in CPHC, public health and health promotion organisations. There is ongoing acknowledge-
ment that inequalities in social, economic and environmental circumstances continue to increase
and erode the conditions for health. Evidence suggests that the CPHC approach delivers better health
outcomes at lower costs in a socially acceptable way (Macinko et al., 2003 in Gillam, 2008; PHM
et al., 2014; WHO, 2008b). It is the only way of reducing the burden of disease among the poorest
of the poor, and in doing so raises the health status of the population overall. To work within a
CPHC approach is to work on the root causes of health and illness—those things that determine
health and illness. Further, greater impacts will be achieved when CPHC including health promotion
become an integral, appropriately funded stream in national policy, in parallel with policies towards
ensuring ecological sustainability (Ife & Tesoriero, 2006; Pettigrew et al., 2015).

SOCIAL AND ENVIRONMENTAL PERSPECTIVES

The philosophy and activities guiding CPHC, the environment movement and the human rights
movement can be seen in the Declaration of Alma-Ata (Appendix 1), the Ottawa Charter for Health
Promotion (Appendix 2), the United Nations (UN) Universal Declaration of Human Rights (Appendix
3) and The Earth Charter, 2000 (Appendix 4). In 1987, the year after the release of the Ottawa Charter,
‘Our common future’ (the Brundtland Report, UN, 1987) called for ‘sustainable development’. This
report, like the Declaration of Alma-Ata and the Ottawa Charter, is also considered to be a landmark
document. Arguably, the Sustainable Development Goals (UN, 2015; see Chapter 3) collectively
integrates social and environmental perspectives and will be a landmark document. One of the
reasons a social justice perspective is inadequate without an environmental justice perspective is
because of the conventional economic prescription for many social problems brought about through
economic growth. People working for ecological sustainability can challenge both the feasibility and
desirability of continued growth (e.g. Ife & Tesoriero, 2006; Meadows et al., 1972; PHM et al., 2014)
as contributing to the current ecological crisis. Both perspectives need to be understood in understanding
the determinants of health. Intersectoral action on social and environmental determinants of health
needs to be strengthened.

CPHC can contribute to the success of the Sustainable Development Goals (UN, 2015) in a
cross-cutting role by addressing the socio-ecological determinants of health. Practitioners can, in
their daily role, promote social and environmental justice and foster healthy, sustainable and peaceful
environments by working to end poverty, promote education, improve nutrition and provide evidence-
based CPHC. This approach enables societies to take action on the prerequisites for health. Health
is achieved by promoting equity through social justice and empowerment. Social movements or
‘strong’ community participation is important. At the local level, people are supported in developing
their own solutions to local issues that determine health. Universal access to quality health care,
education and social services according to people’s needs and not people’s ability to pay is part of
the approach.

CONCLUSION

In the last 40 years, we have seen the development of numerous international, national and local
policies and programs designed to reorient health systems towards CPHC. These developments
occurred as a result of recognition of the socio-ecological determinants of health and inequalities in
human development throughout the world. We have seen some important action based on these
calls for a reorientation of our approach to health issues.

At the same time, however, commitment to the principles of social justice has been challenged.
The impact of the neoliberal ideology around the world can be seen in a narrower commitment to
CPHC. Because of these global policies, it is unclear to what extent countries around the world can strengthen their commitment to CPHC. For many of the world’s poor countries, the choice seems almost taken out of their hands as a result of global economic policies, which seem to have locked them into a system of creating markets for medical technologies through replication of the health care systems of the high-income countries at the expense of more affordable, sustainable and equitable health care. The WHO, sympathetic governments and NGOs with a concern for social justice have an important role to play in maintaining these principles on the international agenda.

Within the context of the policies described in this chapter, and sometimes despite them, many health practitioners have been working to implement the principles of CPHC in their practice. The result has been some inspiring examples of what can be achieved by working in this way. In order to do this, practitioners have been drawing on a range of skills and strategies, which have then been developed and discussed in the professional literature and have been integrated into the education of many practitioners. This process has been taken up around the world by many in the health and other professions and has paralleled the activities of governments, who cannot alone implement the changes required in a CPHC approach.

The challenge for practitioners is to put into practice the principles of CPHC using a socio-ecological perspective. Many of the key strategies and skills required to do this effectively are discussed in the remainder of this book. Health practitioners are encouraged to take up the challenge by incorporating the principles into their daily practice and developing and implementing their skills in health promotion.

MORE TO EXPLORE

THE SOCIO-ECOLOGICAL DETERMINANTS OF HEALTH

- The School of Life. (2014). Why some countries are poor and others rich. [video file]. Retrieved from https://www.youtube.com/watch?v=9-4V3HR696k&app=desktop
### IUHPE Core Competencies for Health Promotion

The IUHPE Core Competencies for Health Promotion comprises nine domains of action. Each domain has a series of core competency statements and a detailed outline of the knowledge and skills that contribute to competency in that domain.

The content of this chapter relates especially to the achievement of competency in the health promotion domains outlined below.

<table>
<thead>
<tr>
<th>1. Enable change</th>
<th>1.1 Work collaboratively across sectors to influence the development of public policies which impact positively on health and reduce health inequities Determinants of health and health inequities</th>
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<td></td>
<td>1.2 Use health promotion approaches which support empowerment, participation, partnership and equity to create environments and settings which promote health Health promotion models</td>
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<td>1.5 Work in collaboration with key stakeholders to reorient health and other services to promote health and reduce health inequities Theory and practice of collaborative working</td>
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<tr>
<td>2. Advocate for health</td>
<td>2.3 Raise awareness of and influence public opinion on health issues Ability to work with diverse individuals and groups</td>
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<td>2.4 Advocate for the development of policies, guidelines and procedures across all sectors which impact positively on health and reduce health inequities Health and wellbeing issues relating to a specified population or group</td>
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<tr>
<td>3. Mediate through partnership</td>
<td>3.2 Facilitate effective partnership working which reflects health promotion values and principles Theory and practice of collaborative working</td>
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<tr>
<td>5. Leadership</td>
<td>5.2 Use leadership skills which facilitate empowerment and participation (including team work, negotiation, motivation, conflict resolution, decision-making, facilitation and problem-solving) Emerging challenges in health and health promotion</td>
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<tr>
<td>6. Assessment</td>
<td>6.4 Identify the determinants of health which impact on health promotion action Available data and information sources Social determinants of health</td>
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<td>6.7 Identify priorities for health promotion action in partnership with stakeholders based on best available evidence and ethical values Health inequities Evidence base for health promotion action and priority setting</td>
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<tr>
<td>7. Planning</td>
<td>7.2 Use current models and systematic approaches for planning health promotion action Use and effectiveness of current health promotion planning models and theories</td>
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CHAPTER 1 HEALTH PROMOTION IN CONTEXT

9. Evaluation and research

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<th>9.5 Contribute to the development and dissemination of health promotion evaluation and research processes</th>
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<tr>
<td>Use appropriate evaluation and research methods, in partnership with stakeholders, to determine the reach, impact and effectiveness of health promotion action</td>
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In addition, IUHPE specifies knowledge, skills and performance criteria essential for health promotion practitioners to act professionally and ethically, including having knowledge of ethical and legal issues, behaving in an ethical and respectful manner and working in ways that review and improve practice. Full details are available at: http://www.iuhpe.org/index.php/en/the-accreditation-system

Reflective questions

1. Review the WHO definition of health discussed in this chapter. What are the implications for health promotion practice of using this definition, rather than the narrower ‘absence of illness’ definition?

2. Think about the socio-ecological determinants of health in your locality. What are they and where would you begin your work as a practitioner to address these determinants to improve health?

3. Do you agree with the WHO support for a comprehensive primary health care approach or do you think it’s an unrealistic goal? Do you believe CPHC is still relevant in the world today? If you do, what makes you think this? If you do not, what gives you that opinion?

4. SPHC and CPHC approaches have both made important improvements to the health of populations. Can you think of some practical examples of each of these approaches?

5. Despite the evidence that advances in complex medical care have a limited impact on death rates, most countries still want to incorporate these technologies into their health care systems, sometimes in place of funding basic public health measures. What influences inequitable decision-making such as this? What are the real reasons for declining death rates?

6. Many people are openly critical of the IMF and the World Bank efforts to reduce debts for severely impoverished nations. Others praise their efforts to reduce world poverty. What evidence would you use to outline both perspectives?

7. What is universal health care (UHC) and what are some of the ways countries such as China, Mexico, Rwanda and Turkey implement UHC? What are the essential questions for countries implementing UHC? Watch WHO: the many paths towards universal health coverage (https://www.youtube.com/watch?v=VQ3sHFyZcv8&feature=youtu.be). How do these compare with the systems in Australia and New Zealand?
REFERENCES


