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An Introduction to Why
Health Promotion is Important
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Introduction

In 1978, the Alma Ata Declaration identified the goal of ‘health for all by 2000’, and although this has not yet been achieved, it is evident that throughout the world improving health through health promotion is clearly on government agendas, for example, the UK Government White Paper Healthy Lives, Healthy People (DH 2010). This chapter explores health, health beliefs, health determinants and health inequalities, and briefly discusses strategic actions taken to improve the health of the population, identified by the World Health Organisation. Four case scenarios are presented, which will be used throughout this book to help you understand how health promotion can empower individuals to make the decision to change their health related behaviour. Policy underpins all health promotion work, however specific policies will not be covered in this book.
and therefore readers will need to explore policies that relate to their own countries.

Learning objectives

By the end of this chapter the reader will be better able to:

- Discuss the historical perspective and role of the World Health Organisation in international health promotion work
- Identify the dimensions and determinants of health
- Critically evaluate definitions of health
- Explore the concept of inequalities in health, and its role in health promotion
- Differentiate between inequalities and inequity in health care
- Identify and locate local and national policies relating to their own country

The case scenarios

Case scenario 1: Emily

Emily is 6 years old and is reluctant to take exercise; she prefers to watch TV or play on her hand-held computer terminal, and she is choosy about the food she will eat. Her mum, Karen, is a single parent and lives in a rented house in a small town with Emily and her younger brother Josh who is 3 years old. Karen tends to feed them quickly prepared, cheap food which is high in saturated fats and carbohydrates. Karen mainly does this because this is what the children like, but also because it is cheap and her cooking skills are limited.

In Emily’s class, many of the children are similar to her in that they dislike physical activity and prefer to play computer games rather than play outside. The class has been doing a project on healthy eating, and
the teacher is dismayed by their lack of knowledge about food. She asks the school nurse to become involved, and they design a primary health promotion project on healthy diet and exercise for the children and their families. Part of the project includes cookery demonstrations, which parents are invited to, and free activities at the local sports centre for the whole family.

Furthermore, to raise the children’s awareness of their physical fitness, they are all weighed and measured. They plot their measurements on a class chart to identify that they are all different, and to help to develop their self-awareness. Parents are invited to come in and see the results of this exercise. Emily’s mum realizes that Emily is one of the heaviest in the class, and she discusses with the school nurse how to reduce her weight. An action plan for Emily is designed by Karen and the school nurse, and Emily’s mum asks if Josh can be included in the plan, as she is concerned about his weight too.

Case scenario 2: Hamed

Hamed is a 42-year-old married man who lives in his own house with his family, his wife Halima and two boys aged 10 and 8. He works in the family taxi business, and since taking over the responsibility for promoting the business the annual profits have increased. His hours are long and involve lots of sitting and very little exercise. Hamed enjoys his food, and his wife is a good traditional cook. Recently he has put on quite a lot of weight and he is always thirsty.

Hamed’s father was diagnosed with diabetes at the age of 45 and Halima is concerned that Hamed may also have a problem. She notices a poster, at the local surgery, which explains the signs and symptoms of diabetes. It also offers free diabetes screening tests to anyone with a family history of diabetes. She enquires further and is referred to the practice nurse. The practice nurse takes Hamed’s details, and makes an appointment for him to come in and see her.
Hamed goes for the appointment, and his blood glucose level indicates that he may have diabetes type II. The nurse gives him written information about improving his diet and increasing exercise, which she goes through with him to ensure he understands. She also offers to see Halima, as Hamed states that Halima does all the cooking and shopping. The nurse also suggests that he might like to attend a support group at the local community centre, that has been set up to help newly diagnosed diabetics cope with the change in lifestyle.

**Case scenario 3: Richard**

Richard is a 62-year-old deputy head of a large secondary school. He is divorced, having separated from his wife five years ago. He has a son and a daughter, both married and well. However, they do not live nearby and at times this makes Richard feel sad.

Richard has had three admissions to a psychiatric unit for depression, the last admission being a year ago. Recently he presented to the GP with two or three episodes of chest tightness and generally feeling unwell. An ECG was undertaken in the GP surgery, and it showed a degree of ischaemia that needed further investigation. Richard was referred to the Acute Chest Pain clinic at the hospital, and assessed for cardiac disease. At the clinic Richard took a stress test and after five minutes of the protocol was found to have chest ECG changes and to have experienced some chest pain. On angiogram it was found that Richard's two major coronaries were blocked and he required insertion of a coronary stent.

Richard's father died 20 years ago (aged 64) following a myocardial infarction. He has two brothers; one has hypertension and the other, as far as he knows, is fit and well. Richard has never had his cholesterol checked.

Richard has smoked 20 cigarettes a day for 35 years; he does no formal exercise although he does walk to work every day. He admits to drinking approximately 30 units of spirits per week. He lives on his own and often cannot be ‘bothered’ to cook, so tends to snack. He does not
feel overly stressed; however work is very busy and he works long hours with very little relaxation time.

He has had his stent inserted and is on anti-platelets for a minimum of one year, and has been commenced on an ACE inhibitor for his hypertension. His cholesterol result came back as 7.1 so he has also been commenced on statins.

He has been referred to the cardiac rehabilitation team prior to discharge. His main needs are weight control, exercise, diet, smoking and alcohol input, and medicine management.

Case scenario 4: David

David is 27 years old and has served a number of prison terms. Currently he is serving a two year sentence for drug related crimes.

David had difficulty at school and was labelled as having a hyper-activity disorder. He left school at 15, has never been employed and has been homeless on and off when not in prison, but sometimes stays with friends.

David’s mother visits when she can, but finds it difficult to afford the fare.

David has a history of drug misuse, and as and when he can, drinks large quantities of cheap alcohol. He continues to take drugs, but has changed his normal substance to avoid detection. He has also smoked cigarettes since he was 11.

David receives health services within the prison system, and is part of a programme to combine health care with rehabilitation and resettlement in the outside world, and to reduce the incidence of re-offending. Recently he attended the medical clinic with a nasty cough and received advice on how the prison quit smoking campaign is particularly successful. He has signed up for a smoking cessation group and is beginning to commit to giving up smoking. There are more and more no-smoking areas within the prison and some with good TV.
David notices that the prison is cleaner than the last time he was confined. He attended a clinic where his drug misuse was addressed, and he can now take part in a needle-exchange programme. He has been offered a place on a detox programme and is reassured by the promise of contact with support services when he is released. He has been screened for blood borne viruses and had an immunization for Hepatitis B.

A mental health nurse (from the in-reach team) within the prison meets regularly with David to discuss his learning difficulties, and has organized for him to work in the prison kitchen. He has also been offered a place in a reading class to help him catch up on his lost schooling.

A new programme is being offered by the prison on building respect and understanding. David would like to sign up for this, although places are limited, as he finds life outside the prison a great hardship, and would like to make some changes to his life when his sentence is complete.

Health

Before we consider health promotion theory, it is important that we first consider the concept of health. Defining the concept of health is not straightforward. Due to the different dimensions and determinants of health, a number of definitions have been presented. Definitions of health can be influenced by culture, religious beliefs, age, gender, education and life experiences.

The World Health Organisation (1946) originally defined health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity’. Although this definition is widely used in the literature, it only really considers that health is the absence of disease, and this indicates a medical model. One could also argue against this definition, because those who could be considered ‘not in a state of complete physical, mental and social well-being’ may well view themselves as healthy; for example, an individual with rheumatoid arthritis who is able to achieve their objectives on a daily basis may not consider themselves unhealthy.
This definition implies that ‘health’ and ‘well-being’ mean the same. However, Walker and John (2012) refer back to the ancient Greeks, who defined health (Hygeia) and well-being (eudaimonia/happiness) differently. Health is linked to well-being but tends to have a disease focus, whereas well-being includes the social determinants of health. Well-being can be measured, both subjectively and objectively, and therefore could be used to evaluate the impact of policies and health promotion programmes (Walker and John 2012).

For some time now the UK Government has promoted the importance of five-a-day fruit and vegetables, to improve health and well-being. The New Economics Foundation (2008, cited in Walker and John 2012: 41) takes this further and suggests that it is important for well-being for individuals to include the following five actions in their daily lives:

- **Connecting with people** For example, children can develop friendships at school, through local organizations such as guides and scouts and through the church. These friendships can support and sustain them throughout life.

- **Being active** Choosing an activity that is enjoyable is crucial and this does not necessarily mean strenuous exercise. Outdoor bowls, walking, gardening, rowing, running and playing golf are just a few examples.

- **Taking notice** Noticing the environment around us, for example, the changing colours of the leaves in the autumn; noticing that it does not get dark so early in the evenings; listening to the sounds of the birds singing; noticing the first lambs in the spring.

- **Continuous learning** Learning can be fun and does not necessarily mean studying to degree level or a qualification. Setting ourselves goals and challenges can increase our self-esteem and confidence, such as learning how to follow and cook a new recipe once a month; learning to swim as an adult; learning the basics of a new language; learning to mend a bicycle puncture.

- **Giving** Giving something to a friend or colleague at work does not need to cost anything and could include offering to help a colleague who feels pressurized. It could involve joining the WI (Women’s Institute) and
volunteering to help serve coffee and sandwiches in hospitals. Helping others can increase our own happiness and also helps us to make connections and establish friendships with others.

So it would seem that health and well-being are both important concepts for us to consider.

Forty years later the World Health Organisation (WHO 1986) reviewed its first definition of health given above, and this is stated in the Ottawa Charter (WHO 1986: 1):

To reach a state of complete physical, mental and social well-being, an individual or group must be able to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is therefore seen as a resource for everyday life, not the objective of living. Health is a positive concept, emphasizing social and personal resources, as well as physical capacities.

This definition is more holistic in that it considers the individual’s needs. Seedhouse (2001, cited in Whithead and Irvine 2010: 2) views health as being ‘equivalent to a set of conditions that enable individuals to achieve their realistic, chosen and biological potential – and recognizes that the importance of these conditions depends on the individual context’.

Lucas and Lloyd (2005: 7) consider a number of definitions, for example ‘health is about achieving personal potential’; ‘health can be bought by investing in private health care, sold via health food shops, given by drugs or surgery, and lost by accidents or disease’; (Aggleton 1994, cited in Lucas and Lloyd 2005: 7) and ‘individuals have a reserve of well-being, individually determined by constitution and temperament as well as a positive state of equilibrium’ (Herzlich 1973, cited in Lucas and Lloyd 2005: 7).

What all of these definitions have in common is that although health relates to each individual, the level of health achieved varies depending on beliefs, circumstances and other factors, such as those considered above.
Health beliefs, health dimensions and determinants

The World Health Organisation, along with international governments, has consistently worked to improve the health of the population; however, health inequalities continue to exist internationally.

In order to understand why inequalities continue to exist, we need to recognize that health beliefs, dimensions and determinants of health can also affect whether an individual considers themselves to be healthy or not. Health beliefs and personal perceptions can be influenced by gender, age, culture and socioeconomic status (Piper 2009). Individual health beliefs can also change during a person’s lifetime, due to life experiences, and therefore individual definitions of health may also change. For example, if someone believed that being healthy was the absence of disease, but later develops a chronic disease such as diabetes, they may still feel that they are healthy despite the disease. Therefore their perception of health has changed; if they are able to achieve everything they want, then they may well perceive themselves to be healthy.

As stated in the Jakarta Declaration (WHO 1997: 1), ‘health is a basic human right and is essential for social and economic development’. The Ottawa Charter (WHO 1986: 1) states that ‘good health is a major resource for social, economic and personal development and an important dimension of quality of life’.

Therefore when considering health it is important to reflect on the physical, mental, emotional, social, spiritual and sexual aspects of individuals. It is also crucial to take into account how societal, environmental and global issues influence these dimensions.

Physical health relates to body status, i.e. fitness and absence of disease and illness. Mental health concerns the psychological status of the individual; their perceived feelings of value and well-being. For emotional health it is important that an individual can both recognize and express their emotions (Naidoo and Wills 2009; Scriven 2010).

Naidoo and Wills (2009) and Scriven (2010) go on to highlight that feeling cared for and loved is also essential, and can affect the ability to make and maintain relationships. Feeling that support is available from friends and family and being able to engage with others leads to social health being sustained (Naidoo

Key point
Health promotion work must consider all of the dimensions of health
and Wills 2009; Scriven 2010). In 2005 the World Health Organisation established the Commission on Social Determinants of Health (CSDH). The remit for the CSDH was to investigate what could be done to promote global health equity. This commission, which reported in 2008, provides advice on how to reduce inequities in particular resulting from social determinants of health.

Three key recommendations were made:

1. Improve daily living conditions
2. Tackle the inequitable distribution of power, money and resources
3. Measure and understand the problems and assess the impact of action.

(WHO 2008: 6)

For **spiritual health** it is important to be able to recognize, express and practise one’s own core beliefs, i.e. religious views, morals and values. It is also important for an individual to recognize, express and practise their own sexual preferences for sexual health (Naidoo and Wills 2009; Scriven 2010).

As well as the above dimensions, there are wider determinants (societal and global) that could impact on whether an individual is healthy or not. In a society where the infrastructure is inadequate to the extent that basic shelter, clean water, food and income are limited, and where basic human rights may also be restricted, then health could be affected. The third international conference at Sundsvall (1991) identified that women, the majority of the world’s population, are oppressed and discriminated against in the labour market and to some extent today this remains the case (Naidoo and Wills 2009; Scriven 2010).

Over the last few years a number of countries (Haiti, China, Japan, Australia, New Zealand and USA) have experienced severe floods, cyclones, earthquakes and tsunamis. Individuals have lost their homes; children have lost access to education; sanitation has been affected, leading to outbreaks of cholera in some areas; and all of these have an impact on health. Lastly, according to Naidoo and Wills (2009: 4), ‘caring for the planet and ensuring its sustainability for the future’ is vital.

Health is also dependent on a number of dynamic interactions of different variables, and the health and well-being of individuals is influenced by a range of
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Factors, both within and outside the individual’s control. These factors are often known as determinants of health.

Figure 1.1 illustrates a number of aspects that could affect the health of individuals and is based on Dahlgren and Whitehead’s (1991) model. The age, gender and hereditary factors in the main are fixed; individuals may like to deny they are getting older, however, the fact is that each year we all become another year older. Individuals are able to express their sexuality, and in some cases due to technological advances, undergo surgery to change gender; however, as already said, age, gender and hereditary factors in the main do not change.

Dahlgren and Whitehead’s (1991) model will now be illustrated using the example of smoking.

*Applying this model: smoking*

Initially individuals may choose whether to smoke or not, however, smoking is addictive. There are also *social and community influences* that may affect the decision to begin smoking or to stop smoking, for example, peer pressure and family norms. If an individual’s friends and family smoke, then they may feel

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**Figure 1.1 The main determinants of health**

*Source:* Adapted from Dahlgren and Whitehead (1991)
pressurized to smoke. Living conditions and unemployment could be factors in determining whether an individual makes the decision to smoke or not. Living in poor housing where amenities are limited can cause depression and stress as can unemployment, and so smoking can relieve this stress and reduce anxiety momentarily. Poor environmental conditions such as pollution can also cause stress and anxiety so individuals may choose to smoke to relieve these emotional feelings. General socio-economic, cultural and environmental conditions might influence the decision to smoke, such as the cost and accessibility of cigarettes.

Activity

- Reflect on some of the individuals you work with and think of a different example to smoking.
- Apply Dahlgren and Whitehead’s (1991) model.

Health inequalities

In this section inequalities are defined, the difference between health inequalities and health inequity is explained, and the links to health promotion practice are explored.

The determinants of health were discussed in the previous section and this helped us to see that health is complex and is influenced by a variety of factors. Understanding the complexity of health will help to develop your understanding of health inequalities.

Definitions of health inequalities vary in different countries and have changed over time. In the UK, health inequalities are debated but are acknowledged as important (DH 2010). In the USA the term is not used; instead there is discussion of health disparities, which makes comparisons between different countries difficult (Graham 2007).

It is suggested (Graham 2007) that there are three different meanings to health inequalities:

1. differences between the health of individuals;
2. differences between the health of populations;
In health promotion, it is generally the differences in health status between different populations, and those as a result of social hierarchies, that are of concern. The differences can be between those who have limited economic and social resources compared to those with greater economic and social resources, and this is often seen as being linked to social class (Scriven 2010). This gap between rich and poor is reported to be widening in many societies (Scriven 2010). However, Davies and Macdowall (2006) propose that it is not just social class that has an impact on health, but also geography, age, gender, disability and ethnicity. These factors can also cause health inequalities.

Examination of the health differences between groups demonstrates that health follows a social pattern. An example might be examining perceived differences in health status linked to household income. Those in the lowest quintile of incomes tend to have a more negative view of their health (40 per cent reporting their health is not good), as opposed to those in the highest quintile, where only 15 per cent report their health is not good (Graham 2007). This reflects that those in low income groups tend to have poorer health.

Looking at health in relation to social hierarchies suggests that it is those from socially disadvantaged groups – whether as a result of finance or position in society, for example, ethnic groups – who are more likely to have poor health than those from advantaged groups. This suggests that inequalities in health are linked to social inequalities, rather than just being the result of general health (Graham 2007). Green and Tones (2010) suggest that inequalities are the result of unequal opportunities in health, which lead to further social inequalities.

Since the 1970s and the Black Report (Townsend et al. 1992), there has been an increasing interest in inequalities and the causes of them. Reports by the UK Labour government during their period in office support the breadth of inequalities, indicating that inequalities are due to the interaction of a range of factors and cannot be ascribed to any one area (Hubley and Copeman 2008). The current government has indicated that they intend to continue to try and address inequalities (DH 2010). This continuation is important as comparison between countries shows that it is not the richest societies that have the best health, but those that have the smallest difference in income between rich and poor, leading to an
egalitarian society with equal opportunities which results in better health overall (Ewles and Simnett 2003).

Graham (2007) suggests that heath inequalities are descriptive, and although they help to explain patterns of health, they do not address the whole issue of difference. Health inequity, in contrast, refers to different opportunities for health for populations. Inequities may be as a result of unequal access to resources such as nutritious food, housing or health services. Regardless of the cause, health inequities are differences in health which are considered to be unfair and unjust (Whitehead 1990, cited in Graham 2007).

Differences between individuals and groups at different points in their lives are to be expected; for example individuals are often healthier when they are young rather than older. This can also be seen in groups, i.e. younger people as a group tend to be healthier than older people. Nevertheless differences in health as a result of social hierarchies can be considered as examples of health inequity: if an individual is unhealthy because they are unemployed and cannot afford healthy food, this is inequity because their lack of healthy food is the result of their position in society, rather than any choices they may have made. The same is true of groups of people. For example, if those from an identified ethnic group live in poor housing through their inability to afford better quality housing rather than through choice, this is an inequity which will have an impact on their health. Health inequity links to moral debates about what is fair and just in society, so it tends to be a complex matter.

As health promoters it is essential that there is an understanding of the health of populations, and how this is influenced by a range of factors often beyond individual control to enable the planning of appropriate interventions (Green and Tones 2010). Health promotion is criticized for focusing on individual behaviour change, which does not recognize the range of influences on health that have been discussed, and as a result does not address inequalities (Hubley and Copeman 2008). Scriven (2010) suggests that health promotion activities might only reach those with the resources to address their health issues, thus widening inequalities, therefore it is essential that we as health promoters have an in-depth understanding of inequalities in health.
Activity

- From your practice, identify a health inequality.
- Now try to identify a health inequity.

The role of the World Health Organisation in supporting health promotion

As mentioned above, a number of international conferences have helped to develop our understanding of health promotion strategies, and have placed ‘health for all’ and health promotion firmly on the agenda. Policies have been developed from these conferences in order to narrow the health divide in society and ensure equity within health care, thus reducing the inequalities within deprived and vulnerable groups.

Activity

- Identify some national policies linked to improving the health of the population.
- What is the key aim of each policy?
- What are the key objectives?
- Is an action plan identified? If so, make a note of strategies suggested.

Representatives from developed countries attending these conferences helped to develop policies that would impact positively on developing countries. Delegates from 42 countries participated in the Adelaide conference of 1977, and by the time the Nairobi conference was held in 2009, over one hundred countries engaged in discussions. Table 1.1 summarizes key points from each conference held to date.
Table 1.1 World Health Organisation conferences

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<tr>
<th>Year</th>
<th>Event</th>
<th>Key Target</th>
<th>Emphasis</th>
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<td>1978</td>
<td>Alma Ata Declaration</td>
<td>An acceptable level of health for all by the year 2000.</td>
<td>The role of health education, developing and implementing primary health care and the need to reduce health inequalities.</td>
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<td>1986</td>
<td>The Ottawa Charter</td>
<td>Built on the Alma Ata declaration.</td>
<td>Focused on the key functions of strategies, advocacy, enabling and mediation.</td>
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<td></td>
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<td>Emphasized five action areas for health promotion:</td>
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<td>1 Building healthy public policy</td>
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<td>2 Creating supportive environments</td>
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<td>3 Strengthening community action</td>
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<td>4 Developing personal skills</td>
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<td>5 Re-orientating health services</td>
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<td>1988</td>
<td>Adelaide Charter</td>
<td>Emphasized health as a fundamental social goal, which could only be achieved with the development of public policy and public participation and cooperation between all sectors.</td>
<td>Emphasized healthy public policy needed to ‘ensure that advances in health-care technology help, rather than hinder, the process of achieving improvements in equity’.</td>
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<td>1991</td>
<td>Sundsvall conference</td>
<td>Emphasized the need to develop supportive environments, i.e. the social dimension, the political dimension, the economic dimension and the need to use women’s skills and knowledge in all sectors.</td>
<td>Focused on the importance of action to achieve social justice.</td>
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<td>1997</td>
<td>Jakarta Declaration</td>
<td>The first conference to be held in a developing country, and the first to involve the private sector in supporting health promotion. This conference focused on health promotion into the twenty-first century and emphasized the need to promote social responsibility; to involve families and communities in health promotion activities; to develop partnerships with the private sector; to develop the infrastructure for health promotion; to empower individuals and increase investment in health.</td>
<td>(WHO 1991)</td>
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<td>2000</td>
<td>Mexico City global conference</td>
<td>Emphasized that in order to achieve ‘health for all’ and ‘equity in health’ in the twenty-first century, health promotion must be an essential component of public policies and health promotion programmes internationally.</td>
<td>(WHO 2000)</td>
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2005 Bangkok Charter
Reviewed health promotion strategies internationally and identified the need for ‘coherent policies, investment and partnership across governments, international organizations, civil society and the private sector to ensure that health promotion is central to the global development agenda’.
(WHO 2005: 1)

2009 The Nairobi global conference
Adoption of Nairobi Call for Action and identified ‘key strategies to reduce the implementation gap in health and development through health promotion’.
Focused on practical issues in ‘building empowered communities; identified strategic actions required to achieve health literacy and practical linkages between health promotion and health care systems’.
(WHO 2009: 1)

Common themes

There are a number of common themes from these conferences. Each conference identifies the importance of health promotion work and that the focus of health promotion should be on equity, enablement, empowerment and community action. Each also identifies that policy should avoid harming the health of the individual; protect the environment; restrict the production of, and trade in, potentially harmful goods such as tobacco; safeguard both the citizen in the marketplace and the individual in the workplace; and include equity-focused health impact assessments as an integral part of policy development (Jakarta Declaration, cited in Green and Tones 2010).

Key point
Policy underpins all health promotion work

Chapter summary

In this chapter we have illustrated that the concept of health is not straightforward, and therefore when promoting health and well-being, we need to recognize and understand the various dimensions and determinants of health and recognize the difference between health inequalities and health inequities. In addition we have to recognize that health beliefs can also affect an individual’s health-related decision making, and that the health and well-being of individuals can be influenced by a range of factors, both within and outside the individual’s control. This chapter
has also introduced a number of World Health Organisation conferences that have led to the development of policies that aim to narrow the health divide and achieve equity within health care.

### Key points

- Health is multidimensional and can be influenced by culture, religious beliefs, age, gender, education and life experience.
- It is important for those working within health promotion to consider the dimensions and determinants of health.
- Inequalities in health persist, and as health promoters, it is vital that we understand why they occur and address them through our work.
- The World Health Organisation is committed to improving the health of the population, and is active in pursuing this aim.
- Governments in all countries are stewards of the health of their nation.

### Implications for practice

- Practitioners need to understand that there are many factors that impact on health.
- Practitioners need to acknowledge that inequalities continue to be an issue that needs to be addressed through health promotion.
- Improving health and well-being involves individuals as well health and social care professionals and international organizations such as the World Health Organisation.

### End of chapter questions

1. How does an understanding of health and its determinants impact on your practice?
2. What is the difference between health inequality and health inequity?
3. What is the role of the World Health Organisation in promoting health and well-being?
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References


