Overview

In this chapter, you will explore the history of health promotion within the context of the development of public health from the nineteenth century to the present. You will learn that ‘health promotion’ as a specific concept came into use in the 1980s, but to understand its meaning and significance you need to see health promotion in the light of the broader history of public health and changes in its definition over time. Three crucial phases are identified. The first phase took place during the nineteenth century, a period when promoting good health was part of the broader development of public health measures in the West, such as the improvement of sanitation. The second phase occurred in the early to mid twentieth century, a time when the focus of public health shifted away from the environment as a cause of ill health and began instead to focus on families and individuals. The third phase encompasses the late twentieth century and beyond. This is the period of the ‘new public health’, characterized by its focus on prevention, risk and the environment, and of health promotion as a national and international movement. Finally, you will assess some of the critiques levelled at health promotion, and you will see that these can be related to the past just as much as the present.

Learning objectives

After reading this chapter, you will be able to:

• describe the historical roots of the current concept of health promotion
• place changing definitions of public health and health promotion in social, economic, and political context
• evaluate political and scientific critiques of health promotion

Key terms

Eugenics: The science of human heredity, informed by evolutionary theory. In the early twentieth century, eugenics was concerned with racial improvement and the prevention of degeneration.

Health promotion: The process of enabling people to increase control over, and to improve, their health (WHO, 1986).
**History and concepts of health promotion**

**New public health:** Form of public health that developed from the 1970s onwards. Emphasized risk, prevention, and individual behaviour as a cause of disease.

**Primary health care:** Health services and care delivered at the local level often through community health workers, which has been particularly important in the global south from the 1970s onwards.

**Social medicine:** Form of public health developed in the inter-war years. Concerned with the effect of social conditions on health and mortality.

**Introduction**

‘Health promotion’ is a relatively new term, but it is an old concept. The phrase ‘health promotion’ was first used at national and international policy levels during the 1980s (Berridge 2010), but promoting good health as an idea has been around for as long as there have been attempts to improve the public’s health. One of the earliest public health texts, Hippocrates’ *On Airs, Waters and Places* (written around 400 B.C.) was intended as a guide for settlers going to new environments to help prevent them from getting sick (Porter, 1999: 15–16). To understand health promotion, and its place within contemporary public health, you need to know where it came from and how it developed. Health promotion and public health are not static concepts, and after reading this chapter you will be able to explain how and why these have changed over time. By learning about the history of public health and health promotion, you will be better equipped to deal with the problems that health promotion faces today and also be able to envision where it might go next.

**Activity 1.1**

This activity encourages you to reflect on how the meanings of both public health and health promotion have changed over time. Your task is to read the three quotations below and decide when you think these statements were made. Each extract is taken from a key document from the history of health promotion since the nineteenth century. One is from 1843, one is from 1943, and one is from 1976. Which is which? What are your reasons for dating the extracts in this way?

**Extract 1:** ‘we need to interest individuals, communities and society as a whole in the idea that prevention is better than cure’.

**Extract 2:** ‘The primary and most important measures, and at the same time the most practicable ... are drainage, the removal of refuse from habitations, streets and roads, and the improvement of supplies of water’.

**Extract 3:** ‘There is no sharp division between individual and social medicine. Health education and periodic health examination will some day supplement the remedial activities of the general practitioner.’
Feedback

Extract 1 is from 1976, Extract 2 is from 1843, and Extract 3 is from 1943.

You might have decided that the first extract was the most recent one because of its emphasis on the idea that prevention is better than cure. Indeed, this extract is taken from the UK Department of Health's (1976) report, *Prevention and Health: Everybody's Business*, which was indicative of the greater emphasis being placed on preventive measures as part of the new public health, the third phase in the evolution of health promotion discussed in this chapter.

You might have thought that the second extract was from 1842 because of its foregrounding of environmental factors. The extract, which comes from Edwin Chadwick's (1843) *Report on the Sanitary Condition of the Labouring Population of Great Britain*, is typical of nineteenth-century public health that focused on sanitation and the environment as both the cause and the solution to public health problems. But, as you will see, the environment made a re-appearance (albeit in a different way) in recent formulations of health promotion.

By the process of elimination, the third extract must be from 1943 (Ryle, 1943), but the clue to the date here is the use of the term 'social medicine', a concept that was integral to public health in the middle of the twentieth century. The emergence of social medicine was one aspect of the second phase in the development of public health discussed in this chapter. Each extract thus typifies one of the three phases that you are going to explore in more detail.

Phase 1: The nineteenth century

Environment and sanitation

Over the course of the nineteenth century, the populations of Britain and other Western nations grew rapidly. The population of Europe expanded from 123 million in 1800 to 230 million by 1890 (de Vries, 1984: 36). Moreover, this population growth was accompanied by industrialization and urbanization. The number of people living in towns and cities expanded as they left the countryside to find jobs in the new factories. This process was most pronounced in Britain, the heart of the Industrial Revolution. Small towns like Birmingham in the West Midlands became large cities: the population of Birmingham increased more than seven-fold between 1800 and 1900, from 74,000 to over 522,000. Major cities like London grew even larger: in 1831 the population of London was around 1.6 million, but by 1871 it had doubled to 3.2 million (UK Census).

Living and working conditions in these rapidly expanding cities were extremely poor, as key facilities, such as housing and sanitation, did not keep pace with the growth in population. For example, in 1840 the River Aire in Leeds was described as 'a reservoir of poison carefully kept for the purpose of breeding a pestilence in the town' and was composed of 'refuse from water closets, cesspools, privies, common drains, dung-hill drainings, infirmary refuse, wastes from slaughter houses, chemical soap, gas, dye houses and manufacturers, coloured by blue and black dye, pig manure, old urine wash, there were dead animals, vegetable substances and occasionally a decomposed human body' (quoted in Wohl, 1983: 235). In these conditions, infectious diseases thrived. Throughout the nineteenth century, there were a series of epidemics of diseases such as cholera and typhoid; around 53,000 people died in England and Wales in the 1848 cholera outbreak alone (Snow, 2002).
History and concepts of health promotion

The environment, perhaps unsurprisingly, was seen as a cause of disease. However, in the early part of the nineteenth century it was widely believed that disease was caused by bad smells and noxious gases – what was called ‘miasma’. Such beliefs were undermined eventually by the investigations of men like John Snow, who in 1854 deduced that cholera was a waterborne disease. Although it took some time for Snow’s findings to be accepted, by the second half of the nineteenth century sanitary reform was well underway (Hamlin, 1998). Measures such as the removal of sewage and other refuse and the provision of clean water were paid for by the more affluent city dwellers and by municipal governments (Melosi, 2000).

Social control?

Such actions were not, however, rooted solely in altruism. Although the middle and upper classes that lived in urban areas could, of course, also be exposed to infectious diseases, they were driven to take measures to improve public health for socio-political reasons as well. Epidemic disease posed a threat to the nation’s health, but also to its political, social, and economic well-being. Sick individuals were less able to work and so generate wealth, or to perform military duties and protect the nation and its empire. Political leaders therefore began to develop a series of public health policies that were intended to secure the health of the working population. Measures such as compulsory vaccination against smallpox were introduced, despite considerable popular and scientific opposition (Hennock, 1998; Durbach, 2005). The notification of incidences of infectious diseases was also made obligatory, as was treatment for some conditions, most notably venereal disease (what we would now call sexually transmitted infections) among women suspected of being prostitutes, but not their male clients. This double standard, and the fact that public health measures were often targeted at specific sections of society, has led some historians to see public health in this period as a form of social control (Donajgrodzki, 1977). Other historians, such as Christopher Hamlin, have argued that nineteenth-century public health focused on technical solutions rather than addressing the causal factors underlying public health problems, such as poverty (Hamlin, 1998).

Activity 1.2

In this activity, you will consider historical approaches to public health through a case study on sanitation and public health in the nineteenth century. Read the extracts below, and then answer the questions that follow.

‘consider the kind of public health that arose in Britain, one pre-occupied with water and wastes. It is difficult to acknowledge a need to explain this for it remains a central and uncontroversial part of public health. The water and sewage technologies the sanitarians developed quickly became one of the most widely diffused technological complexes in human history ... That we no longer see this achievement as revolutionary shows only how well the revolutionaries “black boxed” it. A world in which modern sanitation would have been rejected is unthinkable – the overflowing privy transcends ideology, calling only for a minimally competent engineer.’ (p. 7)

‘the early Victorians invented one public health among many. Their sanitary movement was not a systematic campaign to eliminate excess mortality. Its concern was with some
aspects [original italics] of the health of some [original italics] people: working-class men of working age. Women, infants, children and the aged were largely ignored.' (p. 12)

‘Chadwick and company rejected work, wages, and food to focus on water and filth, arguably the greatest “technical fix” in history.’ (p. 13)


1 What argument is Hamlin making about sanitation in nineteenth-century Britain?
2 What, according to Hamlin, would an alternative vision of public health have looked like at this time?

Feedback

Hamlin is arguing that sanitation was central to nineteenth-century ideas about public health in Britain. He states that the technologies developed – such as the removal of sewage and the provision of clean water – were one of the most successful innovations of all time. So successful, in fact, that we can no longer see how revolutionary these were, or acknowledge that it is necessary to explain how and why these measures came into being.

Hamlin suggests that the Victorian fixation on sanitation meant that other factors also crucial to public health were ignored. An alternative vision of public health in this period would have concentrated on reducing mortality for the whole population, not just among men of working age. This, Hamlin suggests, could have been achieved by focusing on improvements such as higher wages and better nutrition. In other words, social conditions were as important as the environment as a cause of ill health. We will return to this argument later when we consider some of the challenges faced by health promotion in the contemporary period.

The bacteriological revolution

Towards the end of the nineteenth century, environmental understandings of public health were pushed in a new, more specific direction. During the 1880s, the work of Louis Pasteur in France and Robert Koch in Germany demonstrated that microorganisms (bacteria) caused many forms of infectious disease. Their discoveries resulted in a significant growth in laboratory and scientific medicine, and led eventually to the development of effective drug treatments, in the form of antibiotics, although this was not until the 1940s. Some historians dispute the extent to which this constituted a ‘bacteriological revolution’, but these developments did lead to a ‘narrower concept of dirt’ and to a more specific understanding of the kinds of material that cause illness (Worboys, 2000). It has been suggested that the bacteriological revolution resulted in a stronger focus on the individual and the disease rather than on cleansing the environment. However, other historians have argued against this, asserting that this was actually a new form of environmentalism that stressed the individual’s place in the environment (Porter, 1999). Indeed, by the early twentieth century, attention was shifting towards a focus on a different kind of hygiene, not in the sense of drains and waste, but on what was called ‘social hygiene’.
Phase 2: 1900–1970

Social hygiene

Social hygiene was concerned with the social influences on individual and public health, and aimed to encourage a focus on preventive medicine. Underpinning this social focus, however, was a strong reliance on biological determinism. Proponents of social hygiene believed that the health and behaviour of individuals was determined by inherited traits and characteristics. Social hygienists thought that such conditions as alcoholism, and many other kinds of physical and mental illnesses, were passed on through the generations. The concept of health was tied strongly to ideas about national efficiency in this period. There was little sign of what we would now see as a notion of positive health, as health being more than the absence of disease. Fears about national efficiency coalesced around the concept of 'degeneration': the belief that bad breeding was weakening the 'race'. The Boer War (1899–1902) brought these issues into focus in Britain, as large numbers of army recruits were found to be unfit to fight; and the supposedly mighty British Army had trouble defeating a few Boer farmers (Jones, 1986).

To overcome such weaknesses, eugenic approaches were adopted. Eugenics was the science of improving the health of the population through controlled breeding (Bashford and Levine, 2010). Eugenic ideas led to the development of what we would now see as reprehensible policies, such as the forced sterilization of those believed to be 'unfit' to have children, including alcoholics and individuals with learning difficulties and mental health problems. At the same time, there was also a strong emphasis placed on improving maternity services and reducing infant mortality and morbidity. Attempts were made to encourage mothers to breastfeed, to produce better meals, and to reach higher standards of hygiene in the home (Apple, 1987). Maternal ignorance and poor personal hygiene were blamed frequently for infant deaths, yet the highest infant mortality was often concentrated in the poorest areas (Dyhouse, 1978).

The focus on motherhood and child health resulted in such developments as the introduction of health visitors, women who would enter homes and advise mothers on matters such as feeding, hygiene, and good parenting. Health visitors could be seen as intruding into the lives of the working class, another form of social control whereby the elite sought to regulate the behaviour of those lower down the social order. Some historians, however, have shown that by the inter-war period health visitors became more accepted and were offering support and advice to women in need (Davies, 1988).

Activity 1.3

This activity looks at early twentieth-century approaches to improving maternal and child health. Examine the image in Figure 1.1, which is a reproduction of a leaflet produced by the East and West Molesey Infant Welfare Centre in Surrey, England circa 1930, and then answer the following questions:

1. Who do you think the leaflet was targeted at?
2. What effect do you think it might have had on its audience?
The history of health promotion

Feedback

The leaflet was targeted at the mothers of small children. We can tell this because of its focus on issues that relate to infants, but note also how it is addressed to mothers (under ‘M’) alone, and not mothers and fathers, a view of parenthood typical of the period. The focus on mothers reflected the idea that the health of the population could be bettered by improving the way in which children were raised. You may also
have noticed that other messages – not strictly related to the health of children – are communicated, such as ‘E’ for economy, ‘F’ for the future, and the rather stern sounding ‘R’ for rules. The leaflet is perhaps intended to inculcate other kinds of ‘good’ behaviours in the attending mothers, and is likely to be indicative of the middle-class values of those running the health centre.

2 It is, of course, difficult to know exactly what kind of an effect such a leaflet may have had on its audience. Some of the mothers may have welcomed the leaflet as an informative list of the kinds of facilities and advice they were likely to find at the centre. Others may have found the leaflet patronizing or condescending, especially if they did not share the values of those running the centre. Some mothers may have ignored the leaflet, and been more focused on the services that the centre offered at a time before free, comprehensive health care was widely available in Britain. Even today, as we will discuss below, efforts to promote good health do not always have the intended effect on their audience.

The development of health services

By the middle of the twentieth century, there were signs in many Western countries that preventing disease and promoting good health might have more of a role to play in health services. The Second World War helped to drive forward the development of centralized health systems in many European nations. In Britain, for example, early plans for the establishment of the National Health Service (NHS) appeared to emphasize disease prevention and health education. In 1944, a White Paper (draft legislation) on the NHS stated that the service aimed to: ‘divorce the case of health from questions of personal means and other factors irrelevant to it: to provide the service free of charge . . . and to encourage a new attitude to health – the easier obtaining of advice early, the promotion of good health rather than only the treatment of bad’ (Ministry of Health, 1944).

The attention being directed to promoting good health, however, did seem to disappear once the NHS was established in 1948. Much greater emphasis was placed on treating sickness rather than promoting health. By the 1950s and 1960s, faith in high-tech medicine, and particularly so-called ‘magic bullets’ – specific drugs that could cure particular diseases – was at its height. There were some justified successes: due partly to drugs like antibiotics and also to vaccination programmes, epidemics of infectious diseases seemed to be a thing of the past, at least in the West. Ironically, this was a difficult period for public health medicine, as its old foes appeared to have been vanquished. Public health needed to find a new role.

Social medicine

One of the ways in which public health was able to revitalize itself was around the notion of social medicine. Social medicine developed in Britain during the 1930s and 1940s, and was concerned with what John Ryle (who was the first Professor of Social Medicine at Oxford University) described as the: ‘whole economic, nutritional, occupational, educational and psychological opportunity or experience of the individual or community’ (Ryle, 1948: 11–12). What Ryle and other proponents of social medicine were proposing was a much wider notion of health as a positive condition and not just the absence of disease. To this end, health professionals inspired by social medicine began to work with local communities to improve health.
Social medicine helped to change the focus of public health in other ways too, particularly by bringing the social sciences into health studies, and especially epidemiology. Research conducted during the 1940s and 1950s using epidemiological techniques identified specific behaviours, such as tobacco smoking and diet, as risk factors for developing diseases like lung cancer and coronary heart disease (Rothstein, 2003). In this way, social medicine was an important antecedent of many of the key aspects of what became known as the new public health.

Phase 3: 1970 to the present

Figure 1.2 US Department of Health and Human Services poster from the 1990s. Reproduced by permission of Wellcome Library, London.

Source: Wellcome Library, London

Activity 1.4

Examine Figure 1.2, which is an AIDS prevention poster produced by the US Department of Health and Human Services in the 1990s, and then answer the following questions:
1 Who was this poster being targeted at?
2 What effect do you think this poster was designed to have on its audience?

Feedback

1 The poster was being targeted at heterosexual women. It is representative of a shift in ideas about who was likely to contract HIV from 'high-risk groups' – like gay men, intravenous drug users, and haemophiliacs – to the wider population of non-drug-using heterosexuals. The poster also tells us something about changing gender relations, or at least the possibility that women may insist that a male sexual partner use a condom.

2 Clues to the intended effect of the poster appear in the text. ‘Risk’ is mentioned, and the campaign seems to be intended to influence individual behaviour in order to prevent the transmission of HIV and the development of AIDS. Risk, prevention, and a focus on individual behaviour were all crucial aspects of the new public health and the development of health promotion, as you will see in the next section. Again, as with the previous activity, it is difficult to know what affect such campaigns actually had on their intended audience. The lower than initially feared incidences of HIV/AIDS could be seen as evidence of the ‘success’ of such campaigns, but in many Western countries HIV/AIDS prevalence is now higher than it was in the late 1980s/early 1990s. Some critics have viewed such campaigns as potentially stigmatizing for people living with HIV/AIDS, an argument discussed in greater detail later in this chapter.

The new public health

Notions of risk, safety, prevention, and individual behaviour – as both a cause of disease and a way to combat it – were central to what was called the new public health. In part, this grew out of the challenge to conventional medicine. During the 1970s, biomedicine came under attack from two sides. First, the rising costs of health care, together with a weak global economy, made high-tech medicine increasingly expensive. At the same time, the shortcomings of health services in both high- and low-income countries were exposed, often through high-profile scandals about poor care. Second, theorists and researchers began to criticize the supposed victories of high-tech medicine. Particularly important here was the work of Thomas McKeown, Professor of Social Medicine at the University of Birmingham. McKeown argued that declining mortality rates at the end of the nineteenth century were the result not so much of medical advances, but of improved living standards and nutrition (McKeown, 1979). The McKeown thesis had an international impact. The influence of his work can be observed in a report produced by the Canadian Minister of Health, Marc LaLonde in 1974. The report, A New Perspective on the Health of Canadians (the LaLonde Report), acknowledged that improving living standards and public health measures were at least as important, if not more so, than biomedicine for the health of Canadians.

Health promotion and primary health care

Following the LaLonde Report, health promotion began to emerge as a specifically identifiable strand within public health (MacDougall, 2007). Health promotion differed
The history of health promotion

from the more medicalized new public health by emphasizing the wider social influences upon collective and individual health. This can be seen in a number of developments globally. There were a series of initiatives introduced by the World Health Organization (WHO) in the late 1970s and 1980s that stressed the importance of promoting good health as well as combating disease. The 1978 Declaration of Alma Ata, for example, advocated a multidimensional approach to health and socioeconomic development, and urged active community participation in health care and health education at every level, with a particular focus on primary health care (Cueto, 2004). In 1986, the Ottawa Charter for Health Promotion was introduced. This document shifted the focus of public health from disease prevention to ‘capacity building for health’. This was tied through the work of the Pan American Health Organization (PAHO) and the European office of WHO (WHO Euro) to an approach that moved beyond health care to a commitment to social reform and equity (Kickbusch, 2003). To achieve this, specific targets were introduced, such as those developed by WHO Euro under the slogan ‘Health for All by the Year 2000’, which emphasized the importance of understanding health behaviours within their social context.

As part of this wider view of the determinants of health, by the late 1980s there were signs that the environment was returning to play a role in public health and health promotion. However, this took a slightly different form to the fixation with water and sanitation so much in evidence during the nineteenth century, at least in the higher-income countries. At the global and national levels, concern was expressed about resource depletion, pollution, and the creation of unhealthy environments and living conditions, especially in towns. There were moves to place the environment at the heart of attempts to secure good health for all. This can be seen in the Ottawa Charter for Health Promotion, which stated that: ‘The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in these basic prerequisites’ (WHO, 1986).

The Ottawa Charter was also part of an attempt to encourage governments to take responsibility for creating environments that would make it possible for their populations to be healthy. But it was not only governments that took the lead here: there was some inter-sectoral cooperation, with the public and the community working together with government to make healthy environments possible. An example of this is the Healthy Cities Initiative. Launched in 1987, this project aimed to bypass national health ministries and localize health promotion, building a strong lobby at the local level (Petersen and Lupton, 1996).

The international health promotion movement initially retained a Canadian and European focus. In some countries such as the US, health education with its much longer history as a strategy was never replaced by health promotion. In other countries such as India, health promoting strategies had been used for longer but were not termed as such. Separate from health promotion, but with similarities, was another international movement that had its main influence in low-income countries. This was primary health care, driven forward after the Declaration of Alma Ata in 1978 (Berridge, 2010). The primary health care movement was concerned to find different ways of organizing basic health services in resource-poor countries. Early initiatives such as barefoot doctors in China and village health workers in Tanzania in the 1960s were important precursors. In Venezuela and Guatemala, ordinary people were trained to provide basic health care and Cuba also introduced a different model of health services. Later, through the influence of WHO and UNICEF, such approaches – in particular the
use of community health workers – spread widely in what were then called ‘developing countries’. There were heated debates about whether programmes should be ‘horizontal’ or ‘vertical’ (i.e. whether they should encompass wide service provision or simply focus on a few conditions and problems). The latter approach was more attractive to external donors (Walt, 2001). Only in the twenty-first century did concerns about chronic disease begin to surface in these countries.

**Prevention and risk**

Indeed, the development of health promotion at the global level had an impact on national and local public health policies too. A strong emphasis on disease prevention can be identified in national public health policy documents from this period, such as the UK’s *Prevention and Health: Everybody’s Business*, which we looked at in the opening exercise of this chapter (Department of Health, 1976). Such an emphasis on disease prevention was underpinned by epidemiology and the notion of risk. The case of smoking and lung cancer illustrates this well. The work of Doll and Hill (1954, 1956) identified smoking as a risk factor for developing lung cancer. Here was a behaviour – not an environmental factor – that was causing disease with the potential to affect the health of the population as a whole. As a result, a new public health agenda began to develop that stressed the need for behavioural change and for individuals to take responsibility for their own health. Advertising and the mass media were both used to promote good health and also encourage behavioural change. As you saw with the poster in Activity 1.4, emphasis was placed on preventing individuals from becoming sick.

In more recent years, it seems that the notion of risk has been broadened to include the risks that individuals or groups of individuals pose to the rest of the community, not just to their own health. Passive smoking is one example of this, with the relatively small risk posed by smokers to the health of others used to justify policies such as banning smoking in public places (Berridge, 2007). We can identify a subtle shift here: instead of focusing on individual behaviour and the risk that this poses to the health of the individual engaging in that behaviour, there is also an emphasis on the impact that behaviour has on the wider community. Is the idea of the risky individual giving way to that of protecting the safety of community?

Evidence for such a view can be found, for instance, in the recent reformulation of the UK’s strategy on illegal drugs, which focuses more on reducing the crime associated with drug use than on providing treatment for individuals. Some critics fear that this could lead to a more punitive turn within the drugs field and in public health more broadly, as emphasis is placed on protecting the community from the risks posed by others. Such an approach adds weight to the arguments made by people who are critical of health promotion. By way of conclusion, we will examine some of these critiques and consider what these also say about the way health promotion has developed over the last 100 years or so.

**Critiques of health promotion**

In this section, we analyse three categories of attack made against health promotion: practical, structural, and surveillance. But first, complete Activity 1.5, which highlights some of these themes.
Activity 1.5

For some critics, health promotion still means health education only. In this activity, you will consider critiques of health education. Read the extracts below, which are taken from an article about health education by the British general practitioner and author James Le Fanu. Health education is a specific strand of health promotion that emphasizes learning to improve health. Once you have read the extracts, answer the questions that follow.

‘Health education is an unexciting subject of marginal intellectual content. In essence, and this is certainly the overriding public impression, it takes the form of advertising slogans – or rather admonitions – which, were they complied with, are presumed to improve the health of the nation: don’t drink and drive; wear a condom; smoking kills; eat healthily etc.’ (p. 89)

‘scientific attempts to evaluate health education promotions almost all show that it is actually very difficult to get people to change their behaviour by cajoling them to do so’. (p. 90)

‘health education like any other branch of medicine is not without its “side effects” which would be – as with the case of drugs – acceptable if it worked, but unacceptable if it does not. These side effects would include frightening the public with misleading concepts about the risk of everyday life, the linking of pleasurable activities like eating and sex with disability and death. Do fish and chips clog up the arteries? Is unprotected casual heterosexual intercourse very risky? For those unfortunate enough to suffer from coronary heart disease or stroke, the health education message might have the “side effect” of blaming the victim where the sufferers believe that their misfortune is in large measure their own fault.’ (p. 91)

‘Over the last decade the Conservative government has enormously increased its direct involvement in the private lives of the nation through its resourcing of health education programmes. There are two sound reasons for regretting this development: it reinforces the ethos of the nanny state in which the notion that individuals are responsible for their own lives is marginalised; further, and this particularly applies to the AIDS campaign, it has been argued by, for example, the Chief Rabbi, the campaigns appear to endorse a moral message which sanctions casual sexual intercourse as long as it is performed “safely”. To this extent health education can be said to have influenced the moral tone of the nation.’ (pp. 91–2)


1 Itemize the different concerns Le Fanu raises about health education.
2 How convincing are his arguments against health education?

Feedback

1 The concerns Le Fanu raises are: (a) Health education lacks an intellectual foundation and is instead based on telling people what to do. (b) There is little evidence to
show that health education works. (c) Health education has side-effects, including blaming the victim for his or her condition. (d) Health education undermines individual responsibility for health. (e) Health education may encourage 'immoral' behaviour, such as having casual sex.

2 Some of you will not have been convinced by Le Fanu's arguments. You may have noticed, for example, that in the extracts presented he does not cite any evidence for his contention that health education does not work. Le Fanu does draw on evidence to support his argument in the full article, such as studies of health education campaigns that have shown that behaviour is rarely changed by exposure to such material. But how do we know what causes an individual to change their behaviour? How long does it take for the effects of health promotion campaigns to be felt? You may also have picked up on the rather controversial tone of Le Fanu's writing. This may have made you feel less confident about his arguments. Yet, some of you could have found Le Fanu's statements more convincing. He does raise genuine concerns about whether or not health promotion works and its unintended effects. Regardless of whether or not you agree with Le Fanu, he does make some important points that health promoters need to take into account, issues that are discussed in more detail in the remainder of this chapter.

Practical

One of the key critiques directed at health promotion is that it simply does not work: it does not achieve the level of improvements in health it aims to. Critics like Le Fanu argue that the resources used on health promotion would be better spent on treating the sick rather than on preventing people getting ill. In practice, many national health systems are designed primarily to deal with the ill and tend to place less emphasis on disease prevention. Moreover, it could be argued, it makes sense when we only have finite resources to spend on health that these are best directed at those who are already ill. At the same time, from a political perspective, even if health promotion measures have an effect, it is likely that these can only be felt over a long period and are often difficult to measure.

Structural

A different kind of attack (often made by those on the left) is that health promotion fails to address the structural issues that underpin health. Insufficient attention, critics argue, is paid to the conditions that produce bad health such as poverty, poor housing, dangerous environments, and so on. Inequalities and health have made a re-appearance in health promotion in recent years, but many would suggest the insufficient attention is paid to this issue still (Marmot, 2004).

Another structural problem with health promotion is that by targeting individual behaviour and placing responsibility for health on individuals, it can have the effect of appearing to blame victims of disease for their condition (Crawford, 1977). In contrast, governments have been slow to target key actors such as the tobacco industry that produce the products that make people sick in the first place. Focusing on preventing sickness can also have the effect of increasing the stigma associated with being ill. As we saw with the HIV/AIDS prevention poster, such efforts state very clearly that being ill is an undesirable state, which increases the stigma attached to those who are unwell.
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Surveillance

Finally, some see health promotion as a project that places large sections of the population under surveillance (Armstrong, 2008). Monitoring the health of the population can become a form of discipline. Exhorting people to behave in a proscribed way undermines individual agency and autonomy. Health promotion can thus become a tool of social control.

Conclusion

Now, whether or not you agree with these critiques, it is interesting that they echo many of the themes we have touched on in the long history of public health and health promotion. Surveillance, social control, stigmatization, whether to emphasize disease treatment or prevention are all themes that we have come across before. We have seen how the social determinants of health have often been ignored. In the nineteenth century, for example, poor living conditions were often to blame for sickness, but instead the working classes were pathologized and regarded as a source of disease. There has also long been a tendency to blame the victims of public health problems – we can see this in the late twentieth century and the emphasis on individual responsibility for health. It is also the case that public health and health promotion measures can be a form of social control. Intervention into people’s lives, such as the introduction of health visitors in the early twentieth century, can have a disciplinary effect. Such issues, present in the past, are manifestly still with us in more recent attempts to safeguard public health and promote good health.

Summary

The history of health promotion illustrates some of the complexities and issues that health promotion continues to face today. Key points include:

- Health promotion as a specific discipline emerged in the 1970s.
- Health promotion was rooted in much earlier shifts within public health that stretch back to the nineteenth century and beyond.
- There is both continuity and change over time within public health and health promotion.
- Some issues appear, disappear, and re-appear, such as the environment.

References

History and concepts of health promotion


The history of health promotion


