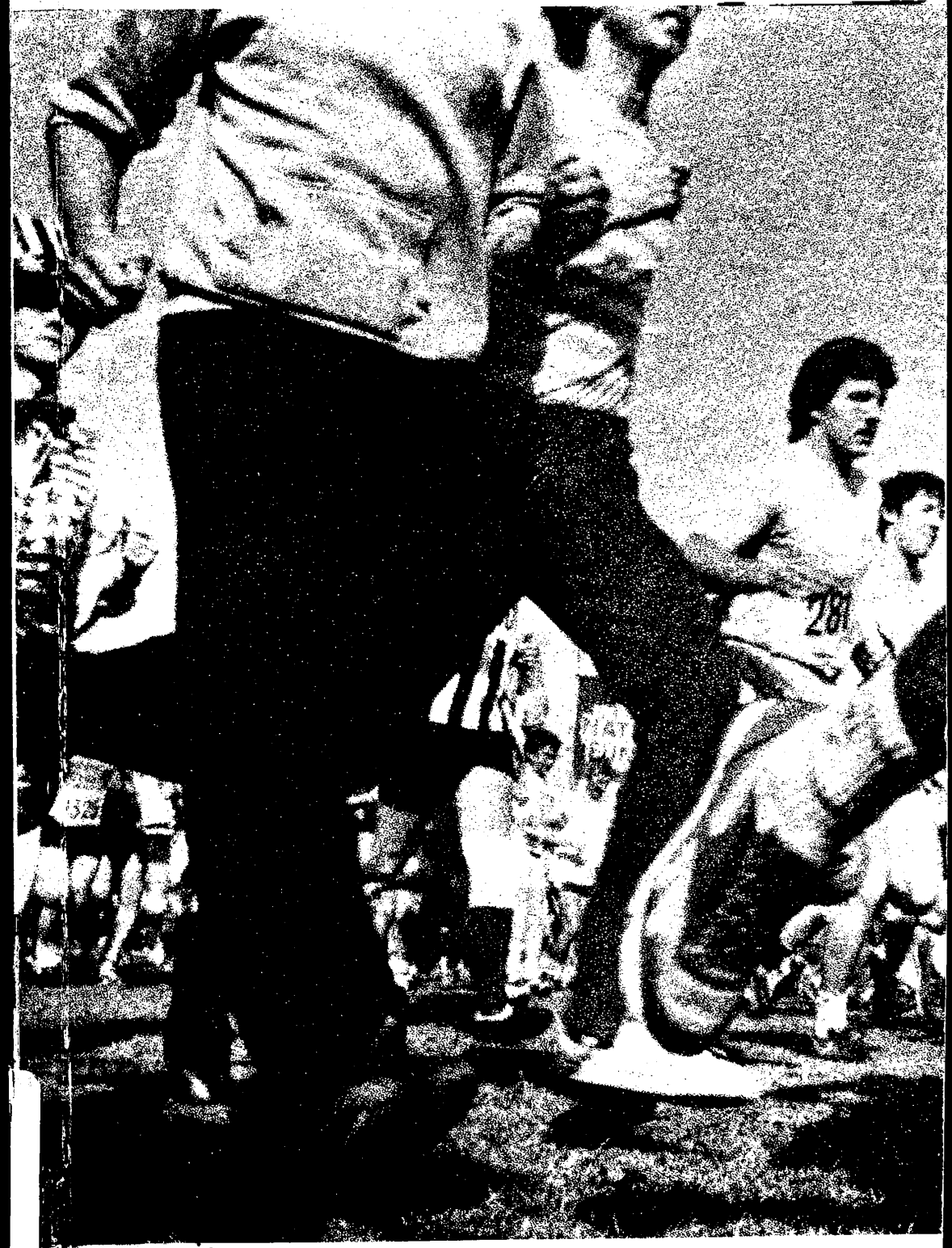
Health Promotion in North America

Implications for the UK

Edited by Christopher Robbins



Health Education Council
King Edward's Hospital Fund for London

ACCESSION NO.	CLASS MARK
27455	HHB
DATE OF RECEIPT	PRICE
28 Apr 1987	donation

ROB

Health promotion in North America: implications for the UK

Health promotion in North America: implications for the UK

A REPORT FROM A HEC/KING'S FUND
STUDY TOUR

Edited by Christopher Robbins

HEALTH EDUCATION COUNCIL
and KING EDWARD'S HOSPITAL FUND FOR LONDON

Typeset by Tradespools Ltd, Frome, Somerset
Printed and bound in England by Hollen Street Press

King's Fund Publishing Office
2 St Andrew's Place
London NW1 4LB

CONTENTS

Foreword

Approaches to health in the community are moving away from traditional disease management models to exploring ways of protecting health throughout life. This is not to downplay cure and care, but to recognise that prevention and health promotion also have major parts to play. Because our bodies age and we are all mortal, most of us will desperately need care sooner or later. But when we need it, and how healthy our lives are, will be equally influenced by our life-style and our social and environmental context.

As those who have examined the concepts realise, there are no short and precise definitions of the new public health. Nor should there be rigid intellectual or organisational boundaries to confine its development. The movement challenges the basic definition of health, accepted views of who should be included in decisions affecting health, and the nature of a society which will promote and protect health. It is not only about professional practice but about processes of communal and individual action. It is a challenging concept.

We saw a study tour of North America as an opportunity for younger health professionals in the UK to study the ideas and practices of countries with different health care systems. Canada and the USA are of particular interest because both have extensive experience of health promotion initiatives nurtured in societies that positively encourage experimentation and innovation. North America provided both an excellent environment for the individual development of health promoters, and a source of stimulation for the growing debate on the role and directions for health promotion in the UK.

The original papers reflect the optimism and success achieved in North America's longer experience with health promotion in practice. Across the two vast countries with their large populations and resources, many different projects and practitioners were visited. Even allowing for the differences in culture, ideology and health service provision between the UK and North America, tour members returned armed with impressive lists of implications for the UK. The sense of urgency, and the wish to share these ideas with others, have also deeply impressed us. There are the stirrings of a new movement in public health

(provisionally named the Public Health Alliance) which can in part be traced to the visit described in this book.

Robert Maxwell, King Edward's Hospital Fund for London
David Player, Health Education Council

Introduction

The report is based on the papers submitted by the members of a Health Education Council/King's Fund sponsored study tour on Health Promotion in North America in October 1985.

The proposal for the study tour came from John Ashton, Regional Specialist in Community Medicine (Health Promotion), Mersey Regional Health Authority. He had been involved in both the academic and practical ends of health promotion for several years and felt that there was much to be learnt from the North American experience. The King's Fund was approached with the suggestion that they consider funding a tour to study North American developments in health promotion over the past ten years. The results were to be published with a view to wide circulation, especially within the National Health Service.

Tour members were invited from among active practitioners who had made a significant contribution to the field and who were considered to have a commitment to developing the field in the UK. The tour was scheduled from the 19th October to the 1st November, 1985. In the months before departure, the tour members met several times to refine a framework for their study and to begin making contacts with individuals and projects they wished to visit. Four groups were formed around the main areas of interest which were:

1 The development of health policy, especially the relationships between various levels of government and how far national health promotion goals are being implemented at local level.

2 Methods to produce change in communities, with particular reference to the promotion of health in adults (especially in urban environments).

3 Health promotion strategies for young people

4 Promoting the health of older people.

North America was taken as the USA and Canada, and the tour was to be based in four centres – San Francisco, New York, Washington and Toronto. Because of the wide range of interests among members and the vast array of possible visits, the tour divided into small groups with their own itineraries. It was

planned that members would be able to meet regularly in small groups if not all together, to discuss their findings and impressions. In the event, the logistics of coordinating travel across such distances and of fitting in with hosts' timetables meant this ambition was sacrificed to maximise the contact with projects and individuals. Full discussion was left until the members returned to the UK.

In March 1986, a workshop was held at the King's Fund Centre in London. The papers produced by tour members on their return were discussed among the invited participants as a means of sharing the personalised experiences expressed in each paper and of taking a wider view on the implications for the UK. The papers were subsequently redrafted to reflect the valuable workshop discussions.

This report is a compilation of the important information and conclusions from the original papers together with material from the workshop and additional discussions between myself and the tour members. The original papers are available from the authors who may also publish them separately in appropriate journals.

Chapters 1 and 2 draw material from all the individual papers and substantial amounts from the papers of Bobbie Jacobson and of John Ashton. Chapters 3 to 9 cover the main subjects studied during the tour and each deals with one of the original papers. The authors are listed on each chapter's title page. The implications at the end of each chapter and the conclusions in chapter 10 have been drawn from the original papers and discussions with the authors.

In preparing this report, the aim has been to provide a context and continuity within which the individual experiences and responses of tour members can be appreciated. I have tried to retain as much of each author's priorities and individual reactions as was possible during extracting and editing. Despite all efforts, the result may not be as perfect as the authors would wish and, therefore, they should not be held responsible for the views expressed in the chapters based on their papers.

The views and conclusions in the report are not necessarily held by the two sponsoring organisations.

Christopher Robbins

MEMBERS OF THE STUDY TOUR

Robert Anderson A social scientist in the Institute for Social Studies in Medical Care, London. Works with the Health Promotion Programme in the European Office of the World Health Organisation. Research interests include prevention and health promotion in primary health care.

John Ashton Senior Lecturer in Community Health, Liverpool University Medical School, and Specialist in Community Medicine (Health Promotion), Mersey Regional Health Authority. Active in developing a health promotion strategy for the Mersey Region and coordination of WHO's Healthy Cities Project. Research interests include the evaluation of health promotion projects and health promotion in primary care.

John Dodds District Health Education Officer with Paddington and North Kensington Health Authority, London. The department is particularly interested in using community development approaches to health promotion at district level within the NHS.

Peter Droog Unit General Manager at Charing Cross Hospital, London. Previously Associate District Administrator, Plymouth Health Authority, where he was responsible for corporate planning and information services. Particular interests in monitoring care group strategies, developing priority services and providing indicators for review.

Lynda Finn Assistant Education Officer in the Schools and Further Education section of the Health Education Council; London. Previously taught further education in London.

Bill Fraser During the tour he was King's Fund Faculty member with particular responsibilities for graduate management training, and for doctors in management training, with an emphasis on primary care and community medicine. Previously a hospital administrator in the NHS and in New York. A member of the Paddington and North Kensington Community Health Council. (Bill was an administrator of the tour as well as a full member but has since left the Fund to work as a freelance consultant.)

Carol Haslam Commissioning Editor, Documentaries, for Channel 4 television, including responsibility for health programming. Particular interests in the role of the media in the health profession and in agenda setting. Since the tour, Carol has become Director of Programming for Super Channel, the new ITV/BBC satellite service to Europe.

John Huntington John is coordinator of two of the HEC's programmes: Adult and Community Education, and Health in Old Age. He is interested in new initiatives for health promotion among older adults and in ways of enhancing the effectiveness of national agencies in increasing national support for health promotion.

June Huntington Fellow in Organisational and Professional Studies at the King's Fund College in London. June is interested in the organisation and management challenges for general practice in moving towards anticipatory care and health promotion, with a particular interest in mental health.

Bobbie Jacobson Research Fellow in Health Promotion, London School of Hygiene and Tropical Medicine. Formerly Deputy Director of Action on Smoking and Health before qualifying in medicine. Interested in public health policy, women and health, and communication in health and medicine.

Madeleine Rendall Executive Assistant to the Director General of the Health Education Council, London. Previously worked in Action on Smoking and Health and in the OECD in Paris on the Radiation Protection Section. Interested in inequalities in health and constraints on health promotion.

Theo Schofield A family practitioner in group practice with a community hospital in Oxford and Health Education Council Lecturer in General Practice, Department of Community Medicine and General Practice, University of Oxford. Previously Associate Regional Adviser, Oxford Region Vocational Training Scheme. Interests include health promotion in primary care, diffusion of innovations, performance review in practice.

Howard Seymour Regional Health Promotion Officer, Mersey Regional Health Authority. Previously Director of Health

Education for Manchester and Honorary Lecturer, Medical School, Manchester University. Also a management trainer with the Unit for Continuing Education, Manchester University.

CHAPTER ONE

A new health promotion

[Based on material from several papers, especially those of John Ashton, Bobbie Jacobson and Madeleine Rendall]

There is a popular realisation that the preoccupying health problems in both developed and third world countries cannot be solved by medical services alone. The persistence of premature mortality rates from disease like cancers, heart disease and high morbidity from mental health and other chronic diseases have forced an assessment of disease control strategies which rely primarily on the traditional medical services. More attention has been given to identifying and reducing the causes of these diseases, most of which lie outside the normal reach of medical services.

But perhaps the most significant developments have been in new attempts to redefine the nature of disease and health within the social context. Attention has been directed to maintaining health rather than simply preventing diseases and this has led in turn to health being defined as a positive goal. Health is more than the absence of disease. It is also a state of wellbeing, of feeling in control of the surrounding environment, of achieving individual and social potentials.

A new impetus for health promotion is emerging from these debates. Health promotion is not new. But since the late 1970s, and with the focus provided by the WHO's 'Health for All by the Year 2000' declarations, its concepts and principles have been refined and are seen as providing a feasible basis for developing a new approach to public health.

In its simplest form, health promotion is doing what needs doing to improve health. Most debate and attention to policy has centred on the 'what', 'how' and 'by whom'. The process of influencing health becomes as important as the medical outcomes which usually receive most attention.

The WHO describes health promotion as a process:

> ... enabling people to increase control over, and to improve, their health. This perspective is derived from a conception of 'health' as the extent to which an individual or group is able, on

the one hand, to realise aspirations and satisfy needs; and, on the other hand, to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not an object of living; it is a positive concept emphasising social and personal resources, as well as physical capacities.[1]

The WHO set out five principles of health promotion which are summarised as:

1 involving the population as a whole in the context of their everyday life, rather than focusing on people at risk for specific diseases;

2 directed towards action on the determinants or causes of health;

3 combining diverse but complementary methods or approaches;

4 aiming particularly at effective and concrete public participation;

5 involving health professionals – particularly in primary care – in the important role of nurturing and enabling health promotion.

In practical terms, health promotion can be seen as a process involving social, political, economic, educational, organisational and individual action. Medical practitioners, who have dominated the planning and decision processes governing health, have clear roles, but these cannot be exclusive of other professional groups, communities or individual involvement. Similarly, health education and disease prevention are integral parts of the process, but are not synonymous with health promotion.

United Kingdom interest in health promotion

Health promotion has been discussed for several years in the UK[2,3] but, although many health authorities are either setting up health promotion teams or are adapting some practices, there is still little sign of significant change in government and some health professions' attitudes to public health policy and practice.

Much of the reorientation of thinking towards health promotion in the UK has been prompted by three striking features of the country's health. First, the high persistent mortality and morbidity from the 'lifestyle' diseases like heart disease and lung cancer; second, the size, stubborn durability and impact on

health of the social inequalities and poverty which were emphasised in the Black report[4]; third, the replacement of medical officers of health within local authorities by the newly-created district medical officers in health authorities during the 1974 reorganisation of the Health Service.

The National Health Service (NHS) is primarily a medical treatment and rehabilitation delivery service. It has little control or influence over the determinants of health. Knowledge, attitudes, skills, and economic, social and environmental resources which determine the potential for, and constraints on, health are largely outside the reach and remit of the NHS. It doesn't build cars or motorways, manufacture cigarettes and foods, or provide the advertising and marketing which ensure their consumption, build houses, recreation centres or art galleries, and it doesn't run the schools, cinemas or media. Health is gained, maintained or lost in the worlds of work, leisure, home and city life.

Traditional health promoters in society – the doctors, nurses, teachers, and community workers – have only a small impact on the total influences on people's lives. They are met infrequently and often in 'unreal' circumstances or environments. The old medical officer of health role did provide a general advocacy function in the community and also a more systematic coverage of the many determinants of health – housing, transport, food hygiene. But the new concept of health promotion is too extensive and wide-ranging to be the responsibility of one person. It calls for new skills and methods of working that might best be gathered through multidisciplinary teams.

The present organisation and practices of the NHS do not easily embrace the promotion of health. The service is biased towards providing hospital services, and health promotion activities receive a low priority in the allocation of constrained resources. But, in addition, the dominance of curative medicine in decisions which allocate these health resources makes it difficult to argue priorities for health promotion. These new concepts of health promotion are further frustrated because both doctors and administrators tend to withhold knowledge and information from the public – ranging from patient records to statistics on health service delivery. Such restrictions contrast with the assumptions of free access to, and exchange of information in, the self-empowering principles of health promotion.

The management of the NHS is highly centralised with the appointment of district general managers and health authority chairmen under the control of the Minister of Health. This means

the NHS functions without accountability to the local community. The resulting lack of individual and local groups sharing in information and decision-making in their local health services is an additional frustration for health promotion.

Of course many exciting initiatives in health promotion have been generated from within the NHS and the community. But these initiatives often arise out of a feeling of dissatisfaction with the formal health services and through the exceptional efforts of individuals rather than the normal consultation and planning processes in the NHS or local authorities.

The low priority that has been given to health promotion is reflected in the absence of national research on the nature and extent of UK initiatives. Within the NHS, apart from the health education staff at district level, professionals including health visitors, midwives and community nurses have significant health promotion roles. In addition, there has been experimental work with nurse facilitators in Oxford and several regions and districts have established new posts in health promotion.

Outside the NHS there is also much activity. Local authorities are expanding their interest and capacity in health. Many have formed new health committees. Schools, which are run by local authorities, have developed many exciting programmes, often in collaboration with the NHS health education staff or the HEC. Large numbers of community groups are active in diverse areas of health promotion and receive funding support from both the private and public sectors. The mass media cannot be discounted. Broadcast media in particular, but also the magazines and newspapers, have contributed to raising awareness and supplying information. 'Off-air' backup services have reached high standards with leaflets, books and resources being made available for individuals and schools.

A brief overview of health promotion in the UK was prepared by tour members for circulation during their North American visits (see Appendix C).

It was clear to the organisers of the study tour that there was much to learn if health promotion were to become widely accepted and successfully adopted in the UK. North America perhaps offers more contrasts than similarities in comparison with the UK, but both Canada and the USA have many years' experience of implementing the new concepts of health promotion in particular circumstances which encourage innovation and experimentation.

CHAPTER TWO

Health promotion in North America

[Based on the paper by Bobbie Jacobson and Madeleine Rendall]

Health promotion in North America enjoys a high profile and a considerable degree of commitment at national, local and individual levels. At the federal level in the USA, it is understood in much narrower terms than in either Canada or the UK, being seen as a process of disease prevention involving risk factor reduction in what is assumed to be a fit population. In the USA, there is a clearly quantified national policy based on an epidemiological assessment of diseases which cause a reduction in lifespan or significant disability. The emphasis therefore is on the physical aspects of health (which is easier to quantify) rather than on the mental or social aspects. The burden of responsibility for action is laid firmly on individuals and their immediate community.

Canadian national objectives for health promotion are less clearly defined, but involve a broader notion of health derived from the WHO view that health is a social rather than a medical ideal. Action to improve health must therefore encompass changes in the social environment as well as in the individual. Implicit in the Canadian approach to health promotion is the idea that 'healthy progress' requires policies which promote social and economic equality as well. This, they argue, can be achieved via a shift in emphasis from disease prevention towards intersectoral cooperation to create a social climate where healthy options are made easier for the individual.

In both countries, health promotion activities are usually based outside traditional medical settings, although doctors and other health professionals still have a role to play. The activities are found in the private and public sector, in workplaces, community groups and organisations, churches and voluntary organisations. The combining of disciplines and sectors is a striking feature and the management is as often as not in non-health professional hands. A wide range of approaches is also found, ranging from simple provision of information or services to self-help groups and community participation programmes and activities.

USA – policy and organisation

President Carter's 1971 Committee on Health Education (CHE) paved the way for a profound change in both the structure and importance of public health. In 1976 the Office of Disease Prevention and Health Promotion (ODPHP) was established in the Department of Health and Human Services (DHHS) in Washington with a staff of 18 and a budget of $3.5m pa. In 1979, the Surgeon General's report *Healthy People* was the first review of the state of the nation's health and recommended national goals for health promotion to be achieved by 1990.[5] They are based on the five major stages of life:

	Target	*Goals*
1	Infants	Reduce infant mortality by 35 per cent
2	Children	Optimise child development; reduce mortality in under 14s by 20 per cent
3	Adolescents	Improve health habits; reduce mortality by 20 per cent
4	Adults	Reduce mortality by 20 per cent
5	Older adults	Reduce the number of days of restricted activity; improve quality of life

To achieve these goals, 15 priority areas for action were defined:

Preventive health services

1 Blood pressure control
2 Family planning
3 Pregnancy and infant health
4 Immunisation
5 Sexually transmitted disease
6 Toxic agent control
7 Occupational health
8 Accident and injury prevention
9 Fluoridation and dental health
10 Infectious disease control

Health promotion

11 Smoking and health
12 Misuse of alcohol and drugs
13 Nutrition
14 Physical fitness and exercise
15 Control of stress and violent behaviour

Since then, AIDS has been added to this list, and cancer screening may be added as a seventeenth priority area.

Following extensive consultations with experts and activists, *Promoting Health Preventing Disease: Objectives for the Nation* was produced in 1980.[6] It defines 126 'achievable' objectives for the years 1990 and 2000 which aim 'realistically' to reduce the burden of ill health rather than to eliminate it altogether. The ODPHP is mandated to conduct detailed reviews of each of the 15 priority areas on a continuing basis, and reports directly to the Assistant Secretary for Health on progress. In 1983, federal plans were published identifying the role of both health and non-health agencies in federal implementation plans for each defined objective.[7] Since then effort has been directed towards implementing only a portion of the objectives set up in 1980.

Increasing emphasis is now being placed on developing, implementing and evaluating intervention programmes at the major federal centres concerned with health, for example, the National Institutes for Health (NIH), which houses the National Cancer Institute (NCI) and the National Heart Lung and Blood Institute (NHLBI) in Bethesda, and the Center for Disease Control (CDC) in Atlanta. This is a significant move away from President Carter's earlier drive to 'cure cancer' by pumping large sums of money into empirical cancer research alone. Although NIH only receives 0.67 per cent of the total DHHS budget, the NHLBI's Office of Prevention has run a successful National High Blood Pressure Education Program, which is being followed by a National Cholesterol Education Campaign. Such intervention, research and education programmes use up $125 millions of NHLBI's total budget of $800 millions. The Office of Prevention, which operates on an annual budget of $4–5 million, has ensured widespread take-up of the Blood Pressure Reduction Program, especially among blacks, by forming an extensive communications and collaboration network with diverse black organisations, including black church groups.

The NCI's prevention work is carried out through the Office of Cancer Communications. The NCI has a stated objective of reducing cancer incidence by 50 per cent by the year 2000 (the federal goal is similar, but expressed in terms of risk factor reduction). In some ways, its emphasis is broader than the federal initiatives. It focuses on high profile public information campaigns, together with professional education on changes in diet, a reduction in smoking, as well as good treatment and care for breast and many other cancers. Curiously, there is little emphasis

on screening for prevention of cervical cancer. The considerable importance attached to marketing principles is shown in a collaboration with the Kellogg's Foundation. A prime-time media advertising campaign promotes high fibre, low fat breakfast cereals which happen to be Kellogg's products.

The 1971 Carter directive also resulted in the establishment of a privately funded centre for health education. After a history of mixed public and private sector financing, the National Center for Health Education (NCHE) moved from San Francisco to New York, 'where the money is'. It now thrives on private funding from large corporations like Kellogg's, Exxon, Chevron, Blue Cross, Ford and IBM. The president of NCHE is an ex-executive of Metropolitan Life Insurance which has donated $2 million to the NCHE. The NCHE sees its role largely as a clearing house on initiatives taken throughout the country, and produces a regular series of briefing documents through its house magazine.

Canada: policy and organisation

Canada's health promotion policy began with an 'ecological' approach set out in the Lalonde report, *A New Perspective on the Health of Canadians,* in 1974.[8] Marc Lalonde was then Minister for Health. His report emphasised the relationships between promoting the health of individuals and generating a healthy environment. He said:

> The Government of Canada now intends to give human biology, the environment and lifestyle as much attention as it has to the financing of the health care organisations so that all four avenues to improved health are pursued with equal vigor.

In 1978, the new Health Promotion Directorate (HPD) was formed by amalgamating four broadly preventive departments within Health and Welfare Canada. The HPD operates through nationwide campaigns, which it controls, and the funding of local community and health professional activities. In this way, the HPD is able both to inform the public about health issues and to empower local groups to pursue their own perceived health needs. Close links with local communities are ensured through five regional offices of the HPD, each of which has considerable autonomy in allocating funds to projects. Most of HPD-funded community projects are for deprived groups.

The overall aims of the Canadian Health Promotion Program are much wider than those in the US. They extend to promoting

physical, mental and social wellbeing among all people, including supporting disabled people in their efforts to deal with their lives. Like the USA strategy, the Canadian approach focuses on a mixture of topics and people. The six major topics which form the focal points of the operational programme are:

1 Nutrition
2 Cigarettes
3 Alcohol
4 Drug abuse
5 Safety
6 Mental health

In practice most efforts are concentrated on diet, cigarettes, alcohol and drugs. There is visible support for citizens and community groups with emphasis on the most deprived, including:

Low income groups
Disabled
Native people
Women
Older people

Long-term planning is central to the success of HPD's implementation programme, which is backed by a cabinet mandate, and the planning/evaluation cycle is currently five years.

The link between national and local initiatives in USA and Canada

The connection between local and national initiatives is not always obvious. Unlike the UK, both the US and Canada have public health departments which are separate from the health care system, and which are accountable to a democratically-elected local authority.

In the USA, collaboration is clearly intended to take place via state and city public health departments. In practice, health and other professionals often work independently, although many clearly use federal 'good intentions' as a springboard for moving their own initiatives in the right direction. Local activities use a mix of competition between different interest groups, collaboration, consensus, and straightforward entrepreneur's sense. The National Center for Health Education plays a key role in acting as

a 'broker' for the many existing interest groups in fields such as smoking, school education programmes, and acts as a clearing house on initiatives taken throughout the country. Local health workers tend to see the federal institutes as valuable sources of information rather than leaders and facilitators in intervention. CDC has developed a unique 'behavioural epidemiology surveillance' system which provides regularly updated national information on the prevalence of behavioural risk factors as well as local information in 26 states. It has also launched PATCH (a planned approach to community health), which now operates in eight states.[9]

The decentralisation of the Canadian Health Promotion Directorate potentially promotes better liaison between federal and provincial activities, but in practice the regional offices often work independently of local public health departments.

A combination of decentralised government in the USA, and the lack of federal commitment to legislative and similar action to support the 'good intentions' statements, have led many states to develop their own laws. Many states now have laws governing seat-belt use, smoking control in the workplace and public places. Toronto was the first in Canada to enact local legislation which gives workers the right to know what toxic agents they are being exposed to at work, and has taken municipal control of cigarette advertising and sponsorship.

The City of Toronto Public Health Department – which is responsible for the health of 10 per cent of Canada's population – has its own 'declaration of intent' in the shape of its report *Public Health in the 1980s*[10], and has developed a 'socio-environmental' approach to health similar to that in the WHO strategy. It focuses on the inequalities in health, and it has a series of educational materials and study groups based on an information pack called *The Unequal Society*[11]. Central to this approach is the Department's 'health advocacy' role. In recognition of this lobbying role, the Department was recently restructured to include a 'promotion and advocacy' section which has 13 full-time staff who work alongside other sections which focus on more traditional – and equally important – approaches. Their work involves actively supporting, and ensuring funding for groups and organisations from deprived sectors of the community. Not only does this help the community to set its own health agenda, it also redirects efforts and resources to the poor and less vocal community groups whose health needs are greatest. The Toronto approach legitimises the key role of political lobbying in the promotion of health

and provides a mechanism, unlike in the UK, for health promotion personnel to challenge the wisdom of local or central government when their actions run contrary to health interests.

A unique feature of health promotion practice in North America is the many multidisciplinary professional and other networks which are united under a common aim to improve public health. There is a powerful alliance of local and national public health associations in both the USA and Canada. These provide a forum where doctors, nurses, community activists, health educators and others can exchange their ideas and experiences in what is genuinely seen to be a multidisciplinary process. More importantly, they can bring together powerful community and professional support for political change.

Health promotion in practice

Both the USA and Canada have a clear political commitment to shifting the emphasis towards health promotion. Demonstration of this has been essential in providing the leadership and support to all individuals and organisations involved in health promotion.

In the USA, government involvement is more limited, and focuses on goals, backed with the provision of exhortation, health statistics and health education materials. The dominance of the free-market philosophy means the public is left to decide what health initiatives to take up and how to implement them. Canada has active exhortation also but, unlike the USA, has a significant involvement in the planning and funding of health promotion initiatives even at the community level.

Government commitment should not be seen as total. The Reagan administration in the USA is fiercely pro-deregulation and would oppose any legislative or fiscal deregulation and would oppose any legislative or fiscal measures which might harm the interests of the food, tobacco, alcohol or gun lobbies. Paid lobbyists ensure their clients' industrial interests are well represented in Congressmen's decisions and their influence on federal health promotion policies is evident. *Promoting Health/ Preventing Disease: Objectives for the Nation*[6] avoids any national commitment to legislative or fiscal measures such as the banning of handguns, seat-belt legislation, or an increase in the prices of tobacco products and alcohol, all of which are proven ways of reducing the burden of disease. The document setting out the plans for implementing the 'objectives for the nation' has dropped several of the original objectives which were designated as high

priority only three years earlier; missing are the reduction of late abortions, control of toxic agents, reduction in fatalities from firearms, the use of seat-belts, fluoridation of water, smoking-control legislation, and reduction of alcohol consumption[7]. The available health statistics are also not comprehensive; comparable data on abortion trends in different states are not readily accessible and the CDC does not routinely publicise data on socio-economic differences in health.

Canada's government department, Health and Welfare Canada, would firmly back legislation to ban all tobacco promotion. However, there would be little chance of its reaching the statute books now because other government departments with vested economic interests are more powerful.

There is an interesting contradiction between advising the population of the best actions for health and not pursuing supporting changes to the background environment. This is most evident in the USA, where is also clear that the government's support for health promotion is focused on behavioural approaches and individual responsibility. The wide social and environmental context is rarely emphasised. 'Victim blaming' approaches are common. An example is the healthy mothers/healthy babies coalition, which is supported by the American College of Obstetricians and Gynaecologists with the aim of reducing maternal and perinatal mortality and morbidity. The focus is on smoking, nutrition, alcohol, and so on, and omits the issues of poverty, social support, and access to good quality medical care which are likely to be the most important factors for underprivileged women.

A noticeable feature of North American health promotion is the relatively diminished power and role of health professionals compared with the UK. Health promotion is a multidisciplinary activity and there is a marked tendency for intersectoral collaboration – involving industry, the media, government, health professionals and community organisations. There seems to be an attitude that knowledge is for sharing and 'territorial boundaries' are to be breached. Coalitions are common and networking to share skills and resources to increase effectiveness of activities is part of normal activity.

Industrial finance is sought and frequently provided. However, much of the industrial interest is related to commercial advantages which can limit the range of fundable programmes or activities.

With the consumer so powerful in deciding what actions are

pursued, it is perhaps not surprising that the better educated and economically privileged consumers end up selecting and organising health promotion activities. These activities also tend to be designed for the interests of the organisers who are usually middle class and the healthiest group in society. A result is that those with the greatest health needs – the blacks, the unemployed, the poor, single parents and the elderly – can be excluded.

Although this system has produced imaginative and energetic health promotion activity excelling in innovative one-off projects which can be highly responsive to need, a major weakness is that there is often no way they can be extended to the rest of the population. Most projects don't cater for the needs of the least healthy groups who are also least able to help themselves to mount such projects. The lack of a comprehensive national system for the delivery of health care in the USA leaves those excluded from the free-market system without access to health promotion.

In both Canada and the USA, the health promotion bureaucracy is much more publicly accountable than in the UK. The USA system leaves most of the responsibility with individuals and community organisations and coalitions. In Canada, the responsibility for health promotion and prevention within the provinces and cities lies with the public health departments. This is similar to the pre-1974 system in the UK where local authorities had significant responsibilities for public health.

Canadian Public Health Departments are both decentralised and more immediately accountable to the community through elected bodies. Canada also has the extensive, state-supported local-community initiatives which give individuals and local communities direct access.

The next seven chapters look more closely at health promotion in North America. They outline the experiences and impressions gained by study tour members during their two-week visit. With only two weeks to explore such large countries and so complex a subject, centres and projects visited represent only a small sample of health promotion activity. The impressions reported are mere snapshots and are not meant to be definitive.

CHAPTER 3

The corporate planning approach to health promotion

[Based on the paper by Peter Droog and Bill Fraser]

Health promotion in North America is dominated by the disciplines of the market economy. This influences every aspect from policy making and implementation to consultation and participation and finally the monitoring and evaluation. The pressures of the health care market have forced health promotion practitioners to acquire corporate management skills and approaches that characterise American business. The results include some innovative approaches to health promotion. Joint commercial enterprises, using cereal packets to promote healthy diets, have proved immensely successful in increasing 'market share' for sound nutritional advice. Pacific Bell Telephones provide a risk assessment programme for its employees and New York University's Medical Center runs weekend residential courses for 'cordon bleu' healthy eating. The American emphasis on the consumer is of particular interest to the UK where the NHS, following the Griffiths' report, is adopting corporate models of management.

Mission statements

Unlike the UK, both the USA and Canada have clearly identifiable national commitments to health promotion. Clear mission statements are issued from the USA Department of Health and Human Services through its Office of Disease Prevention and Health Promotion (ODPHP). Fifteen national health objectives are specified and the ODPHP has a £3.5 millions budget exclusively for monitoring and reviewing their achievement. The objectives are stated with quantified targets and, except for high priority objectives, are presented without strategies or plans for implementation. The government role is defined more as an advocate of the importance and specific directions of health promotion and less as the provider of health promotion planning

or its implementation. These are left to the lead agencies and other community based groups who take up the objectives and act on them according to their own interests.

The system of lead agencies distributes responsibility for backing specific objectives and for coordinating among government agencies and other organisations. Participating agencies can be private, voluntary sector, state or local government. They are seen as the interpreters of the objectives into local priorities and methods of action. In this way, the market philosophy is seen as the means of letting the consumer decide what matters and how to act. The main government agencies remain as suppliers of the central messages and the necessary strategic support.

To support the agencies, there is a commitment to relevant research. The National Institute of Health at Bethseda has almost half its research budget allocated to health promotion topics. Large budgets are also provided to ensure that health data, reports of conferences and workshops, fact sheets and books are widely available throughout the country.

The research agencies reflect the central importance of mission statements. The Center of Disease Control (CDC) in Atlanta no longer follows the epidemiological data gathering approach to disease but has adopted a proactive, community-orientated approach with a mission to develop widely accessible strategies for health promotion.

PATCH planning

PATCH planning, or the Planned Approach to Community Health, is a 'bottom up' process where an agency or similar organisation which is sympathetic to local needs, helps local groups determine and implement their own local activities. The local community can be anything from a geographic area to a local neighbourhood or even an ethnic or cultural group. The process relies on the agency with relevant skills and resources making these available to the local group. The aim is to resource and support the local group. This often results in the agency supporting actions which would not otherwise have been on their list of priorities or following unconventional approaches. PATCH planning is vital to the implementation of the national objectives.

Management approaches

Good management is considered vital to health promotion in the

US. It means identified resources, managed settings and clear priorities. This was best illustrated by the National Cancer Institute which approached it in a number of steps:

it established a scientific base, that is, the known facts and risks through its research programmes;

it sought to act as a catalyst with other organisations;

it sought to develop and use networks throughout the United States and it sought to use leverage wherever necessary.

The National Center for Health Education in New York confines its activity to four identifiable groups – the education sector, the voluntary sector, the public health sector and industry. Its short-term programmes aim at health education in hospital settings, work place programmes and physicians. Its long-term objectives (defined as 15-year programmes) are targeted upon the young and the elderly. Part of this explicit managerial commitment is a strong individual commitment.

In the USA, health promotion is responsive to the needs of the consumer. While there may be a lack of social planning and a comprehensive network of statutory provision, there is recognition that what the people think and want is important.

Good proactive public relations and marketing are a regular part of health promotion. The American College of Obstetrics and Gynaecology, which is campaigning actively to prevent unintended pregnancies, has allocated $100,000 to a full marketing campaign which includes television advertisements, working with community groups and attitude sampling surveys. The National Heart, Lung and Blood Institute's Cholesterol Education Program uses Harris Polls to determine public awareness. Collaboration rather than direction appears to be the method of working with voluntary agencies. Church groups in the South are used as a means of access to the black community and the American Cancer Society provides handout sheets and booklets which encourage the public to compare the treatment which their doctors are providing against a checklist of good practice. The Center for Disease Control's Worksite Initiative Program uses telephone surveys to obtain information on occupational health issues. National Cancer Institute's Cancer Awareness Program provides information on diet and nutrition through a collaboration with Kellogg's. There is a willingness to innovate in tackling the problems of communicating risk.

Implications for the UK

1 It is important to develop clear objectives for health promotion which are stated with quantified targets so they provide a common base for planning. Health promotion and the objectives must be declared as national priorities by government and be seen to be reflected in the execution of relevant policies.

2 The managerial capacity of all organisations in health promotion should be seen to be adequate. This could mean the provision of training to professional health promoters in the NHS and to the practitioners working in community and other organisations. Managerial skills and services should be accepted as legitimate and valuable supports and as fundable items for organisations and projects.

3 It is important that health promotion be included overtly in corporate plans for the NHS at regional and district levels. At present, health promotion is often treated as marginal to the central purpose of the NHS and not sufficiently integrated as a result.

4 There is a need to develop coalitions among health promoters and to establish a central organisation which can act as a clearing house and coordinator of action between all the government, industry, professional and trade organisations, and the voluntary sector initiatives and responsibilities which overlap in the pursuit of health promotion.

CHAPTER FOUR

Primary care in North America

[Based on the paper by Theo Schofield]

Research in Chicago has identified two models of how individuals explain their own health.[12] First, 'health as self-control' where individuals know they are healthy because they 'don't smoke, don't eat a lot of red meat, and get physical exercise'. The second is the 'release' model where health is seen as being able 'to do what you like, when you like'. The researchers saw the models as metaphors for cultural themes in the USA which have implications for health policy. The control model stands for the self-discipline, self-denial, and will-power values associated with middle-class self-improvement while the release model is closely related to the consumerist ethic in a materialist society.

Present economic pressures have led to cuts in welfare programmes which have been justified by the belief that health is the responsibility of the individual. However, how indivuduals are to influence the relevant enconomic and environmental factors affecting their health is not made clear.

This thesis has been studied in the instance of epilepsy in an urban environment[13]. The major cause of epilepsy in adults was head trauma. The incidence of head trauma in a black inner-city area was more than double that of a predominantly white suburb. The leading causes of the traumas were attacks in the inner-city and motor vehicle accidents in the suburbs. Over half the attacks were from people known to the victim. In the background were found overcrowding, alienation, racism and unemployment which led to child and wife abuse. Drug and alcohol abuse were also higher.

Other studies have demonstrated high rates of perinatal and infant mortality, teenage pregnancy and premature heart disease in these communities, but traditional preventive medicine has little to offer these problems. Doctors involved in this research were concerned that medicine should not be trying to offer medical solutions to social problems. They saw medical dominance of health promotion as creating dependent 'health consumers' and increasing the sense of impotence in those with the least resources and opportunities to control their own lives.

Within the hospital setting, the Division of Internal Medicine included a Department of Preventive Cardiology which was screening patients with family histories of ischaemic heart disease, and also was auditing the records of the hospital's interns for the attention that they were giving to risk factors for ischaemic heart disease.

The School of Public Health was conducting a project in two communities to improve blood pressure detection and control: one was an older white suburb in which they were using existing physicians; the other an urban, predominantly black area in which they were using volunteer community workers to follow up patients with high blood pressure who were often only detected when they attended an emergency room.

Another part of the network was the Health Services Research Center, which is interested in topics ranging from doctor/patient communication to developing computerised data sets for primary care. Data on the efficiency and productivity of health care, and feedback to physicians about the detection and clinical management of patients with risk factors were provided.

The Center for Health Education, founded by the State Medical Society and supported by Blue Cross and Blue Shield, is working to change physicians' attitudes in the state to health education and health promotion[17]

Approaches to patient education

Each of the above prevention programmes had carefully considered comprehensive approaches to the education of patients with high blood pressure and other risk factors of ischaemic heart disease. All could cite evidence to demonstrate that effective patient education could both increase blood pressure control and risk-factor reduction and at the same time reduce patients' anxieties and any adverse effects on their quality of life.

Developments in medical education

If the medical profession is to be able to enter into such partnerships with patients and communities to promote health, major changes of emphasis in medical education are required. The Family Practice Residency at Cook County Hospital, Chicago, and the New Pathway Course at Harvard Medical School were using doctor/patient communication, not just to teach new skills, but also to discuss how doctors relate to their patients [17,18].

The difficulty in persuading doctors to apply current knowledge, particularly in the field of preventive medicine has been tackled by a wide variety of strategies. Direct approaches included involving practising doctors in advisory boards, issuing specific guidelines and the provision of health education material. More effective approaches, however, were the provision of specific workshops helping doctors to develop health education techniques which could be integrated into their existing practice and regular feedback to ensure that doctors maintained their performance.

Educational campaigns directed at the population, for example about high blood pressure and cancer screening, were claimed to have major benefits. Their aims were to create more informed and questioning patients, but they could also be seen as sophisticated marketing campaigns to increase the demand for medical care!

Preventive medicine in family practice

One measure of the success of these campaigns is that the commonest reasons for visiting a primary care physician in the USA are regular check-ups and hypertension management. This is in response to consumer demand, and these items are paid for either by the patient or their insurers. There are problems therefore in providing these services for the poor, the uninsured, and the unemployed, all of whom have limited access to other medical services because of their inability to pay. The pattern of payment in private practice also makes it difficult for innovative doctors to create multidisciplinary teams if they are unable to bill for their services.

Implications for the UK

It would be easy to conclude that the improvements in health care in the USA have been due to greater resource availability and their higher standard of living and therefore to believe that the same results are unattainable in the UK. While some programmes were well resourced, others were not. However, there were significant features common to all visits which are believed to have contributed to their success and which could be lessons for practitioners in the UK. There was a realistic awareness of the problems faced, a determination to tackle them, both individually and collectively, and an enthusiastic commitment to the task.

Drawing from the programmes visited in the USA, the

Community action for health

Such research is leading health professionals to rethink approaches to primary care and two conclusions are emerging. First, that many of the causes of health problems would not be solved without restructuring society; second, and more pragmatic, that health professionals should be doing all they can to enhance the power of both individuals and their communities by ensuring they work with people rather than on them, and allowing the community to control the tools for prevention.

Three programmes applying these principles were visited. All were in the USA – the Bethel New Life Holistic Health Center and the South Shore Community Unemployment Union in Chicago, and the Catholic Charities Human Services Center in Brookly.

The three had relevant common themes. They all had close links to parent churches and were based in local communities from which most of their workers were drawn. They started from an assessment of the community's needs and since they were in areas of high unemployment, they have included programmes for job creation, housing improvement and education among their first actions rather than medical care. As their local medical facilities had problems of cost, access and continuity, the projects put a major emphasis on personal development and health education.

Bethel's goal statement is:

> Knowing that God has created us for health and wholeness, our goal is to enable people to have wholeness through quality care. We are committed to care that gets at the underlying causes of sickness, that teaches people how to stay healthy, that enables people to live a full life to the fullness of their years, that prevents illness caused by neglect and ignorance, that enables a healing community and a healthy community (spiritually, physically, mentally).

Apart from the support of their parent churches, each programme had multiple additional sources of funding, including contracts with federal and state agencies to provide specific screening programmes (for example, the Woman, Infant and Child Program). The piecemeal approach posed major problems for administration and evaluation. While it is relatively easy to measure the uptake of screening, no methods had yet been found to evaluate the broader goals to which these programmes were committed.

Programmes for disease prevention

The major efforts of preventive medicine in the USA are directed towards the prevention or early detection of cardiovascular disease and cancer. The Minnesota Health Heart Program[14] was using population-wide, multiple-education strategies to reduce the risk of cardiovascular disease in three mid-western communities and compare the outcome with three similar communities as controls. The target risk factors were raised serum cholesterol, high blood pressure, smoking and lack of physical activity.

The educational strategies included media campaigns, adult education, school education, education for health professionals and other community based activities. In addition, the whole adult population in the study communities was being screened for high risk factors.

The communities have participated in the programmes enthusiastically to the extent there are even tensions between the investigators and the community over ownership and direction. The one group which is least willing to get involved in the programme is practising physicians. Because they are seen as a major source of authority, their support is crucial for its success. Apart from wounded pride, the reasons given for being uninvolved included lack of time, lack of skills, doubts whether health promotion is a legitimate medical activity, and a concern for its effectiveness.

The investigators had no such doubts about the effectiveness of interventions to lower high blood pressure or to reduce plasma lipids. They believed that the results of recent trials such as that of the Medical Research Council (MRC) on the treatment of mild hypertension should be interpreted 'aggressively', and that short trials, in which placebo treatment is also used and patients with other risk factors excluded, understate the potential benefits of long term treatments[15]. It was suggested that in the UK these results are interpreted more conservatively, not for any scientific reason, but as rationalisation of the lack of resources for health care.

Centred on the Johns Hopkins Medical Institution, a network of activities demonstrated that three health education interventions – a prolonged interview, a home visit and small groups talks for urban, poor, hypertensive blacks – could produce a 57.3 per cent reduction in mortality over a five year period.[16] This was, however, just one of a wide range of activities which had been tailored to meet different needs.

following implications for practice in the UK are suggested:

1 The major advantages of the UK system of primary care were clear in comparisons with the USA provisions. Access to medical care is free and the majority of the population is registered with a general practitioner. General practice is also flexible, allowing adaptation to the needs of different communities and, in particular, doctors and other health professionals to work in teams. Preventive services are best provided through general practice, especially with the advantages of having integrated treatment and prevention services.

2 The distinction between health promotion and both prevention and health education, which are two of its components, needs clarification and emphasis. General practitioners should accept responsibilities for prevention as part of the care of practice populations and should accept the important role of advocate within the community.

3 Care should be taken to avoid colluding with the victim-blaming process which can diminish incentives for collective responsibility and action for health.

4 Medical solutions should not be offered as surrogates for tackling the difficult causes of disease. Cardiac surgery should not be seen as the solution to coronary heart disease and neither health visiting nor screening in primary care should be advocated unless they are directed towards increasing individuals' and communities' ability to control their own lives.

5 Doctors and other health professionals need to develop new approaches to communication with patients and clients.

6 More effective methods for the individuals and communities to become involved in their own health services are needed. Community Health Councils and patient participation groups have had limited success. The health professions and NHS administrators could do more to identify and respond to the relevant formal and informal groups in the community.

7 Extensive networks have been developed among health professionals and community groups which allow both rapid dissemination of knowledge and an effective means of sharing experiences of common problems. Coalitions between different

organisations also help design and implement more effective programmes. Both networks and coalitions are relatively uncommon in the UK. They should be seen as a normal part of programme planning and ways of developing both should be explored.

Facing the future

For these implications to be reflected in the policy and practice of primary care in the UK, certain fundamental changes are considered essential. The following are offered for discussion:

1 The shift to group practices and primary care teams, backed by vocational training and health authority-linked computerisation of records could be encouraged. Experimentation should be supported and funded to identify effective structures and methods of change.

2 Medical education needs to reflect the wider roles of health professionals. Peer review and audit methods may help identify appropriate modifications to established curricula and also enable the transition to be through internal encouragement rather than external inducement.

3 Primary care needs to be reorganised to achieve a functional integration of general practitioners, community medicine and other health professionals. Change should be aimed at enhancing the ability to innovate and better respond to the community's needs. Additional resources may be required. Until now general practitioners have been asking for resources without accountability and the government and health authorities for accountability without resources. Both positions should be reviewed.

4 There is an important role for university departments of community medicine and general practice. They can bring the skills of needs assessment, health care planning and evaluation to primary care. They can also provide the valuable link between review of academic research and practice where few health workers have either time or access to the vast resources of literature. Published results of important research or evaluations of primary care initiatives are ultimately of little value if they are not read by practitioners. Special courses for primary care teams on health promotion should be offered.

CHAPTER FIVE

Health education and health promotion for teenagers

[Based on the paper by Lynda Finn]

Health education and health promotion were examined in three settings: schools (and curriculum development agencies), adolescent health centres, and youth projects. Of the three services, only school health education has been developed to a comparable (and, in some respects, superior) extent in the UK.

School health education

Although 43 states address health education in their education legislation, there are enormous variations in the way in which it is delivered. Some school districts limit their health education provision to a small number of uncoordinated 'one-off' health instruction lessons taught by non-specialist staff. Others offer a comprehensive curriculum taught by trained health education teachers. Oregon, Indiana and West Virginia require a full year course of health education in order to graduate from high school.

Out of 15,500 school districts in the USA, less than 1000 have a comprehensive health education curriculum. The size of the country and of its population, the number of school districts, the high degree of state autonomy and the absence of a central curriculum development or dissemination agency have resulted, perhaps inevitably, in an absence of national or regional coordination. Good practice is not necessarily spread throughout the school system. Neighbouring states and even neighbouring school districts can have very different strategies.

For some teachers, health education itself is under threat. In certain states the prevailing political climate has led to pressure for an instruction-based, information-imparting approach. Conservative opinion sees health education, and the questioning of social values in particular, as highly undesirable and even to be excluded from the curriculum.

Health education practice was observed in two schools: one in California and one in New York. The students were of a similar age, but they were different in most other respects.

Huntingdon Park Senior High

Huntingdon Park Senior High, near Los Angeles, is in a poor, largely Hispanic district. Of the 14–17 year old students, 90 per cent are Hispanic, many have language difficulties and are relatively low academic achievers. Health education is a separate, timetabled, compulsory subject taught by specialist health education staff. The academic level of the students, combined with their economic and social circumstances, has resulted in the design of a specific health education curriculum intended to meet their needs. The curriculum is imaginative and broad, and a wide variety of teaching strategies are used – group discussion, use of visitors, role play, projects, case studies, display work, and so on. Student involvement is seen as an essential component of health education.

Huntingdon Park also started the well-known Youth Gives a Damn (YGAD) health education project in 1971. YGAD runs camping weekends with health education activities which aim to 'encourage and promote better health through involvement in health education and health service programs and activities'. YGAD also tries to motivate participants towards health-related careers and to encourage them to become involved in community activities. The underlying philosophy is that, through involvement in its activites, students increase their own personal health education. Although initiated and coordinated by teachers, YGAD has a high degree of student involvement. The voting membership of the board of directors is limited to those between 13 and 18 years of age, and this ensures that the programme of activities is relevant to the needs of teenagers. The programme at the camps includes films, speakers, small group discussion, seminars and demonstrations. YGAD participants have examined such issues as smoking, sexuality, assertiveness training, death education, self defence for women, drugs, environmental pollution and diet. They have seen a demonstration of acupuncture and have learned how to check blood pressure and to undertake cardio-pulmonary massage and diabetic testing.

In addition to the camping weekends, YGAD includes weekend and evening activites in the community. Participants test blood pressure, check for hearing impairment and diabetes,

act as interpreters for people for whom English is a second language, and lobby local and national politicians on health issues. They appear at concerts, parents' evenings, health fairs, and various other public events. Private industry and voluntary organisations such as the American Cancer Association, Red Cross and the March of Dimes are eager to donate money and equipment. Such is the success of YGAD that it is now able to insist that money is donated without 'strings'. Ten states have since adopted YGAD.

Youth Gives a Damn has demystified health. It serves to reinforce and to put into practice knowledge, attitudes and behaviours learned in school and has enabled young people to engage directly with their community. For YGAD volunteers, health education is not just another timetabled school subject but is seen as something alive and real and very much part of their lives.

Uniondale Public High School

Uniondale Public High School, Long Island, has a long history of teaching health education. Senior members of the administration are strongly in favour and the school has a health education coordinator. Students are mostly from skilled working class families and the level of unemployment is low. In New York State, one semester of health education is compulsory in secondary school. The curriculum varies from district to district. Uniondale offers Teenage Health Teaching Modules (THTM), which is a comprehensive curriculum package for the 12 to 17 year old range. It was initiated by the Center for Disease Control in Atlanta and researched and developed by the Education Development Center in Massachusetts. It consists of 16 modules and has a strong emphasis on skill acquisition. Five basic health skills are covered—self assessment, communication, decision making, health advocacy, and healthy self-management. A wide range of health topics are presented as subjects through which the above skills can be acquired and rehearsed. Health topics include diet, stress, health and safety in the workplace, creating a healthy environment, fitness, living with feelings and preventing injuries.

THTM have been widely acclaimed in the USA and the UK. Family and community involvement are essential components of the modules. Environmental and economic factors are tackled as are the social determinants of health. THTM are extremely popular with both staff and students in Uniondale. Students find

that lessons are exciting and enjoyable, and they have a real connection with out-of-school activities. Staff strongly advocate THTM because the materials are student centered and interactive, and lend themselves to small group-based participative learning methods, which lead to a high level of student involvement and improved relationships between staff and students. The modules are currently being evaluated by the Center for Disease Control.

Ten elements have been identified as important in a comprehensive school health education programme[19]

1 Sound, well planned, sequentially developed curricula which provide opportunities for students to learn about their personal, family and community health. Content to be appropriate to age, level of development, and the needs of students.

2 Opportunities for students to learn about health in its larger social context.

3 A coordinated curriculum.

4 Inservice training for staff.

5 Rich teaching/learning resources that support curriculum objectives and are relevant to cultural, ethnic, geographical and environmental realities.

6 Outreach activites which inform and involve parents and families.

7 Regular review of the school environment to ensure that the 'hidden curriculum' does not contradict health education messages.

8 Active involvement by the community.

9 Regular reassessment of the curriculum.

10 Good management within the school.

In their different ways Huntington Park and Uniondale offer many of these elements and can be said to provide a comprehensive programme.

Adolescent health centres

Adolescent health centres complement school health education and although based in a medical setting they provide a broad and comprehensive service beyond medical care.

Mount Sinai, the oldest adolescent health centre on which many others were modelled, is based in New York City and was founded in 1969. Its staff are from varied backgrounds – social work, medicine, family therapy, education, nursing, educational psychology. Six major programmes are offered: an adolescent health care unit, a family life education programme, an alternative school, a mental health counselling programme, an inpatient unit, and a counselling programme. Young people can visit the unit with a medical complaint, to obtain contraceptive advice or sex counselling, to talk to a social worker because they are having difficulty with school work or with family relationships, or with any other adolescent 'problem'. The alternative school provides an opportunity for those who have difficulties with the public school system to study for equivalent qualifications.

The atmosphere is warm and friendly, and although young people are encouraged to involve their parents, confidentiality is assured. The teenagers are encouraged to become actively involved in their health, to ask questions, to make informed decisions, and to develop assertiveness skills. Staff at the Mount Sinai Hospital are reported to have little difficulty in recognising former patients of the adolescent health centre, as these patients ask the most questions and are the most actively involved in their health.

The centre provides an extensive outreach service. Staff work with local schools complementing the health education programme, with groups of parents, and with other agencies.

Gouverneur Adolescent Clinic, also in New York City, was modelled on Mount Sinai. It is located in a public hospital in a poor, largely black area of the city but is much smaller and less well resourced than Mount Sinai. It provides services for young people between the 13 and 19, including medical examinations, guidance and counselling on a range of issues – nutrition, sexuality, relationships, school or work problems, weight control, family violence, substance abuse. Young people are encouraged to involve their parents but, if they refuse, confidentiality is again assured.

The Adolescent Health Center in the National Medical Centre in Washington DC provides a similar range of services and sees over 10,000 patients each year. Although the Center is non-profit making, uninsured people cannot be seen. The poorest sectors of the community, who are most likely to be uninsured, are required to attend the local state hospital and even emergency services are not open to them at the National Medical Center.

Youth projects

Youth projects can provide a similar though less medically-focused service in an educational rather than a medical setting. The Door in New York opened in 1970 and is funded by the city, the state, the federal government and a variety of private and voluntary organisations. Young people are offered a free health awareness programme, prevocational and employment training, careers guidance, a wide variety of recreational activities, a learning centre (which is virtually an alternative school), a food and nutrition programme, a mobile preforming arts unit which operates in the city, legal advice, confidential counselling, and much more. The Door provides a non-threatening environment, a supportive yet challenging atmosphere, a holistic philosophy. It allows young people to explore new patterns of relationships and enables them to gain confidence and discover their own means of self-expression.

The Center for Youth Services in Washington DC was modelled on the Door but adapted its provision to meet the needs of a poorer, almost entirely black, less mobile and less sophisticated clientele. All clients have a primary counsellor who helps decide which combination of services to use. Facilities include educational, prevocational, recreational or medical programmes. Thorough health screening is compulsory for all new clients; for some, this is the first health screening they have ever had. Pregnancy prevention is a major objective. Health education is designed to demystify the health process and create a supportive yet challenging environment in which young people can develop to their full potential.

Urban Adventures is a small New York-based, non-profit making agency specialising in experimental education. It adapts the outward bound model of learning to a wide range of experiences and populations and concentrates on programmes for minority high school students, drop-outs and youths at risk. The agency has close working relationships with the community garden and ecology movement. The philosophy is to encourage them to develop the necessary skills and attitudes to take control of their own lives and become 'independent, productive, responsible, caring human beings'.

Adventure activities include rock climbing and ropes courses, canoeing, weekend camping trips, and a 24-hour urban experience in the 'Big Apple.' There are also training programmes for educators, one-day experimental learning outings for all age

levels, leadership training programmes, consulting sevices and outward bound orientation holidays. The agency runs an environmental education centre which is a commercial organic farm. Its resources include a working solar heating display, a crafts centre, a kitchen, a class room and an outdoor activites centre.

In Canada, an interesting initiative has been made in association with Toronto's mission to become the 'healthiest city in North America'. Forty young people are making a video about how they see Toronto in the year 2000.

The project has two goals. First, to introduce participants to the issues affecting living and operating in Toronto and to help them develop their preferred vision of Toronto in the year 2020. Second, to teach technical and production skills in video which will enable them to make a video on their vision. This video will be presented to Toronto and shown in high schools across the city to encourage other students to develop further alternatives for a better and healthier Toronto.

Those involved will have the opportunity to increase their awareness by working directly with people from every area – political candidates, local celebrities and people on the street. They will develop a thorough knowledge of technical, creative and production skills using professional video equipment under the supervision of accomplished video specialists, develop public speaking, script writing and interviewing skills and will experience the personal challenges of working in a heterogeneous group of peers. The project is intended to provide a sense of social history harnessed to a view of the future and the encouragement of participation.

Canada also has two large volunteer programmes which provide extensive opportunities for developing the individual potential of young people. Canada World Youth is an international exchange programme with third world countries and Katimavik is a national programme.

Canada World Youth (CWY) was founded in 1971. Although it is in some ways similar to the American Peace Corps and the British Voluntary Service Overseas, CWY differs in that it is an exchange programme. It allows young people between the ages of 17 and 21 and other community members to share an educational experience through which they increase their awareness and acquire knowledge related to local and international development. The long-term objective is to encourage young people and community members to participate more actively in local and international development with respectful concern for the

environment and in a spirit of understanding between peoples.

Each exchange programme is between six and eight months in length, half of that time being spent in Canada and the other half in the exchange country. Each Canadian participant is paired with a 'counterpart' participant from the exchange country and seven pairs of participants, together with a Canadian group leader and an exchange country group leader, constitute a group. Each group works together on a community development project which is sponsored by a host community. Participants can expect to gain from any of the following elements: communication skills, critical judgment, leadership skills, understanding other cultures, social awareness, career choices and development (including food, health, education, ecology, population, volunteer work, cooperative systems, technology and disarmament as they relate to Canada and the world.)

Katimavik is a national volunteer programme for young Canadians between the ages of 17 and 21. It was designed in 1977 to promote education and personal development, community awareness and knowledge of the country. Participants come from every region of Canada and are a cross-section of the Canadian population. They join the programme for nine months working in three Canadian communites, living with other young people and learning new skills. It has similarities with the British Community Service Volunteers.

The objectives of Katimavik are: first, to help young Canadians acquire and develop skills that will enable them to contribute to the improvement of the quality of life in Canada; second, to provide useful work training, as well as personal community service experience; third, to give young Canadians the opportunity to increase their awareness of Canada's social and cultural diversity and their knowledge of a second official language; and fourth, to help them to develop an appreciation of the environment in which they live.

The Katimavik programme gives detailed attention to training packages which emphasise health and fitness, language and environmental issues. Funding comes from the sponsoring local communities and the government.

Implications for the UK

1 School health education programmes should be well coordinated and comprehensive with the full backing of teachers and senior administrators. Health education and promotion should be

integrated into school curricula and be seen as part of general education; it should not be omitted because 'it is somebody else's responsibility'.

2 Interactive teaching and learning strategies with student participation tend to make popular and effective programmes.

3 Holistic programmes like YGAD can make school education multisectoral and carry school education into the life of the community.

4 Adolescent health centres are able to provide for the specific needs of teenagers and, through staff and methods which aim at working with young people, can provide a vaulable vehicle for health promotion.

5 Imaginative youth projects organised by community groups can provide self-motivated health promotion activities outside the formal health and education settings.

6 The evaluation of health promotion should be freed from any exclusive need to show large-scale and statistically relevant changes in health related behaviour. Health promoters increasingly see increasing confidence and personal effectiveness, developing assertiveness and decision skills, and so on, as important goals, although they are difficult to measure and evaluate in the conventional sense. Health promotion should be encouraged to experiment with new directions and approaches. The participants in health promotion should be allowed to evaluate for themselves and the results taken seriously in considering the success of programmes by organisers or funders.

Facing the future

School and wider community opportunities for health education in the UK cannot be covered comprehensively in this chapter (and it is not our intention to do so), but there are several indications for future planning which have arisen from reflections on the experiences in the USA.

1 Plans for health promotion directed at teenagers should extend beyond formal schooling. Increasing numbers leave school at 16 and go on to further education, whether they are in jobs or are unemployed. Special youth projects or similar programmes in

the community are, therefore, an important means of providing health promotion to all teenagers.

2 Ways should be found of involving the community (young people and adults) in planning health education. This could allow greater participation in deciding what would be useful and could help generate greater interest in both the schools' own programmes and the links to other sectors in the community.

3 Coordination among schools and other agencies or groups working in health promotion for teenagers is essential if successful programmes are to be replicated. A central 'clearing house' to collect and disseminate information would be advantageous, but the development of networks among workers and projects is even more important.

4 Because of the importance of the role of local authorities in schools and youth work in the community, key personnel could be closely involved in developing multisectoral approaches to reaching teenagers. Staff involved should include advisers and administrators, head teachers and principals, teachers, school nurses and dental educators, parents, youth and community group leaders, trade and employer organisations, trade unions and community physicians.

CHAPTER SIX

Health promotion for older people

[Based on the paper by Robert Anderson and John Huntington]

In North America, it seems that the emerging interest in targeting health promotion on the elderly is a response to seeing old age as a social and economic problem. There are two important trends.

The first trend is the so-called aging of the population. In the twenty years from 1960 the population aged 65 and over grew by by 55 per cent, which is twice as fast as the growth of the younger population. Today in the USA about 11 per cent of the population is aged 65 or more; this is projected to rise to 18 per cent by 2030. Similar projections are made for the population aged 75 and over, but the trend which appears to cause most concern is that among the population aged 65 and over. The proportion aged 85 or more is projected to increase from 10 per cent to 20 per cent by 2040 – an increase of five times in absolute numbers. The concern arises because of the association between the age and disability and the consequent demands on health and social services.

The second trend is that the proportion of the population with chronic illness has been rising over the last decade. This led, within health promotion projects, to particular interest in the use of prescribed medicines and in the health impact on so called 'informal' carers in the community.

There are two other social trends which appear to have important implications. First, the growing numbers of relatively affluent and healthy older people, with reliable sources of income from pensions and investments, who can afford lifestyles which contrast sharply with those of the poor elderly. Inadequate income is described as the major problem facing older people (who comprise 11 per cent of the populaton); it is also a major problem for 30 per cent of the people with incomes below £3000 per year and is disproportionately prevalent among women and the black elderly. Second, there is a trend towards the increasing residential segregation of older people. For example, there are now about 275 continuing-care retirement communities in the USA, where some 90,000 people live in their own apartments. And there are about 1.5 million older people in nursing homes, a

figure that is projected to increase almost four times by the year 2040. The potential and need for health promotion in different residential communities is becoming apparent.

Finally, there are two other trends which are resulting in opportunities and demands for new ideas about health promotion for older people: the growth of self-help initiatives and signs of a retreat from public welfare provision. The former has been manifested in exercise classes, meals and cooking groups, arthritis and stroke self-help groups, pollution reduction efforts and home safety organisations, which have been established as social movements independent from perceived failings in public sector provision. However, many older people with low incomes are dependent for health and nursing home services on the insurance provided by Medicaid and Medicare. In 1981, Medicare underwrote 44 per cent of the costs of care to people aged 65 and over. There were also many instances of health promotion carried out in health service facilities – from screening clinics in primary health care to geriatric assessment in hospital outpatients – and programmes for maintenance of older people in the community through comprehensive medical and social assessment. But many of these were entirely dependent on government funding and viewed the future with uncertainty.

Organisations and policies

Organised groups of older people exert pressure on government in the USA in a way that is not seen in the UK. In the larger context of USA interest groups, elders do not form a particularly powerful lobby, yet the strength of advocacy for older people is impressive. The National Council on Aging, a membership organisation, convened the first national seminar on health education and health promotion in 1982. In 1985, the giant American Association of Retired Persons (ARRP) attracted 2 to 3 million new members to bring its subscribing membership to over 19 million.

The AARP has joined with the US Office of Disease Prevention and Health Promotion to make joint 'public service announcements' as a contribution to the federal government sponsored Healthy Older People campaign. The campaign stresses partnership between all levels of government, voluntary agencies, professional organisations and business. Like the HEC/Age Concern sponsored Age Well campaign in the UK, it is aimed primarily at disseminating information and encouraging

experimentation and replication of health promotion initiatives. The campaign includes consumer education, professional education and technical assistance. The principal messages are focused on four modifications of individual lifestyles: exercise and fitness, nutrition, injury control and safe use of medicines. Encouragement is also given to cooperation between community service agencies and health professionals in preventive health services, including regular physical examination screening for older adults.

The AARP Health Advocacy Services division promotes 'healthy lifestyles' and 'wise consumer choices' through the development and dissemination of audio-visual packages and the training of volunteers. The organisations' seven point Cut the Cost, Keep the Care campaign includes health promotion as modification of individual lifestyles. The Gray Panthers (a consumer group of older people) do not agree with the shift from public to private responsibility and are advocating a federally-funded health care system comparable to the UK's National Health Service.

US politicians are increasingly aware that older adults form a significant and growing proportion (possibly 16 per cent) of the electorate. The range of age-specific legislation and institutions in the USA is evidence of this awareness. There is after all no equivalent in the UK of the USA Senate Special Committee on Aging as a wide-ranging forum for discussion at the highest level, and nothing comparable to the federally-funded National Institute on Aging established in 1975.

The recent interest in health promotion among older people in the USA Senate Special Committee on Aging, the Senate Finance Committee and the Department of Health and Human Services is part of the wider search for policies that help contain rising acute and long-term care costs for older people. However, several prestigious agencies have increased health promotion among older people, including the DHSS Office of Disease Prevention and Health Promotion itself[20], Duke University's Center for Aging and Human Development, the Health Services Research Center at the University of North Carolina and the Aging Health Policy Center, University of California [21,22].

The growing involvement of business and corporate interests in health promotion and wider health policy issues is a major trend in the USA. Workplace health promotion now includes special attention to older workers and retirees for whom employers have a significant responsibility for health insurance coverage. Sixty per cent of retired workers remain eligible for some type of employer-related health insurance cover.

In 1985, in evidence to the USA Senate Finance Committee, the President of the Washington Business Group on Health debunked the two most prevalent myths about health promotion for older people. First, that prevention will be too costly because it may help people to live longer, thus consuming more social security and retirement benefits; and that prevention is too late for older people to benefit from it. Employer self-interest can mean adopting a positive position on the role of older people in society: a merger of necessity and opportunity [23]. The Group has recently formed the Institute of Aging, Work and Health with an agenda of managing health care costs, health promotion for older workers and retirees, and maximising productivity of an aging workforce.

Initiatives for health promotion

Over the last ten years, a large number of programmes have been developed throughout the USA, many being short-term and little known, but with a significant number of others now well-established and making increasing efforts to disseminate ideas about their organisations and methods. (A national directory listing more than 250, and providing details on 50, has been prepared by the Aging Health Policy Center with funding in part from the Administration of Aging). The diversity of programmes should not be surprising in a country where the population aged 65 and over is equivalent in size to the total adult population of England and Wales.

Many of the programmes address the national health promotion initiative priorities. Some take up other specific issues such as screening for hypertension, relaxation and stress management, coping with physical illnesses, environmental assertiveness, use of services, social isolation and coping with transitions such as retirement and bereavement. Several are organised around more comprehensive interests. Some of these more comprehensive programmes are illustrated in Appendix D, which indicates the diversity of funding bodies, goals, settings, methods, staffing and approaches to evaluation. All these programmes have in common the aim to increase the control older people have over their health (through increased awareness, social support or the availability of services) and to offer opportunites to people to improve their health. Many go beyond concern with risk factors for specific diseases (the prevention of which raises many doubts about effectiveness), and many go beyond medical intervention as a means of improving health.

There are thousands of community, business, government and voluntary organisations disseminating information that can be described as health education. In San Francisco, over 80 agencies come together as the Coalition of Agencies Serving the Elderly. This meets once a month and has initiated activities like Elder Abuse Prevention. One of the main agencies, the Department of Public Health, runs an office for Senior Information, Referral and Health Promotion which has been established for two years. Based in the city centre and offering other services like the transport pass and discount cards for older people, this office sees 600 people, and deals with more than 1600 telephone calls every month. It provides information on housing, transport, employment, food and other issues. A library of consumer health information has been developed, among which are the Age Pages produced by the National Institute of Aging. These are easy-to-read sheets of basic facts on topics such as anxiety or exercise, available in the languages of 11 different population groups, and developed in collaboration with the client groups. Their evaluation involved asking communities whether the materials met needs, but there was little information on how these materials were used or by whom.

In San Francisco, the Department of Public Health has also been responsible for providing materials for health professionals involved in teaching health promotion, and it organises events and activities around the issue of exercise and nutrition. In this and in other activities, the public body worked collaboratively with a consumer group – the Gray Panthers. Both groups saw their role at the community level as facilitators for health promotion activities, and advocates for older people. This has required them to go out into the communities, adapting their programmes to the everyday interests and problems of older people, and exploiting their 'natural' foci such as the seniors' centres. The major difficulty identified was the increasing demand for classes and events in the face of short-term or discontinued funding.

Specific projects

Five examples have been selected to illustrate how new projects have been established, their priorities identified, and how their success has been evaluated.

WISDOM PROJECT

The Wisdom Project developed from concerns about access to medical care in an inter-city area in New York. A voluntary

committee with representatives from the health department, hospitals, community, consumer groups and the Commission on Aging looked at the needs of all elderly, particularly those with chronic illnesses. The rationale was that if these people were under-served, and did not have a doctor, they could benefit from some preventive service to help, for example, with control of diabetes or monitoring of hypertension. The project was established in seniors' centres, which were seen to be accessible places, more personal, and less intimidating than health facilities. The project has two main components – screening tests and health education. The medical team is led by a geriatric nurse-practitioner, though each person sees a physician once. Medicare finances the processing of tests, and cost of prescriptions. The Red Cross provides money for equipment, staff and space.

People using the service see a health educator to develop personal plans regarding diet, exercise and stress management. As a result, health education modules have been developed for dissemination in other seniors' centres, mainly using peer counselling and experimental learning techniques.

The project depends upon the support of local hospitals and communities, which has made replication slow. It took two years to establish credibility in one poor Hispanic community, and without this involvement, the project does not develop. Community identity is an important reason for under-utilisation of a project because older people in one area are reluctant to go to another seniors' centre for the service.

The project used several approaches to assess its success. A random telephone survey found that only a minority knew that the seniors' centre existed. Surveys, in centres, of older people's preferences found a consistent demand for health education, but less enthusiasm about using the medical services. Health education volunteers counted heads and made their own assessments of its success; users were asked how they felt – 99 per cent were satisfied; changes in health status were monitored – among those with uncontrolled chronic illness (diabetic hypertensive), 88 per cent, improved, but without a control group it was impossible to know why.

It was argued that although the Widsom Project adopted a medical model this enchanced its effectiveness. Older people were interested in their physical well-being and in the risks of diseases. They were interested in changing their behaviour as long as the project was related to what they veiwed as their health problems.

SENIOR HEALTH AND PEER COUNSELLING, SANTA MONICA

Senior Health and Peer Counselling in Santa Monica developed, like the previous project, from a concern that public health provision for older people was inadequate. Five older people saw a need for preventive services which were not covered by Medicare and which they felt should be free to older people. From an original focus on health screening, the centre had added peer counselling and health education as the three elements of a strategy to keep older people well, active and living at home. Services are provided by 100 volunteer health and medical professionals, nurse practitioners and trained by volunteers. Peer counselling is available to people aged 55 and over, both individually and in groups; and those older people who volunteer as counsellors may visit people in their homes. This 'community outreach' element of the programme is important; in fact all services, including exercise classes and health fairs are offered throughout the community, and the executive of the centre represents the interests of the users through adovocacy at state and county levels. The programme aims to maintain the health of both well and sick individuals. Specifically, there are 180 volunteers who visit and structure activities for people with chronic mental health problems, providing a structure of community support to reduce isolation and improve the social skills of group members.

Both health education and peer counselling are intended to promote 'healthy lifestyles' and to help people deal with the challenges and concerns of growing older. The programme's success is seen in terms of detecting illnesses, changing lifestyles (losing weight, taking up exercise, dancing), and improving morale. The number of people using the centre's services has increased from 2400 in 1978 to 13,500 in 1983 and the programme has become (through national TV exposure) something of a model for promoting 'healthful aging' on a relatively large scale in a personal and cost-effective manner. The centre has begun to attract funding from foundations for the development of training manuals and materials.

ELDERPLAN

Elderplan in Brooklyn, NY, is one of four national demonstration sites to evaulate the role of social health maintenance organisations (SHMO's)

In exploring health maintenance for older people, the 1981 White House Conference on Aging recommended that 'future

service delivery should be developed within the framework of health promotion, prevention and health maintenance rather than take the more narrow approach of treatment and long-term care'.

SHMO is an experimental health care programme for elderly people. Prior to the emergence of the SHMOs the incorporation of health promotion activities in health maintenance organisations (HMOs) had been limited. Unlike the HMO, the SHMO assumes responsibility for both well and disabled elderly people across a full range of acute, inpatient, ambulatory, rehabilitative, extended care, home health and personal support services. The SHMO's fixed budget, negotiated per caput, will combine Medicare, Medicaid and individual monthly premiums to cover the costs of these services.

In Brooklyn's Elderplan, healthy lifestyle behaviours and emotional well-being will be fostered in sessions on exercise, nutrition and stress management. Information will be presented on patient's rights, and participants will be offered training in communication and assertiveness skills. They will also be assisted in coping with the aging process, sexuality and 'ageism.' Medical self-care will be included to help participants recognise and treat common illnesses and manage chronic conditions as well as the appropriate use of medications and responses to emergencies. Since prudent use of resources is crucial to the success of prepaid capitation systems, participants will be encouraged to learn what are appropriate and effective uses of services.

TENDERLOIN SENIOR OUTREACH PROJECT

Tenderloin Senior Outreach Project is one of the apparently few examples of community organisation in disadvantaged communities. The Tenderloin area in the heart of downtown San Francisco is home to 8000 low-income elderly men and women, most living alone in residential, single-roomed occupancy hotels. Many suffer multiple health problems, especially drug and alcohol abuse, mental illness and physical disability. The project was begun in 1979 by three students from the University of California, Berkeley, as a health education initiative. It was intended to respond to the problems of poor health, social isolation and feelings of powerlessness. The underlying philosophy is of commitment to community participation, self-reliance and community action.

As in many community projects, the students first worked to gain some acceptance by the residents through being identified with one of the 'respected' helping agencies in the area (a Catholic

church with a large free meals programme). They offered services to a local hotel, using free checks of blood pressure as an initial base for contact and for establishing rapport. It emerged that crime, not blood pressure, was the major concern. So they began planning to resolve the problems with the involvement of the community through steps like policing and safe houses. The residents took the lead in this development and in the organisation of a nutrition programme which focused on getting enough food rather than nutrition education. Mobile mini-markets were set up in the hotels. This increased access to food and increased opportunities for social contact and for developing more control over a critical aspect of their environment.

In reviewing their work, the project's support staff emphasised the importance of generating mutual support between residents, the social function of free coffee and doughnuts, and the need for personal contacts with residents. There were difficulties in meeting the different agendas of the residents and the funding agencies, in developing local community leaders when there is a frequent turnover (often due to ill health) and in developing groups which can become autonomous and independent of outside facilitators. Assessment of a project like this could not be by a questionnaire measuring social isolation or feelings of powerlessness, but was assessed by the nature and extent of community participation, by attitudes to the project, and by changes resulting from initiatives by the residents.

MEDICATION AWARENESS

Medication Awareness is one of the several projects on the use of medicines by older people which have won major health promotion awards from the Department of Health and Human Services. All these are community-based drug education programmes intended to help older people to improve their use of medicines, thereby reducing the risks of misuse. Most use community settings for group teaching, aimed at increasing knowledge about drugs and, at the same time, fostering a network of mutual advice and support.

The 'SRx' (prescribed medicines) programme began in 1977 with finance from the Family Fund, an organisation which, from the start, wanted continuity and to encourage collaboration between private and public funding from the country's health department. The main components of the programme are: medication education for the elderly provided by pharmacists trained in health education and adult learning behaviour;

continuing education of professionals, para-professionals and staff of housing units; and evaluation. Other elements include: work with family care-givers (who use the project's materials as a resource); a touring theatre group which consists of eight older people and a director who produce their own plays (the most recent of which was on the use of alcohol as a drug); and advocacy, which resulted in a proposal for statewide expansion of the programme being incorporated into the California Senior Legislature for 1985/86. Direct requests from communities led to the establishment of mini-classes and workshops for older people and their care-givers. These are held in seniors' centres or homes, and community pharmacies with an aim to target low income and ethnic minority sites.

The programme must continually 'count heads' as part of the county's requirements to justify funding and has reached about 30,000 people since it began. Each mini-class has pre- and post-test assessment with questions about knowledge of the content of the class – appropriate drug use, prices, sources of information. Formal testing like this is seen to be difficult with groups of older people, who sometimes view it as insulting to be asked the same question twice in half an hour – but the funding body want some quantitative assessment. Staff in the programme are also carrying out a longitudinal study of random samples of the population aged 65 and over in San Francisco and one other county. In particular, they are looking at the use of 'personal medicine record cards', which are intended for use with pharmacists and doctors to keep track of medicines.

In 1984 the programme expanded from San Francisco to six Bay Area counties. Staff identify the main ingredient of their success as involving older people in the development of strategies and materials, taking their advice and suggestions at all stages of development and testing.

One issue that was not yet on the national list of priorities, but which was attracting much research and programme development, was related to the health of 'informal ' carers. It has been described as the new and major challenge for promoting the health of older people and it has been described as the fourth level of prevention – preventing disease in or breakdown of the primary care-giver to people with chronic illnesses. There were several examples, in particular of the development of mutual help groups among the care-givers of people with senile dementia, e.g. the Duke Family Support Program operating in 23 North Carolina communities.

Evaluation

In the examples of specific projects there have been several examples of approaches to evaluation – in terms of participation, attitudes to the project, and changes in knowledge and behaviour. Other criteria for assessment have included documenting inputs (such as the development of curricula and materials, recruitment of volunteers), describing the process and detailing expansion into other parts of the town and country, or the movement from local practice to public policy.

Depending on specific programme objectives, what is process for some is outcome for others. There was little evidence of assessment in terms of changes in health status, use of services and costs, or even in terms of changes in level of perceived health, quality of life, or self-esteem. Several of the project organisers pointed to practical reasons why the traditional ideas about 'outcome' assessment were inappropriate or impossible in their settings. Evaluation in this field is complex and difficult; it is at an early stage, where the focus is upon 'counting heads' and 'number of activities.'

For the most part, where evaluations do take place they are programme specific, so there is little opportunity to compare different methods used in different programmes. In general, it appeared that few systematic attempts were made to conduct assessments of programmes 'due to limited funds' combined with a belief that 'limited funds' in an uncertain future were better spent on programme development and maintenance. Evaulation may cost more than the programme activities if long-term, longitudinal studies are established. There appears to be a need for more modest measurement, acceptable to staff, programme participants and funding bodies. Two basic questions could be asked by all projects. Whose heads are being counted? Whose objectives does the programme aim to achieve?

Implications for the UK

There is no real evidence that there are more health promotion initiatives for the elderly in the USA than in the UK. Indeed, such initiatives among the 10,000 different kinds of health promotion in the UK recently listed by the Community Health Initiatives Research Unit (CHIRU). However, unlike those of the USA, few of the activities here contain significant components aimed at self-empowering and direct involvement. Notable advances in this direction include the Age Well campaign.

Important lessons from the USA experience include the following:

1 National and state public health authorities take a leading role in advocating that health promotion among older people is worthwhile and effective. Although local community initiatives are widespread, the importance of strong support 'from the top' must not be underestimated. Clear national priorities and objectives would be an important stimulus and support for local actions in the UK.

2 The organisation and political power of older people in the USA has ensured them of a public and government hearing and of effective means of bringing pressure to bear when necessary. These groups also readily organise together in coalitions. A strong coalition of all groups working for the interests of older people in the UK is necessary.

3 Deliberate and successful efforts have been made to tackle common misconceptions about both the social value and abilities of older people and the effectiveness of preventive health actions for them. The Age Well and Age Concern's forthcoming Celebrating Age campaigns are moving these barriers.

4 More can be done to convince practising health professionals that resources and effort applied to prevention among the elderly are effective in terms of health and well-being and in helping to change attitudes among the elderly and the rest of the community. There is already abundant evidence that elderly people are interested in prevention.

5 Elderly people should be seen more as a social resource and ways of helping them to contribute most effectively should be explored at all levels. Planning should begin during working life and involve employers. Many existing initiatives by elderly groups would gain from assistance to organise and implement their schemes.

6 More attention should be given to the segregation of the elderly through either income status or the forms of care given to the less capable. Special health promotion initiatives could be developed for such groups as those in sheltered homes to help keep them integrated with the rest of the community; such initiatives should be aimed at people in their local setting.

Facing the future

1 More attention could be give to developing the effectiveness of joint planning between the NHS and local authorities because of their responsibilities for elderly people. Similar relationships could be developed between the voluntary and statutory sectors where much could be achieved by continuing the breakdown of artificial boundaries between the two.

2 Community projects for the elderly may take many years to become adequately established and resources and other support from funding organisations should reflect the need of projects to have security during their early development. Experimentation should be encouraged and should allow for the development of new and more useful ways of evaluating these processes.

3 Ways of helping existing community-based or national organisations to coordinate and form coalitions should be found and supported.

4 In helping to change attitudes to the elderly, the media could be encouraged to review their presentation of stereotypes in written and broadcast materials. Negative stereotypes could be reduced but there is also considerable scope for helping reshape attitudes among the elderly and the rest of the population, especially through portrayal of the elderly in drama, light entertainment and news broadcasting.

5 There is a need for more research to identify the needs and aspirations of older people and for monitoring their achievements in programmes which set out to satisfy these needs.

CHAPTER SEVEN

Community development approaches to health promotion

[Based on the paper by John Dodds, Bill Fraser and Madeleine Rendall]

Community development offers a flexible and positive response to locally perceived needs and can be complementary to the work of national agencies and programmes. Most community development initiatives have two main themes. The first theme is personal or group development and the second is social or social structure development. They embrace a diverse range of interests – women's health, ethnic minorities, older people and self-help groups. Their flexibility and local specificity comes from the general characteristic of being run for and by local people. They also have connections with funders, voluntary bodies or other agencies related to their purpose, and often the local and health authorities. They may not be staffed entirely by local people and often employ outside workers with the required expertise, including health workers.

Community development philosophies have developed in response to the two basic failings of the statutory services with which they can come into conflict. Community development activity most commonly arises in association with deprivation or disadvantage. Often NHS and welfare provisions do not reach the intended groups or communities or, increasingly commonly, the official perceptions of people's needs and expectations are out of line with reality.

Community development approaches are able to identify specific local problems and needs and draw together local skills and support to tackle issues. Support can come from primary care staff, teachers, community organisations, churches, and local authority staff. Because they are outside existing organisations and arise under locally specific conditions, they draw freely from all available means of organising, planning and achieving their purpose. In the UK, there are thousands of these projects but their respectability among formal health promoters is not as accepted as it is in North America.

There is widespread debate in the UK on the potential and future direction of community development and the study of North American developments in this area provides a valuable contribution.

North American approaches

A good reason for community development being so widespread in North America is the recognition by health planners of social inequalities, coupled with the lack, or relative lack in the case of Canada, of health and welfare provision matching that of the UK. As a result, community development is an accepted part of health promotion and has the support of many academics, planners and health professionals as practitioners. It has become not only a legitimate method, but is often the first choice.

There has been a strong base of academic study of the process of community development in North America. Much thinking has been influenced by the Alinsky and McKnight tradition[24] where the process of organising is considered a contribution to health, even if health is not the direct subject of the activity. The premise is that increased confidence, social support and achievement within the process are essential to health.

The variety of different approaches to community development could be classified as follows:

Classification of community development approaches

1 *Social action/Alinsky style organising*

Small geographical area, patch-based, for example, one housing estate; modelled on trade union organising. Common issues which can unite the community are identified as housing repairs, traffic safety and so on. Uses confrontational tactics, for example, sit-ins. Builds confidence and comradeship for future problem solving; however, problems and solutions tend to be seen narrowly and are restricted to the local community.

2 *Community/locality/ development*

Small patch-based; issues either identified by the community, or sometimes as a mechanism to get a response to issues identified externally. Uses less confrontational, more reformist, tactics, and

with greater emphasis upon discussion and negotiation with authorities.

3 *Social planning/consultation*

Can be based upon an issue or a small or large patch. Explicitly a mechanism for public consultation and/or to encourage citizen participation in planning and policy-making; usually of statutory agencies. Generally, the community has no ultimate power of veto, so it may be tokenistic. UK examples might range from public transport enquiries to community health councils.

4 *Consciousness raising*

This is a response to a shared personal identity and may be based on a work-place or a patch. Concerned with mutual support and analysis of shared personal issues including the reaction of the majority/dominant community. Examples are women's groups or groups based upon shared ethnic background.

5 *Self-help groups*

Response to a shared health condition or disability. May be small patch-based or draw members from a much larger catchment area. Concerned with mutual support and, in some cases, an outward focus, for example, by lobbying, campaigning or fund-raising. There are UK examples, for example, Alcoholics Anonymous, National Childbirth Trust, Gingerbread, Sickle Cell Society.

6 *Public advocacy/pressure group tactics*

Usually concentrates upon a single issue for a larger area, city, country or country-wide. Style of organising is deliberately 'top down'. Main concern is lobbying and pressure for legal/political change rather than building mass membership and grassroots action; for example Child Poverty Action Group (UK).

7 *Mass based organising/coalitions*

Acts as a combination of 1 and 6 in that it uses both 'top down' and 'bottom up' approaches to defining issues and developing structures. Equal priority given to developing mass membership and grassroots action which is used in support of lobbying for legal and organisational change. Usually single-issue based and

covering a large catchment area. May be one organisation, for example, Campaign for Nuclear Disarmament, or represent a coalition of various groups or organisations, each with their own membership and structure, for example, Maternity Alliance (UK).

8 *Community control/community-based economic development*

Concerned with a major decentralisation of institutions, and particularly of economic production, so that individual neighbourhoods start to become economically self-sufficient. This involves the creation of labour-intensive small businesses under community control, for example, community vegetable gardens, food co-ops, small-scale cooperative manufacture and services. In turn, these provide jobs and economic investment in the community. This represents a radical shift from poor communities organising primarily around issues of consumption (for example, demands for more services) to organising around production issues (for example, demands for the resources to establish the community's capacity for small-scale production). Examples include the Community Garden and the Community Pest Control Service in Toronto; in the UK, maybe, the Greater London Enterprise Board.

Types 1 and 3 of the above classification may represent the two extremes of UK tradition, but the classification is more precise than reality and many activities may have components from several types. However, the terminology and classification must be seen as imprecise and used as a guide to understanding rather than a means of 'pigeon-holing'. Certain aspects of community development are long established here. The present community worker is a specialised social worker and can be employed by social services departments. In 1969, the Home Office set up 12 local community development initiatives under the National Community Development Project which was part of the poverty/urban development programme.

PATCH – A federal (national) initiative in the USA

The federally-funded Center for Disease Control (CDC) has established the Planned Approach to Community Health (PATCH) programme. This is an attempt to set up partnerships with state governments to involve local communities in looking at

their own health problems and to agree a strategy to deal with them. CDC provides assistance to the relevant state agency in assessing local risk factor prevalence, in the collection of epidemiological data and the surveying of community opinion. On the basis of all this locally relevant data the community is then involved, via meetings and telephone surveys, both in defining local priorities and objectives for health promotion and in running the activities. There was evidence that where the community's priorities for action differed from professionally defined or federal priorities, the community's view took precedence. In one example, home accidents and fires emerged as a locally-determined area of concern which differed from the priorities of the sponsoring agency. The PATCH programme could be located around types 1 and 2.

A similar approach in the UK with a central organisation charged with the collection and distribution of locally relevant data on a regular basis could provide useful support and impetus for community development initiatives. HEC's recent 'Big Kill' initiative providing detailed local statistics on smoking-induced diseases would be a UK example.

Prevention Research Center, Berkeley, California

This is a national centre for the study of environmental approaches to the prevention of alcohol-related problems. In designing community-based programmes, the importance of environmental influences, and the need for multiple strategies with a range of complementary approaches, are emphasised. In the Center's view, shortcomings of major projects like the Stanford Heart Project and MRFIT in the past lie with overemphasis on the individual, and lack of attention of the influence of the environment on behaviour. This could be seen as a mixture of types 2 and 7.

Bethel New Life Inc, West Garfield, Chicago

This is an inspiring project in a very deprived black neighbourhood, which was started in April 1979 by a small local church committed to reversing the process of urban decay. Through hard work, astute fund-raising, sponsorship by larger churches in richer neighbourhoods, and maximum use of federal, state and city funding, considerable progress has been made. There is commitment to community economic development, the provision

of decent housing and local employment under community control. All of this is being achieved. It has recently extended into health care, and March 1984 saw the opening of the Bethel Holistic Health Center providing affordable primary care and outreach health promotion. The director of the health centre believes the community's health needs can be tackled only after the basic problems of housing and employment have been dealt with (types 2 and 8).

South Shore Community Unemployment Union, Chicago

This provides some contrasts with Bethel. Also located in a deprived black neighbourhood and started by a local church, South Shore has had less success with attracting funding – perhaps because of a more confrontational approach. They have had the opposite experience with community economic development because generating local employment was the initial priority, but the mental and physical health problems, including poverty, drugs abuse and the low self-esteem engendered by either having never worked or long-term unemployment, were found to be such that community members could not cope with employment. Their priority is now prevention, health promotion, food kitchens and primary care – to ensure that the community becomes healthy enough for local employment projects to work (types 1, 2 and 8).

Health and Medicine Policy Research Group, Chicago

This is a stimulating combination of 'think tank, policy forum, research and lobbying body, established by a self-selected group of concerned individuals, from a variety of backgrounds, who shared widespread criticisms of current US health policy. The group is non-profit making and is run primarily by volunteers with minimum expenditure on headquarters. It develops its own areas of interest, and responds to both other groups and campaigns. An unusual free consultancy service providing the organising and research expertise for effective campaigns involving coalitions of community groups is offered. The Group also provides advice and expertise on policy development and publishes a magazine/journal to help disseminate its work (types 6 and 7).

The Martin Luther King Health Center, Bronx, New York

This was an early attempt to deal with long-standing urban decay in the Bronx by substantial federal funding. The Center established a model where access to good primary health care was seen as only one factor, although an important one, in the attainment of good health. The appointment of family health workers, community advocates, and the setting up of home maintenance teams and locally appropriate courses were seen as important parts of the whole programme. With the recent shift in the national political climate, the community development initiatives have disappeared, and the Center is fighting for survival as a free-standing primary health care centre with some emphasis on preventive care. An expensive medical model is substantially all that is left of an exciting and effective community action programme which had insufficient time to demonstrate its impact. In its original form this could have included types 1, 2 and 5.

The Bridge Project, Brooklyn, New York

The project started out of concern for teenage mothers in a deprived Hispanic part of Brooklyn. Whilst it is church based, and the headquarters are in the parish buildings, the programmes are located on several sites. For young mothers, there are classes in homemaking, basic parental skills and courses to become qualified babysitters. There is an emphasis upon developing self-awareness and esteem. The framework for all the programmes is 'what does the community want, and how do we assess it?' Surveys establish the relevance of their programmes (types 2 and 5).

Toronto Public Health Department initiatives

The Public Health Department of Toronto has a commitment to community development. Eight community health educators have been employed to work throughout the city and are supported by a substantial central resource unit. They have helped in the establishment of projects like the Community Garden Project which involved a deprived local community demanding and winning the right to use some waste land as a community garden. This has resulted in the production of fresh

vegetables, paid employment and organising experience, all under the management of the local community. A further development has been a 'second harvest' which involves the recycling of surplus food from markets, supermarkets, canteens, and so on, to poor neighbourhoods (types 2 and 5).

Staff from the Public Health Department have also helped establish the Multicultural Health Coalition. This was seen originally as a local Toronto initiative, but it has been so successful that it has become nationwide. The coalition serves as a body for information exchange, research and for lobbying in relation to health care provision for ethnic groups (type 7).

Immigrant Women's Center, Toronto, Canada

This was founded in 1975 to offer immigrant women a unique counselling and referral service in family planning and related health problems. All counselling at the centre is by counsellors who share cultural backgrounds and language with their clients. Six counsellors are available, with Chinese, Vietnamese, Italian, Portuguese, Spanish or West Indian backgrounds. Over 50 per cent of Toronto's population are from immigrant cultures. The counsellors do outreach work in their own particular communities. Funding has recently been obtained for a mobile health clinic which will visit local factories to take health promotion, counselling and screening to the places where immigrant women work. This successful three-year experiment has been funded by the federal health promotion programme out of the one-third of their budget which goes towards direct support for local projects. (This could be type 4 or 5.)

Parkdale Partners for Employment

This project was established by church and community groups in a deprived community in Toronto. The aim is community economic development, generating real jobs of benefit to the community. One of their first projects is directly related to health. It established a community-managed pest control business to cope with cockroach and other infestations in poor quality housing (types 2 and 8).

The Catherine McAuley Health Center, Ann Arbor, Michigan

The Center comprises a lavishly-equipped private hospital complex serving a mainly affluent county in Michigan, with a large health promotion department within the hospital. It is funded by a religious foundation. Among a full range of conventional programmes, such as patient education, workplace stop-smoking, and cancer education, are five community outreach programmes. These were specifically targeted at the only substantial local area of poverty, with black workers recruited to work in the primarily black neighbourhoods.

Professional development

Two university departments involved in public health and health promotion were visited. The university of Michigan School of Public Health and the University of Toronto Department of Community Health both had masters of health sciences programmes which had a strong emphasis on community development approaches and involved substantial field work placements with community groups.

Implications for the UK

1 Community development approaches offer an effective and adaptable form of health promotion, which also has the distinct advantage of filling in gaps and omissions of the statutory services.

2 However, community development should be recognised as an important component of health promotion methods and should be supported by statutory and other services or agencies active in health promotion. Although community development initiatives often arise out of conditions of minimal resources and succeed under those conditions, the North American experience shows how effective they become if they are given appropriate levels of resources and other support.

3 It is recognised that for community development to be fully accepted in the UK, there needs to be greater understanding of the health inequalities, of their causes, and a commitment to see them as a part of national priorities for health and health

promotion. In addition, health authorities and health professionals must be prepared to relinquish total control over all health decisions and to work with community groups in deciding priorities.

4 The DHSS and HEC could review their roles in promoting community development with particular reference to the balance between national and local components of health promotion strategies and also review the proportion of health promotion funding which is committed to community development activity.

5 Community development processes, by their nature, tend to encourage networking and the formation of coalitions which are important to the success of the new approaches to health promotion.

6 The development of City-based intersectoral strategies for health promotion provides new opportunities for community development approaches.

Facing the future

1 Community development offers many advantages to health promotion in the UK. But its value lies in complementing the existing health and welfare services which are superior to either system in North America if allowed to be fully effective. The future of community development should be seen within the present UK systems and not as a form of 'voluntary alternative' to the NHS.

2 Efforts to increase awareness of and support for community development within health and local authorities should be initiated. Training workshops, multidisciplinary teams, involving health, local authority and community members to review current practice and community development agendas and to initiate an annual review and report on progress at national, regional and local levels, could help increase awareness and acceptance of community development.

3 Future resource allocations to health promotion should be reviewed to ensure that community development receives an increased share in relation to its value among complementary approaches.

4 Given the diversity of approaches within community development methods, a nationally-funded research and development programme over an initial five year period could help to identify the potentials for community development for different agencies and contribute to a systematic base of theory and practice relevant to the UK. There is already extensive knowledge and experience in the field and the research would help collect this UK resource and make it widely available. An important element of the research could be to develop locally feasible and useful means of evaluation of such activities. Initially a series of demonstration projects could be identified and funded as action research. Many existing projects may qualify. All projects would need to be replicable to justify inclusion. Essential features of the projects might include:

a) an emphasis on interagency work, including a careful examination of the balance between voluntary and paid workers;

b) the production of practical guidelines to facilitate replicability by similar agencies elsewhere;

c) emphasis upon developing more sophisticated and relevant techniques of evaluation;

d) the scope for a public advocacy role;

e) the scope for building coalitions;

f) the effect of community development work upon the overall aims, organisation and operation of the agency;

g) the implications for the basic and post-basic training of the agency staff and others linked to the project;

i) each project will probably need to be funded for a minimum of three years. Research is also needed on planning within community development approaches to help develop effective planning and monitoring methods for use by local community groups and supporting agencies.

CHAPTER EIGHT

Populism in health promotion

[Based on the paper by John Ashton and Howard Seymour]

One of the most striking features of health promotion in North America is how it thrives without formal ownership by either the health professions or any particular institutional base. It is difficult to say how much this freedom is a precondition for the energy, diversity and degree of community participation in health promotion. Across the two vast countries, there are many initiatives among which are a number of shining examples of the new concepts of health promotion; but, of course, many are mediocre. While there is no suggestion that the North American models should be transplanted to the UK, there are many aspects of the general philosophy and organisation of their health promotion which could be adopted here.

Holistic definition of health

Health is defined beyond meeting physiological needs, food requirements, shelter, and avoidance of disease to include social needs and the personal needs of respect, dignity, approval and self-fulfilment. The wider view has an important consequence in encouraging a great diversity of health initiatives to develop. Beause the definition goes so far beyond traditional medical definitions, it has allowed people other than health professionals and institutions other than hospitals to take up the promotion of health.

Entrepreneurship

There is little public funding of health care in the USA and in Canada has less than the UK; there is, however, a greater contribution from private funding. Industry and individuals bear a greater and more direct cost for treating disease. This tends to provide an impetus for industry and individuals to get healthy and encourage others to be healthy.

The entrepreneurial 'go-getter' approach is all-pervasive. The

model people in health promotion use is one where someone has a good idea, and then goes 'hell for leather' to develop it whatever the cost. The ethos is very different from this country where people often seem to work from the position of having to consider 'how much money can I expect to get, and for what purpose?' and then create a programme tailored to these constraints!

The US system seems to create a breed of wheeler-dealers. Programmes are not necessarily financed inhouse but by (sometimes ephemeral) coalitions of individuals, agencies, businesses and local communities. They involve people who are, or can be made, interested in an issue. The amount of money then available for a programme is dependent on the skills of salesmanship and of gaining community involvement. The programmes that survive have a better chance of real support and of obtaining the level of resources necessary for them to be put into practice at the desired scale.

Coalitions and networks

There is little feeling that specialist knowledge is the property of any discipline or that artificial boundaries between disciplines or sectors are respected. This has allowed the development of health promotion activities wherever the most suitable structure is found and with the support of any interested group or organisation. Large corporations like Campbell's and Kellogg's finance and sometimes run national or local health promotion campaigns. Such corporation involvement is normal. Most large companies have their own charitable foundations and large sums are given to community and charitable activities. There are, of course, attendant tax concessions. Voluntary sector agencies become formal lead agencies in national programmes.

Coalitions form between public health authorities, industry, workplaces and local or voluntary sector groups, all aiming to contribute to common aims by pooling interests, energy and resources. Networking across sectors and programmes ensures rapid spread of information and experiences and the sharing of skills.

Creativity counts

Many of the imaginative programmes would not have surfaced were it not for the support given by the system to the creative spirit. Tackling complex and new problems requires the freedom

to explore new, even radical, approaches. In North America, creativity is valued and specifically encouraged by a system which will fund new ideas. This may derive from the entrepreneurial drive which pervades society and the multisectoral approaches which must gain from the cross fertilisation of ideas and the willingness to share in the pursuit of common aims.

In North America, to try is almost as acceptable as succeeding. Failure is not penalised as it is in the UK, but is seen as a learning opportunity. In the UK, the need to demonstrate that new initiatives will succeed and the fear of disapproval from medical authorities, often stifle creativity and help to keep health promotion within established 'formulas'.

Methodological freedom

Community organisation/development methods can flourish more easily in an environment where a wider definition of health can be contemplated. At the other extreme from community work is the rapidly developing private profit-making service industry based on health promotion. The two ends of this methodological scale combine in the case of some community organisation activities. For example, a number of community industries have developed which both improve the general health of a community (jobs, improved local economy and an effect on the climate of hope) and sell healthy products and services (re-cycling paper, community horticulture, pest control).

Participation

The University of the Third Age illustrates the importance of participation. It was started in France by doctors who were worried by the demands of an increasing number of ill elderly people and decided that keeping them active might help their health. One of the successes of the University is that it is fundamentally a participative activity. This participation is at two levels. First, students choose which courses they attend and can end up with their own unique learning programme. Second, a number of the students also participate by running, organising and controlling the University. Participation is in itself a stimulant to good health; making choices for oneself, taking control of one's own destiny and being responsible for, and to, other people can all be in themselves health promoting activities.

Popular participation in programmes can provide a way of

overcoming the cost dilemma of health promotion. Participative programmes develop best where there is perceived need. This may offend the wisdom of professional health promoters who would attempt to give priority to actions which appear to fit the research on effectiveness and cost efficiency. However, participation is probably a more important factor than maintaining overt control or intellectual purity. In these circumstances it is for the professional to try to guide the programme.

One important element of participation is that people can find themselves with open learning opportunities. This is necessary for the success of mass programmes. It means providing learning environments in which people can start from their present state of development, knowledge, skill and emotional involvement, and then take a journey which is under their control and provides them with their own unique experience – an experience which is unique to them and yet can be catered for within a mass programme. The experience is not in this case entirely dependent on where 'people are at' or constrained by a popular lowest common denominator of experience, attitude, knowledge or skill.

An example of this type of mass health promotion experience is provided by the Mersey Travelling Health Fair scheme in the UK. This health promotion scheme, which is about physical fitness and healthy lifestyle, has been visited by more than 300,000 people in under two years. Everyone who has visited the scheme, at the International Garden Festival or on the five converted double-decker buses, had has the opportunity to have a personalised test of their fitness, stamina, strength and suppleness and a test of their healthy lifestyle. Open learning is provided by the use of simple computers with user-friendly and branched programmes. As a result, everyone who decides to participate can have their own unique computer printout about their health.

Implications for the UK

1 An important starting point should be the development and widespread use of a wider definition of health which reflects more accurately the living experience of people rather than merely states of disease.

2 Creativity and experimentation should be encouraged which could mean a more enlightened view from funding and support organisations.

3 Coalitions and networks should be explored more openly by all groups and agencies involved in health promotion and actively encouraged.

4 A national coordination base for health promotion is necessary but it should be outside the NHS and attention should be given to establishing a new organisation involving local authorities, the NHS and the voluntary sector, to reflect more adequately the values and methods appropriate to the new concepts of health promotion.

5 Special funds should be found to encourage innovative and experimental activity.

6 To encourage industry and the workplace entry into coalitions with other sectors, incentives including tax concessions and reduced employer National Insurance contributions for employers supporting workplace health promotion activities could be considered.

CHAPTER NINE

The role of broadcast media in health promotion

[Based on the paper by Carol Haslam]

Background and history

The growth and diversification of the mass media has been more extensive in North America than anywhere else. This diversity has been reflected in both print and broadcast media, and has recently spread to the new communications media – information technology, satellite and cable. This chapter is concerned only with the broadcast media, particularly with television.

It is difficult for visitors to North America to understand the range of programme sources that feeds the multi-channel television sets in homes, hotels and institutions. (Many areas can now receive between 60 and 100 services.) In addition, there is a further range of audiovisual materials distributed in other forms to specific markets or target audiences. This apparent abundance of choice appears to be a rich resource, but it is not until one looks more carefully at the structure and funding of the system and at programme content that the real value of the output in particular areas can be estimated.

Commercial networks in the USA

The USA broadcasting system is dominated by the three major networks – NBC, CBS and ABC. In addition to the network headquarters in New York and Los Angeles, there are many affiliated stations throughout the States, which supplement the main services with locally originated programmes. The schedules are strong on news, sport and entertainment, but have little documentary or educational programming. The other smaller local commercial stations have a similar mix of programmes, but with more locally originated news and low cost, studio-based conversation programming. Radio networks function on a very similar basis.

Public broadcasting system

The nearest equivalent to our own public service form of broadcasting (particularly BBC 2 and Channel 4) is the PBS system. This has the same federal structure as ITV, but is not funded by paid advertising space. Most programmes are funded individually by a combination of corporate and foundation sponsorship, supplemented by government funds through the Corporation for Public Broadcasting. The resulting service provides a rich mix of factual, cultural and entertainment programmes, with a substantial proportion purchased from the UK. However, the precarious nature of their funding means that few of the PBS stations can undertake major projects, or even modest series and single programmes without months or years of fund-raising before production can begin. This financial vulnerability also leaves them open to overt or covert political, moral and economic pressures.

Cable TV

Cable services began in the fifties as a means of overcoming local reception problems. Once communities had been cabled to receive the normal broadcast service from local relay transmitters, the opportunity arose to provide additional services to households, in return for subscriptions. As the cable networks spread, the advertising potential grew stronger until by the mid-seventies a number of cable-only services had been established. With the development of satellite transmission, these cable services could be beamed to local transponders through the USA. Now there is a number of flourishing national networks providing 24 hour news (CNN from Atlanta), entertainment (Showtime and Home Box Office), cultural programmes (Arts and Entertainment), 'lifestyle' programming (Lifetime), plus specialist channels for sport, music, children's material, and so on. Many of these networks can reach between 20 and 40 million households.

Canadian broadcasting

In Canada, the broadcasting system is similar to the States, particularly since the national publicly-funded service, the Canadian Broadcasting Corporation, was asked some years ago to supplement its income with advertising revenue. The federal structure of Canadian provinces is reflected in a range of

provincially based stations, both commercial (CTV, Global) and education (of which TV Ontario is the largest). All these networks rely on a mix of syndicated programmes and locally originated material. The educational stations have a strong track record of producing instructional series with accompanying study packs for formal and informal distance learning. However, because of the proximity to the USA, the majority of the population can also receive a full range of their services, both broadcast and cable. To compete with these, even Canadian stations transmit 75 per cent USA material.

Independent production

In the face of this cultural dominance from the USA and in an attempt to preserve some form of genuine diversity, both Canada and the USA have found ways of funding a small amount of independent production. Both the National Film Board of Canada and a publicly funded film financing body, Telefilm, receive applications from independent film-makers to make programmes and tapes that would have difficulty finding commercial backing. Similarly, in the USA the Corporation for Public Broadcasting and major foundations like Annenberg, fund educational and cultural projects for both broadcast and non-broadcast distribution. In the health field, foundations like Kaiser perform a similar function in relation to health promotion materials.

Community access to the media

The opportunities for community access to broadcasting should be greater in such a pluralist system, but the commercial base of virtually all services makes it difficult to get any real, 'no strings attached', community participation. There are a few community workshops that offer local people the opportunity to experiment with the use of film and video, and institutions like colleges and hospitals also use video for internal communication. However, even though local television stations are funded by advertising, they often reflect local interests and issues more effectively than the mainly centralised UK system is able to. In fact, the lack of resources for making expensive programmes means that local stations rely more on local contributors, phone-ins and video coverage of local events. However, real collaboration between broadcasters and community organisations or pressure groups remains patchy and is certainly rare at a national level.

Most worrying for the future is the increasing accumulation of

information in data-bases which is privately owned, which makes some groups 'information rich', while others become increasingly 'information poor'. Recent government policies on deregulation means that the 'owners' of the main media of communication are accountable only to their shareholders or subscribers, or to those pressure groups that wield economic or political influence.

Despite these very obvious constraints there is a surprisingly high level of health coverage and encouraging trends in cooperation between health and media professionals in the field of health promotion.

Policies and practices

From the description above, it is obvious that the interests and objectives of most media people have little connection with those of health and medical professionals. For those members of both professions who share a genuine commitment to public health issues, the chances of finding each other and working together fruitfully are small. Even where the spirit of collaboration does exist it is not often based on shared aims but more on a self-interested, even exploitative, relationship on both sides. Broadcasters need doctors, particularly eminent ones, because viewers like them and they provide authority and credibility. Health professionals need broadcasters because they want to reach the public or, like many others, they want to publicise their own good works.

At a policy level, all have one fundamental common concern – to attract the attention of the public and to hold it. For the health educator the aim is to convey a 'message'; for the broadcaster it is to increase audience size and thereby secure further funding. Insofar as 'health messages' or 'medical news' can hold public interest, the two sides can work together. Once the viewer turns away, both sides lose interest and the alliance ceases, at least temporarily. Examples of this process can be found at many levels and in different contexts. In the late 1970s NBC experimented with a weekly health show, made with medical advisers. The ratings dropped – so was the show. In 1982 the Health Cable Network was started by a cable entrepreneur and a physician; it failed to achieve economic viability and within three years had merged with another 'life-style' network. On the other hand, Dr Frank Field's regular medical features on CBS news have built and sustained audience loyalty and a high level of response to health promotion initiatives; as long as he selects attractive stories and holds that audience, these slots are secure. Similarly,

'Doctor's Sunday' on Lifetime Cable Network has provided the medical profession with a predigested, three-hour update on medical news in specialist areas. Their willingness to use this service will ensure a steady flow of advertising revenue from pharmaceutical industries and other medically oriented products.

Public service announcements (PSAs)

Most television viewers, if asked about health information on television, would probably refer immediately to PSAs. These are between 30 seconds and two minutes in length, often professionally made to look or sound like a commercial, and paid for by an organisation or government agency that wishes to address the public. They give information, offer a service, or raise funds or volunteers for a charitable cause[25]. PSAs are offered to commercial networks and cable systems to slot inbetween programmes or advertisements at the discretion and good will of the station. Where they require active viewer response, the results suggest that they are usually very effective in triggering action. Where they aim to promote longer term changes in behaviour, there is no clear evidence to suggest they are successful. However, because they still provide the main form of public access to large audiences they continue to be produced and distributed (CBS in Baltimore receives over 200 per week).

Researchers who have studied the use of PSAs in anti-smoking campaigns have concluded that the most significant cause of behaviour change is firsthand experience of the physical consequences of smoking, but that the media, combined with interpersonal support, can achieve results.[26] The Standford Five City Project indicated that, long term, the 'media only' town showed as good results as the 'media and community' town, although it's obviously impossible to control all other local factors over a long experimental period.[27]

As a result of cumulative research findings suggesting that it's more effective to reinforce existing positive behaviour than to change undesirable behaviour, many health promotion agencies are aiming their messages at keeping healthy people healthy, slim people slim, non-smokers not smoking, and so on. One example of this policy is the five centre experimental project set up by the National Cancer Institute to prevent 10–14 year olds from starting to smoke. The North Carolina part of the project will experiment with both radio and television PSAs, focusing, as in the UK, on immediate benefits of non-smoking rather than long-term health gains.

The style of PSAs is also changing to include some humour and more 'positive' rather than 'punitive' messages. This is partly to be more attractive to viewers, but probably also to appeal more to station managers, forced to select a few spots from the hundreds submitted. Personal contacts and influence also affect this selection process. One of the advantages of a long-term project like Stanford is that good relations are established with local stations and there is time and scope to experiment with different forms (for example, recent 'Healthy Living' spots include personal testimonials, consumer-type information and humourous vignettes). NCI and others, however, predict that the use of PSAs as a primary source of health information has already begun to decrease, although they may well continue both for those target audiences who do not watch much factual programming and by those agencies who have both the resources and the influence to compete with advertising for some space on commercial networks. Few organisations can afford a sustained programme of paid-for spots.

Some health groups and individuals are increasingly devoting their energies to influencing programme content and this again brings them into competition with commercial interests.

News coverage

It is hard to find a daily new programme on any US channel that does not cover at least one health or medical story; there are sometimes several. As ever, the interesting question is – what are the criteria for selection? Here's a new taxonomy:

'Gee-whiz' – these are pieces about high-tech, medical wizardry that display the application of new technology to surgery, transplants, pharmaceutical products, new limbs and so on.

'Sob, sob' – personal stories of illness, disability or accident, hopefully combined with a happy ending. These are particularly attractive when they feature children, old people, stars or national hero-figures.

'You next' – pieces about health hazards that have struck some and could affect others. Occupational and environmental hazards are most common, as are infectious diseases, drug damage or medical negligence cases.

'Quirky' and 'sexy' are terms that ensure that an unusual or

inexplicable health story secures a place in the news, probably at the end. AIDS started out this way but now has moved to the 'you next' category.

The journalistic quality of these items will partly depend on whether the station employs a specialist health or medical correspondent or news team. Those who do will exercise better judgment about the key features and main spokespeople on a particular issue, and are more likely to put the piece into an informed context. For example, Cable News Network employs a specialist team of reporters to produce two short medical features a day. These are repeated several times and combined into an omnibus weekend programme 'Health Week'. This enables the team to build a wide range of contacts and maintain a more sophisticated level of coverage than even major networks without such a commitment. The PBS station in San Francisco, KQED, produces a series, 'Health Notes', covering such topics as stress, home diagnostic tests, headaches, and so on.

All news journalists seem to have fairly broad definition of health except in one fundamental respect: they all work on an individualist model of change in health status. That is not to say they never take a critical position on a public health issue, but it tends to be from a consumer's perspective. Sometimes they work in close cooperation with health promotion groups and will often publicise booklets or referral services, although they would not take the initiative in doing this themselves.

However, most television news remains event-oriented and often over-dramatised. The same applies to most radio news, which tends to be as fast-moving and superficial as most commercial television news. The only exception is the National Public Radio service, transmitted for an hour and a half at breakfast time. With more political and international coverage, there is less room for personalised health stories, but coverage of major medical or policy items is more informed and systematic.

Documentary features

Documentary material forms a very small proportion of all television and radio output in North America. Some channels would never expect to originate factual material in documentary form but would be more likely to include 'information' in studio-based 'chat with an expert' shows. Documentaries cost a lot more money and therefore require a high level of commitment from a broadcasting organisation.

This means that most documentary coverage of health issues tends to be found on PBS in the USA and CBC in Canada. Here, however, the focus is broader and more likely to address political, social and environmental factors. One producer at WNET (New York PBS) has made a particular point of tackling social policy issues (such as home care for the elderly, the shift to community care for psychiatric patients, the impact of the Reagan economic policy on health care, and so on), but can only raise enough funds from liberal foundations to make one a year. Another well-respected current affairs series on the PBS network, 'Frontline', from WGBH in Boston, often tackles health and policy issues of this kind, but runs considerable political and financial risks with its more contentious films like one on legal action taken by lung cancer suferers against tobacco companies.

A different perspective has emerged at CBC in Toronto where the Science Programme Unit has developed a very clear ecological approach to environmental and health issues. This interest is not only reflected in their choice of subjects for their regular science documentaries, but in the approach they take to each subject. For example, a programme on hearing loss looked particularly at the impact of a noisy environment on middle range hearing.

As in the UK, one particularly popular subject for television audiences is films about the human body and how it functions. These range from major series like 'The Brain', produced by WNET, but seen by substantial audiences throughout the states, to 'The Body Human', a sequence of 10 one-hour documentaries shown on CBS over a period of seven years, dealing with different aspects of human physiology like birth, blood, genetics, and so on. Whereas the former was similar in style to the UK's 'Horizon', the latter used a wide range of entertaining and eye-catching devices to capture large audiences, but paid less attention to scientific detail and accuracy. NBC's attempt to win a similar popular audience for a series in 1978/79 about doctors and their work, 'Lifeline', was successful only as long as the doctors chosen worked in particularly dramatic areas, where lives could be saved in a spectacular way.

The key distinction between producing such high-cost programming in the USA and in the UK, is that there every film needs to find an underwriter before it can be made or transmitted. Prestigious, non-contentious programming can find corporate sponsorship, but for politically sensitive or intellectually stimulating material it is necessary to raise money from a charitable

foundation; even liberal foundations find it hard to be associated with too provocative a film, as would the broadcasting station. It is said that one independent producer making a film about chemical hazards was approached by representatives of the chemical industry and offered $500,000 dollars to stop production. Other pressures are exerted on stations which transmit programmes that could damage business interests. For example, pressure from USA's National Meat and Livestock Board on all the PBS stations which transmitted 'The National Nutrition Quiz'.

Dramatic programming

The most substantial piece of research on the health content of drama serials and soap operas appears to have been done at the Annenberg School of Communication at the University of Pennsylvania. Their findings suggest that after doctors, people get most of their health information from television, and much of that is probably from drama serials. Even their attitude to the medical profession may have been influenced by the high proportion of medical professionals portrayed in drama, within which 80 per cent of the doctors are male.

A study of all day-time serials broadcast in 1977 found that 'sickness and injury is a most important and pervasive problem' and that nearly half of all characters are involved in health-related occurrences. However, despite this apparent focus on individual well-being, people in dramas are consistently portrayed as eating, drinking, driving fast without seat-bealts and engaging in a wide range of sexual activity, without much ill-effect on their personal health. An analysis of one week's programmes showed that less than 6 per cent of males and 2 per cent of females were obese and none of these was a leading character. They hardly ever need glasses – even the elderly have a one in four chance of wearing them.

Particularly interesting is the representation of food in drama and in TV commercials – up to nine times per hour in drama and more than a quarter of all commericals are for food. In both, snacks and 'junk' food are most prevalent, particularly in children's programmes. Paradoxically, fruit and vegetables are three times more likely to be found in commercials than in programmes. Alcohol was also a heavy presence and between a third and a half of all dramatic characters are seen to drink, although only about 1 per cent are portrayed with any kind of drinking problem. By contrast, smoking is found in only 11 per cent of major male and 2 per cent of female characters.

The overall conclusions drawn by this study are that people who watch a lot of television are more likely to be complacent about their health, to have poor levels of nutritional knowledge and a high level of confidence in the medical community. Whether this is a causal connection was not explored, but in any case the overall findings suggest that 'the cultivation of complacency, coupled with an unrealistic belief in the "magic of Medicine", is likely to perpetuate unhealthy life-styles and to leave both patients and health professionals vulnerable to disappointment, frustration and litigation'.[28]

Similar findings emerged from a later study on the representation of alcohol in peak-time viewing, conducted by a team at the Prevention Research Center at the Pacific Institute for Research and Evaluation, Berkeley.[29] In addition to carrying out the research, the team, led by Larry Wallack, drew up strategies for combating the uncritical portrayal of alcohol on television. These involve mobilising parents and viewers to make their concerns known to broadcasters and advertisers and initiating integrated community education projects. They have also established contact with a group of Hollywood film writers, with the aim of providing an information resource on alcohol and related problems that could improve the accuracy with which these are represented in film and television drama.[30]

Educational programming

The opportunitites for transmitting health programmes as an educational resource are extremely limited – for all the obvious reasons. However, where audio visual materials are produced, either as transmitted programmes or as video software, they are extensively used within both formal and informal education. One of the best examples can be found in Canada, through the network of educational stations, of which TV Ontario (TVO) is the largest. Television series form part of a multi-media package, or 'tele-course', aimed mostly at adults at home. Others are used in colleges, adult education centres and schools. The health topics covered by such projects include child-rearing, personal fitness and nutrition. Two earlier series also covered public health policy and the environmental aspects of health[31]. In addition to the programmes, viewers can send off for accompanying study packs. They also have a chance to phone in for information and advice on the particular subjects covered by the weekly studio-based

discussion programme, which features a range of health, medicine and alternative treatment topics.

This more structured approach to adult learning is less obvious in the range of health series produced by some of the PBS stations in the USA. Subjects like nutrition, fitness and exercise are regularly covered, but they are rarely accompanied by specially written print material. Where possible, they make available information leaflets, produced by local health promotion agencies, and sometimes offer transcripts of programmes. Like TVO, however, phone-ins are quite popular – particularly on local radio – and are attractive to stations because they generate very low-cost programming and offer opportunities for interaction with the community.

Educational programming for children is sparse. The vast bulk of children's programmes, both on network and cable, is entertainment-based and heavily reliant on commercial advertising (toys and junk foods particularly). The exceptions include the output from Children's Television Workshop, who are responsible for 'Sesame Street' and the successful science series '3-2-1'. The scientific adviser to '3-2-1' regards nutrition as too contentious an area to cover in the series, although health topics are occasionally covered in both programmes. A new departure for them recently has been to win a commission to make an anti-alcohol promotional film, for transmission between programmes aimed at 8–12 year olds.

Audiovisual resources

A fairly extensive range of non-broadcast material is produced by various agencies for use in schools. These are usually based on school curricula and made in collaboration with health educators, again as part of multi-media packs. Some of the main producers of such material are the Educational Film Center in Washington, the Agency for Instructional Technology and the Education Development Center, Massachusetts. Much of this material is of high quality and has been extensively tested and evaluated. Such material covers the full range of traditional health education topics, but tends to be particularly strong on family relationships, personal growth and assertiveness, which are well covered in Britain. The only subject area where little such material exists is, inevitably, sex education.

In the area of professional education and inservice training, a huge market has been identified of the production of distance-

learning materials. Rapid changes in health care policies and practices need to be taken to large numbers of paramedical workers, and doctors need to be kept up-to-date with medical research and new technology. This need has generated hours and hours of 'update' programming, some transmitted on cable, some on the hospital satellite system and some on cassette and disc. The quality of this material is varied: coverage of conferences and digests of journal articles are useful and cheap to produce; interviews and discussions can be good, depending on the contributors; but some programming, often sponsored by pharmaceutical companies, amounts to little more than extended promotions or PR exercises.

There has also been considerable recent growth in the production of videos on personal fitness and occupational health for use in the work-place, much of it commissioned by large corporations for use with their own employees. In 1984 the National Center for Health Education published a guide for small businesses on health promotion at work, as part of its 'Working Healthy' project. It aims to stimulate closer links between employers and community health agencies.

The NCHE also publishes the most comprehensive guide to the best audiovisual and print resources in all fields of health education, updated every three years, with interim reports on new resources in its regular journal *Center*. The fact that selecting the best resources (over 2000) involves screening the tens of thousands of publications on the market, indicates the wealth of health-related materials published in the USA each year. As NHCE points out: 'Health is certainly selling, but who is profiting?'

Implications for the UK

There are a number of conclusions to be drawn from the American system, particularly in the light of future changes in the structure of broadcasting in the UK. Were the BBC to take advertising, it would need to compete vigorously for such revenue. This would start a spiral of moves towards more and more mass entertainment programming, and less informative or educative output. At the same time, the development of new modes of distribution will help cable and satellite services to get established as more and more households are brought into the system. The public service dimension of BBC, ITV and Channel 4 would be eroded and the differences between the main services

would begin to disappear, since existing regulation policies would not longer be viable. But beyond Peacock, the expected trend is to still less regulation and each step down this path is expected to lead the UK's broadcasting to become more like that of the USA today.

1 Without a dramatic increase in revenue for making programmes, increasing use will be made of imported material, particularly from North America. By the end of this century, much of the UK's televised material could resemble closely that of the USA, with the shortcomings outlined in this chapter.

2 While in theory the increasing range of broadcast media allows greater community say in content, experience in North America shows this to be untrue. Broadcasting is profitable and the more powerful economic interests gain control. Profits are maintained by keeping large audiences and this influences the programmes chosen for broadcast.

3 Economic interests can influence content by deciding where to place advertising expenditure, but more subtle and negative trend from the health promoters' point of view is the increase in 'product placement' deals with film-makers or sponsorship of televised events. The present concern in the UK with tobacco and alcohol industry sponsored television and the weakness of the voluntary controls protecting the viewer is pertinent.

4 While coalitions have been developing in other UK sectors, involvement of the media has yet to occur. Considering the multitude of ways in which the media can 'support' the new concepts of health promotion, all avenues for establishing coalitions with the media should be explored. Initiatives could come from journalists, programme makers and others in the media and health promoters.

5 Networking to exchange information and experiences, and to speed the spread of information could usefully involve the media more. Already in the UK there are good examples of collaboration in both programme content and publishing or promoting health information.

6 The broadcast media have a strong influence on public attitudes and agendas. It is difficult to influence how the media

present health and related issues, but is appropriate for health promoters and media workers to set up a coalition with the specific aim in identifying these issues and discussing ways of achieving a positive influence.

CHAPTER TEN

Conclusions

In stepping back from the intense experience of the tour and drawing general conclusions for health promotion in the UK several differences between the countries should be borne in mind. Some caution against the direct transplantation of ideas or activities to the UK, while others contain the essence of solutions to many of the dilemmas facing the UK's health promoters.

First, each country has a different national system for organising health promotion. The USA relies on national advocacy with community coalitions responsible for action; Canada also uses national advocacy but has a provincial and local authority base with community coalitions; the UK is health authority based. Second, in North America there is a striking diversity of approaches to, and activity in, health promotion through which permeates creativity, energy, and a willingness to embrace experimentation in the pursuit of aims. Third, there are significant cultural, ideological and structural differences between the UK and North America. It is difficult to say how much they have determined the North American approaches to health promotion and their achievements.

The study tour was limited to two weeks. This restricted the depth of study but the primary objective was to identify initiatives and ideas and not to attempt a definitive comparison. The individual development of the members who were all active participants in different disciplines in health promotion was considered an important contribution to the development of the field in the UK. Their experiences and perceptions from the tour are presented for discussion.

The implications at the end of each chapter are the responses of the individual tour members who studied the subject of the chapter whereas these general conclusions represent the collective views of the tour members and have evolved during lengthy discussions during the tour and especially after returning to the UK.

Broad conclusions for health promotion in the UK

1 **The WHO Health For All By the Year 2000 strategy and the WHO concept and principles of health promotion should be**

adopted as the basis for developing appropriate approaches for the UK.

The WHO stresses the social and environmental determinants of health which locate health promotion within the social and individual sphere. This emphasises the importance of full participation of all people in the development of their health (Appendix A).

2 **A renewed emphasis on public health policy including the development of health promotion is required.**

Social and environmental threats to health are likely to increase in significance compared to other forms of risk. The population is now better informed than ever before of these issues, is more sensitive to the possibilities of influencing these factors, and is increasingly taking an active interest in change to safeguard health and wellbeing.

Health promotion can bring significant social and individual benefit form its prophylactic effects alone and should be given a greater emphasis in national health policy relative to that given to the therapeutic services. The public health can be seen to be concerned with prevention (breast cancer screening, CHD programmes), protection (from food poisoning outbreaks, pollutants) and promotion (of opportunities for healthy lifestyles, living environments, individual involvement and fulfilment). The three are closely connected and none is exclusive. Promotion is the enabling element but has been largely neglected in the UK to date.

3 **There is a need for more national advocacy of health promotion.**

Government should take a lead in advocacy of health promotion. This could include stating its support of the WHO strategy and making clear statements of national priorities, objectives and targets.

There is relatively little advocacy at present. Even with cigarette smoking, there is no unequivocal statement that smoking is a public health hazard, backed by clear supportive actions within existing government responsibilities. As a result, extensive promotion of tobacco products continues, often in breach of voluntary agreements, and many smokers feel the risks 'can't be that bad, or the government would act'. It is not uncommon to

see conflicting policies and actions between government ministries and departments in matters affecting health.

Government advocacy helps set agendas, establishes a respected base from which to judge health risks, legitimises community action and can help create coalitions between industry, community and other groups.

Areas where clear and positive advocacy from government could help clarify current health issues and encourage appropriate action include smoking, healthy eating, alcohol, the taking of drugs and other substances.

The DHSS or the HEC could be the base for national advocacy.

4 **A new organisation should be established to take responsibility for health promotion and should include representation from the NHS, local authorities, voluntary bodies and consumers. The new organisation should be placed within the direct responsibilities of the Prime Minister's Office.**

In the 1974 reorganisation of the NHS, the public health responsibilities of local authorities were taken into the NHS. However, the NHS has little responsibility for many of factors affecting health (housing, unemployment, leisure facilities, motor-vehicle safety) and many of the community services which contribute to health are outside the direct control of the NHS (homes for mental handicap, the elderly, school meals). Local authorities are already covering many services with direct health relationships and have responsibility for many others which fall within the areas of interest of health promotion (environmental health, housing, sport and recreation, education, community programmes, social workers, trading standards). Local authorities also have extensive links with all forms of local groups and organisations, including commerce and industry and, in contrast to the NHS, are more directly accountable to the local population.

The organisation would be responsible for producing national objectives and targets for health promotion and for coordinating policies and actions across all levels of government, industry, the NHS, health professionals, community organisations and groups, and the media in matters relevant to achieving the national objectives. Since health is such a national priority and all elements of government, the economy and social activity and organisation are involved, it is appropriate that responsibility rest with the Prime Minister's Office. The organisation should produce an

annual report containing a national health audit and a review of progress in achieving the national objectives for health promotion.

As the leading national agency for health education, the Health Education Council would be a key member of the organisation.

In keeping with the principles of health promotion, the organisation should not be established with traditional medical professionals as the designated management. Much of the activity falling within the field of health promotion does not require medically qualified decision-takers and some of the required skills lie outside medical training. But an important principle of health promotion is that close and direct involvement of individuals and community groups should be encouraged in defining their health needs.

It is clear that medical skills are necessary among the many disciplines which would be involved in the organisation. Community physicians are the most appropriate medical profession linkage to health promotion. They have the medical training and, in addition, skills in epidemiology, management and training.

5 **The NHS system of health care delivery is preferred as a means of ensuring that all the population has access to medical and other health services.**

Both North American systems rely on 'buying power' for access to the health care market which inevitably means that the poor have reduced access despite their need being greater.

Attention to the funding and operation of the NHS is necessary to ensure it meets its objectives of adequacy and access.

More should be done by the NHS to reflect the community's perceptions of health and to provide for local involvement in decisions. There is a contradiction between exhorting individuals to take more responsibility for their own health and the present form of health authority administration which has no local accountability and which does little to involve the community it serves in decisions about services and resource use.

6 **The public health responsibilities held by local authorities prior to 1974 should be reinstated in combination with a broadly defined role in health promotion.**

The present organisation of the NHS focuses on hospital and family practitioner services. These should remain within the NHS and efforts should be directed to improving them. Health

promotion responsibilities now with the NHS could be transferred to the local authorities with overall planning of health promotion being through the new organisation described in 5 above.

More than 20 local authorities have created health committees in response to demand from their consitituents and there is scope for creating new community physician posts within these authorites to provide appropriate medical advice and health planning support to the new responsibilities.

7 **Local authorities and health authorities should be required to prepare and publish an annual report on health promotion.**

The report would contain a local health audit and present details of health promotion priorities, initiatives, organisations and sectors involved, funds allocated (and their sources), monitoring and evaluation reports on projects in progress, and a review of overall achievements towards the authorities' objectives in health promotion.

8 **Coalitions between different sectors in the community should be encouraged in the planning of health promotion activities.**

Different sectors include industry, social services, education, leisure, the media, voluntary organisations and community groups. Not only do different sectors have similar objectives which can be satisfied through health promotion initiatives, but the advantages of cooperation can help remove barriers, increase resources and increase effectiveness of activities. There are also real advantages to be had from networking among interested groups and organisations to share information, resources and experiences.

Both coalitions and networks are relatively uncommon in the UK where disciplines tend to regard knowledge as property and territorial boundaries between disciplines and organisations are too easily erected. The HEC's Great British Fun Run in 1984 was an example of succesful intersectoral collaboration. Over 150 local authorities around the country joined with the HEC to organise it; there were 100 coordinated health fairs around the country and the bread industry provided some sponsorship and produced special bread wrappers which carried nutritional information, healthy messages and information on local activities during the Run. The Body and Mind Museum Project in Liverpool is an

example of another approach to health promotion which also explores opportunities for intersectoral collaboration (Appendix B).

9 **Community development approaches to health promotion should be explored and more resources allocated to support initial research and pilot projects.**

Community development approaches aim to include the WHO principles of local definition of needs, local involvement in decisions and implementation, and the related sense of achievement and of being in control.

The concept is difficult for many health workers and administrators to adopt because it requires that habitual criteria for decisions and procedures are modified and that power over decisions is shared. The benefits of these approaches to health promotion are significant. Training and support at the policy level will encourage wider acceptance of the approach, but it is also important that initiative, experimentation and innovation are positively encouraged within the funding and support organisations.

10 **Enabling legislative changes may be necessary to allow the new concepts of health promotion to be implemented more successfully.**

Changes that are anticipated include freedom of access to information for local community groups needing local health service statistics, information on toxicity testing of food additives and so on, changes in tax concessions allowing deductions to industry for donations to health promotion activities, and incentives for employers supporting health promotion in the workplace.

It is recognised that new legislation to regulate practices which are antipathetic to health promotion objectives may also be required; for example, a ban on the promotion of tobacco products and stricter controls on drinking and driving.

APPENDIX A

*Health Promotion: a discussion document on the concept and principles**

[World Health Organization, Regional Office for Europe]

Background

In January 1984 a new programme in 'Health Promotion' was established in the WHO Regional Office for Europe. It is the first programme of this kind in WHO and its development has had strong support from Member States. Planning began in 1981; since then a number of meetings, bringing together people from professional and academic disciplines and consumer groups, have helped to clarify the special approach of such a programme. This work has been documented by the Regional Office in a number of working papers and publications listed on page 110.

As part of the continuing process of programme development, a working group met in July 1984 to discuss 'Concepts and Principles in Health Promotion' (see list of participants on page 109. This document is a result of that working group. It is designed to clarify some of the most important issues in relation to the development of policy and programmes in health promotion. It is not intended as a final statement, but as a focus for discussion on which to base the development of health promotion activities in Europe.

The group is fully aware that the development of priorities and practices for health promotion depends upon the prevailing economic and cultural conditions. In each country, region and district, health promotion should involve the full participation of all people in the development of their health.

*This discussion document constitutes the summary report of the Working Group on Concept and Principles of Health Promotion, Copenhagen, 9–13 July 1984.

Introduction

At a general level, health promotion has come to represent a unifying concept for those who recognise the need for *change* in the ways and conditions of living, in order to promote health. Health promotion represents a mediating strategy between people and their environments, synthesising personal choice and social responsibility in health to create a healthier future.

Basic resources for health are income, shelter and food. Improvement in health requires a secure foundation in these basics, but also: information and lifeskills; a supportive environment, providing opportunities for making healthy choices among goods, services and facilities; and conditions in the economic, physical, social and cultural environments (the 'total' environment) which enhance health.

The inextricable link between people and their environment constitutes the basis for a socio-ecological approach to health and this provided the conceptual framework for discussions by the working group. The discussions were organised around four main themes – principles, subject areas, priorities for the development of policies, and dilemmas in health promotion.

Principles

Health promotion is the process of enabling people to increase control over, and to improve, their health. This perspective is derived from a conception of 'health' as the extent to which an individual or group is able, on the one hand, to realise aspirations and satisfy needs; and, on the other hand, to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living; it is a positive concept emphasising social and personal resources, as well as physical capacities.

1 *Health promotion involves the population as a whole in the context of their everyday life, rather than focusing on people at risk for specific diseases.* It enables people to take control over, and responsibility for, their health as an important component of everyday life – both as spontaneous and organized action for health. This requires full and continuing access to information about health and how it might be sought for by *all* the population, using, therefore, all dissemination methods available.

2 *Health promotion is directed towards action on the determinants or causes of health.* Health promotion, therefore, requires a close cooperation of sectors beyond health services, reflecting the diversity of conditions which influence health. Government, at both local and national levels, has a unique responsibility to act appropriately and in a timely way to ensure that the 'total' environment, which is beyond the control of individuals and groups, is conducive to health.

3 *Health promotion combines diverse, but complementary, methods or approaches,* including communication, education, legislation, fiscal measures, organisational change, community development and spontaneous local activities against health hazards.

4 *Health promotion aims particularly at effective and concrete public participation.* This focus requires the further development of problem-defining and decision-making lifeskills both individually and collectively.

5 While health promotion is basically an activity in the health and social fields, and not a medical service, *health professionals – particularly in primary health care – have an important role in nurturing and enabling health promotion.* Health professionals should work towards developing their special contributions in education and health advocacy.

Subject areas

Health promotion best enhances health through integrated action at different levels on factors influencing health: economic, environmental, social and personal. Given these basic principles an almost unlimited list of issues for health promotion could be generated: food policy, housing, smoking, coping skills, social networks. The working group sought to frame the *general subjects for health promotion* in the following areas:

1 The focus of health promotion is *access to health:* to reduce inequalities in health and to increase opportunities to improve health. This involves changing public and corporate policies to make them conducive to health, and involves reorienting health services to the maintenance and development of health in the population, regardless of current health status.

2 The improvement of health depends upon the *development of an environment conducive to health,* especially in conditions at work

and in the home. Since this environment is dynamic, health promotion involves monitoring and assessment of the technological, cultural and economic state and trends.

3 Health promotion involves the *strengthening of social networks and social supports*. This is based on the recognition of the importance of social forces and social relationships as determinants of values and behaviour relevant to health, and as significant resources for coping with stress and maintaining health.

4 The predominant way of life in society is central to health promotion, since it fosters personal behaviour patterns that are either beneficial or detrimental to health. The promotion of lifestyles conducive to health involves consideration of personal coping strategies and dispositions as well as beliefs and values relevant to health, all shaped by lifelong experiences and living conditions... *Promoting positive health behaviour and appropriate coping strategies* is a key aim in health promotion.

5 Information and education provide the informed base for making choices. They are necessary and core components of health promotion, which aims at *increasing knowledge and disseminating information* related to health. This should include: the public's perceptions and experiences of health and how it might be sought; knowledge from epidemiology, social and other sciences on the patterns of health and disease and factors affecting them; and descriptions of the 'total' environment in which health and health choices are shaped. The mass media and new information technologies are particularly important.

Priorities for the development of policies in health promotion

Health promotion stands for the collective effort to attain health. Governments, through public policy, have a special responsibility to ensure basic conditions for a healthy life and for making the healthier choices the easier choices. At the same time, supporters of health promotion within governments need to be aware of the role of spontaneous action for health, i.e. the role of social movements, self-help and self-care, and the need for continuous cooperation with the public on all health promotion issues.

1 *The concept and meaning of 'health promotion' should be clarified at every level of planning,* emphasising a social, economic and

ecological, rather than purely physical and mental perspective on health. Policy development in health promotion can then be related and integrated with policy in other sectors such as work, housing, social services and primary health care.

2 *Political commitment to health promotion* can be expressed through the establishment of focal points for health promotion at all levels – local, regional and national. These would be organisational mechanisms for intersectoral, coordinated planning in health promotion. They should provide leadership and accountability so that, when action is agreed, progress will be secured. Adequate funding and skilled personnel are essential to allow the development of systematic long-term programmes in health promotion.

3 In the development of health promotion policies, there must be *continuous consultation, dialogue and exchange of ideas* between individuals and groups, both lay and professional. Policy mechanisms must be established to ensure opportunities for the expression and development of public interest in health.

4 *When selecting priority areas for policy development a review should be made of:*

indicators of health and their distribution in the population
current knowledge, skills and health practices of the population
current policies in government and other sectors.

Further, an assessment should be made of:

the expected impact on health of different policies and programmes
the economic constraints and benefits
the social and cultural acceptability
the political feasibility of different options.

5 *Research support is essential for policy development and evaluation* to provide an understanding of influences on health and their development, as well as an assessment of the impact of different initiatives in health promotion. There is a need to develop methodologies for research and analysis, in particular, to devise more appropriate approaches to evaluation. The results of research should be disseminated widely and comparisons made within and between nations.

Dilemmas

Health related public policy will always be confronted with basic

political and moral dilemmas, as it aims to balance pulic and personal responsibility for health. Those involved in health promotion need to be aware of possible conflicts of interest both at the social and the individual level.

1 *There is a possibility with health promotion that health will be viewed as the ultimate goal incorporating all life.* This ideology, sometimes called healthism, could lead to others prescribing what individuals should do for themselves and how they should behave, which is contrary to the principles of health promotion.

2 Health promotion *programmes may be inappropriately directed at individuals at the expense of tackling economic and social problems.* Experience has shown that individuals are often considered by policy makers to be exclusively responsible for their own health. It is often implied that people have the power to completely shape their own lives and those of their families so as to be free from the avoidable burden of disease. Thus, when they are ill, they are blamed for this and discriminated against.

3 *Resources, including information, may not be accessible to people in ways which are sensitive to their expectations, beliefs, preferences or skills.* This may increase social inequalities. Information alone is inadequate; raising awareness without increasing control or prospects for change may only succeed in generating anxieties and feelings of powerlessness.

4 *There is a danger that health promotion will be appropriated by one professional group and made a field of specialisation to the exclusion of other professionals and lay people.* To increase control over their own health the public require a greater sharing of resources by professionals and government.

Conclusions

The concept of health promotion is positive, dynamic and empowering which makes it rhetorically useful and politically attractive. By considering the recommended principles, subject areas, policy priorities and dilemmas it is hoped that future activities in the health promotion field can be planned, implemented and evaluated more successfully. Further developmental work is clearly required and this will be an ongoing task of the *WHO Regional Office for Europe.*

Working Group on Concepts and Principles of Health Promotion, Copenhagen, 9–13 July 1984

Mr ROBERT ANDERSON
Institute for Social Studies in Medical Care
14 South Hill Park
London NW3 2SB
United Kingdom

Professor BERNHARD BADURA
Fachbereich Soziologie
University of Oldenburg
Postfach 2503
Westerstrasse 3
D-2900 Oldenburg
Federal Republic of Germany

Dr JOHN CATFORD
Regional Specialist in Community Medicine
Wessex Regional Health Authority
Highcroft
Romsey Road
Winchester SO22 5DH
United Kingdom

Dr KIMMO LEPPO
Director, Department of Planning and Evaluation
National Board of Health
P.O. Box 223
SF–00531 Helsinki 53
Finland

Dr SLAVEN LETICA
Andrija Stampar School of Public Health
Rockefeller Street 3
Zagreb
Yugoslavia

Professor DAVID MCQUEEN
Director, Research Unit in Health and Behaviour Change
University of Edinburgh
7 Roxburgh Street
Edinburgh EH8 9TA
United Kingdom

Professor BERNARD PISSARRO
Médecine préventive et sociale
Faculté de Médecine St. Antoine
27, rue Charligny
F–75571 Paris Cedex 12
France

Dr WERNER SCHMIDT
Director, Institute of Health Education
WHO Collaborating Centre for Health Education
German Hygiene Museum
Lingnerplatz 1
DDR–8012 Dresden
German Democratic Republic

Ms MARIANNE SCRUGGS
96 Harberton Road
London N19
United Kingdom

Ms BIRTHE VANG
Health Sciences Centre
Vaardscentralen
S–24010 Dalby
Sweden

Dr JUAN VILLALBI
83 Sepulveda
Barcelona 15
Spain

Professor ILLKKA VUORI
Director
Institute for Health Promotion
Kekkonen Institute
SF–Tampere
Finland

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

Dr ILONA KICKBUSCH
Regional Officer for Health Education
(Secretariat)

Dr JOHN DAVIES
Consultant, Health Education Unit

Dr KATHRYN DEAN
Consultant, Health Education Unit

Ms SUSANNE HOUD
Consultant, Maternal and Child Health

Professor LOWELL LEVIN
Temporary Adviser, Health Education Unit

Ms JANINE MORGALL
Consultant, Health Education Unit

Dr MARSDEN WAGNER
Regional Officer for Maternal and Child Health

WHO HEADQUARTERS

Dr D C JOHNSON
Associate Director (Health Education)
Division of Public Information and Education for Health

Working papers and publications relevant to health promotion produced by the Health Education Unit, WHO Regional Office for Europe

Working Group on the Concepts and Principles of Health Promotion, Summary report on a Working Group, Copenhagen 1981.

Involvement in Health: a Social Concept of Health Education by Ilona Kickbusch, International Journal of Health Education, Vol. XXIV, issue 4, December 1981.

Lifestyles and Their Impact on Health, Technical Discussions Papers, 1982.

Influence of Health Beliefs on Lifestyles: What Do We Know? by Kathryn Dean. Technical paper 1983.

Scenarios for Lifestyles and Health by James Robertson. Technical paper 1983.

Health Promotion and Lifestyles Change in the Workplace by Malcolm S. Weinstein. Technical paper 1983.

Lifestyles and Living Conditions and their Impact on Health. Report of a meeting. European Monographs in Health and Health Education Research No. 5, 1983.

Health Promotion and Lifestyles: Perspectives of the WHO Regional Office for Europe. Hygie, Vol. I, 1983.

Health Promotion: An overview. Technical paper by Robert Anderson, 1983.

Self-help and Health in Europe. Stephen Hatch and Ilona Kickbusch (ed). WHO/EURO 1983.

Intervention Studies Related to Lifestyles Conducive to Health. Report on a WHO meeting, Copenhagen 1983.

Health Promotion. European Monographs in Health and Health Education Research No. 6, 1984.

APPENDIX B

The Body, Mind and City Museum

[Howard Seymour]

Introduction

This paper outlines, briefly, the concept of a Body, Mind and City Museum for the City of Liverpool. It describes a project of national standing which has a good deal of support from a wide variety of sources.

It is not within the scope of this paper to specify, at this stage, the scale of the project; an 'enabling' study is needed to explore this and other issues. It should be emphasised, however, that this attraction will be unique, stimulating and of real impact, not only on Liverpool, but also on the wide audience at which it is addressed.

The Body, Mind and City Museum will attract young people, adults, Liverpool residents, tourists and overseas visitors, and is envisaged as an asset of national importance.

The health connection

Underlying the promotion of good health in its widest sense is an implicit belief that people have an understanding of themselves and their potentials. This, when combined with the WHO (World Health Organization) 'Health for all by the year 2000' programme, provides the health connection.

The museum is a leisure, tourist and commercial sector approach to health and many other factors which contribute to quality of life. The World Health Organization, the Regional Health Authority, the Health Education Council and many other groups around the world are moving to accept the value of the type of approach outlined in this proposal.

Evidence of this is given by: the Health Education Council's offer of £5,000 towards the cost of an enabling study; the workshop on health exhibits in museums to be held in New York in June 1986 (American Association of Science and Technology Centres); a WHO conference on health museums in Dresden in

the autumn of 1986; and the proposed health museum in an old brewery in Gothenburg (Sweden).

There is little doubt that the museum will form a part of the prestigious WHO Europe 'Healthy Cities' project, of which Liverpool is one of eight collaborating European cities. The Museum would receive collaborating centre status as a focus for learning and education.

Finally, however, it must be stated firmly that the health connection is only one factor. It is in the end, a popular, enjoyable and novel experience for visitors from all over the country. The unique nature of the museum would almost certainly make it a national attraction.

Objectives

The main objectives, which relate to the experience to be gained by the visitor and the Museum's impact on Liverpool, include:

1 to provide an experience which will encourage visitors to learn about themselves, their bodies, minds and sometimes untapped potentials;

2 to provide an experience which will show how the city works, what opportunities it provides, or could provide, and how individuals can develop their talents and skills in a city;

3 to provide Liverpool with a national focal point for health education and quality of life.

The philosophy

The museum takes as a main focus the concept of *open learning.* Exhibits will be differentiated to allow a very wide choice of experience and will enable the Museum to attract:

Liverpool residents (young people and adults);
domestic tourists;
overseas visitors.

Many of the exhibits will be participative and will draw on the skills and experiences of the user. The environment of the museum will be designed to give an impression of colour, movement and excitement. The efficient movement of large and varied groups of people through the museum is seen as a critical factor in the design and operation of the attractions.

The structure

The museum will consist of three themed areas; the mind, the body and the city. Each area will have the same basic structure: a core ride or rides which give an impression of the theme, and a series of exhibit areas, some in the form of passages. The passages will interconnect in logical and exciting ways with other passages in the same and other themed areas of the museum (hearing in 'the body' connection with creativity in 'the mind' through music).

Each of the segments will have a *demonstration area* where appropriate live events, demonstrations and lectures can take place.

The experience

The body will consist of one 'core ride' surrounded by fifteen theme and demonstration areas. Visitors to the body will take a ride into a cell, the cell is attacked by a virus – they then travel through the body's immune system's response, then into the lumph system, pumped along veins and arteries to the heart and lungs and, finally, out of the body.

The fifteen associated areas will range in content from evolution and internal defence, through movement and respiration to aging, to health and disease, and so on.

Wherever possible, exhibits in these areas will be participative, they will use either analogies of functions or tests on the visitors themselves. Two examples serve to illustrate this principle: the area on 'movement' will have displays which will test the visitor's stamina, strength, flexibility, coordination and balance: the area about speech will use an analogue of the human mouth which allows the visitor to use bellows to 'blow out' sounds from a 'mouth', the shape of which can be altered, the position of the tongue moved and the shape of the lips changed.

'Individual' exhibits will be mixed carefully with 'broader' exhibits to enable the effective flow of people. In the demonstration area, a wide variety of 'acts' will be staged to entertain, inform and involve the visitor.

One main route from the body into 'the mind' will be along the exhibit devoted to the senses and then into a tactile maze. Visitors will feel their way in the dark through a number of chambers of different shape and texture. The experience gained providing a true link between mind and body; and insight into the sense of

touch, into what it feels like to be blind and very strong social and psychological experience gained through feeling a way through a maze in the dark with other people.

The mind area involves an exploration of consciousness, thought and self. There will be three elements to the core ride through this area.

1 THE MIND MACHINE

The mind as an information processing machine is demonstrated in various ways. Exhibits will borrow from the concepts and technology of the new generation of intelligent computers.

2 THE GIANT MIND

An enormous semi-realistic brain which actively demonstrates the functions of different parts of its structure. In and around the 'brain' are a series of inter-connecting rooms and platforms. Each will have exhibits that display the activity of that part of the brain.

3 THE MIND'S I

This imaginative area poses the questions: Who am I? What am I? Am I different from my body? How do I see I? How do others see me? There will be an eclectic use of exhibition methods: actors, automata, mirrors, video techniques. Examples of these exhibits include: a shadow box where visitors can leave and view images of their own bodies, video mixer arrangement so that they can talk through other people's faces or put their heat on someone else's body or onto an inanimate object.

These three core rides will have surrounding them a number of intermediate areas emphasising a wide variety of complementary themes which could include:

emotions;
creativity and dreams;
problem solving and lateral thinking;
spiritual life;
personal change and development.

The city will be based on the individual and show how it can cope, or change to cope, with the personal needs of its citizens. Most of the exhibit areas will lead from 'me' to how a need can be provided for in a city.

The core rides will consist of two rooms. The first, a camera

obscura, showing a moving panorama of the city of Liverpool. The second, a cinema with a 3D film of a dream of a city of the future. The associated city exhibit areas will include:

a sense of space;
a sense of place;
a kid's place;
a woman's place;
a man's place;
communities affinity;
reproduction in the city;
work and economy;
communication;
what a city should look and feel like;
productive areas;
planning a city;
governing a city;
energy in a city.

Associated activities

There will be a number of areas and activities associated with the museum, some of these are commercial, some educational and some to link the museum to the local community.

The conference centre will offer educational facilities for 200 people. Users will include school groups, the public and academic/professional audiences from this country and around the world.

The imax theatre will be a major attraction, the theatre uses very high resolution projection onto a large curved screen, the images are so powerful that it gives the impression to the audience of actually being at the event filmed.

Souvenirs and catering Inside the museum there will be a cafeteria and two specialist restaurants as well as a number of rest areas. There will be at least one large souvenir shop. The accent will be on quality and it will provide a wide range of souvenirs: books, models, posters, tee shirts, games, and so on.

The lifestyle shopping mall will provide a 'whole' service and will aid the generation of income. The museum will be surrounded by shops where people can buy a lifestyle:

a body shop;
restaurants, particularly health cuisine restaurants (Spanish, Mexican, Japanese, Italian, and so on);
a bookshop/coffee bar;
a sauna and Finnish products shop;
a sports shop and clothes shop;
personal health improvement services;
a pure food (no additive) shop;
a left hander's shop;
city products shop.

Links with the city

The museum will maintain links with the city in a number of ways. it will call upon the craftsmanship still to be found in Liverpool in the production of some of the exhibits.

It will also foster local enterprise more actively by opening its *workship* to local groups and to entrepreneurs to help them to develop new products and economies, particularly healthy products (a healthy products market survey and feasibility study has been agreed in principle by the Director General of the Health Education Council).

Potential sources of funds

It will be important to seek funding and support from a number of sources, including the follows:

the regional health authority;
Health Education Council;
central government.

Each of these organisations has expressed interest in the project. In addition, the Museum offers a wide range of sponsorship opportunity from the following sectors:

the drug industry;
the communications industry;
the food industry.

It is not within the scope of this paper to estimate revenue from the various commercial elements of the projects. Revenue, however, would arise form:

museum entry fees;
souvenir and catering sales;
lifestyle shopping;
Imax entry fee.

The enabling study

While the broad concept, scale and likely interest in the Body, Mind and City Museum have been outlined in this document, the detailed information required to take the proposal further has, as yet, to be accumulated.

An enabling study is required, in order to progress this concept further. It is proposed that such a study is divided into two phases: first, a market testing phase and, second, an implementation phase.

Two critical audiences must be tested in order to gauge the likelihood of success of the concept:

1 the public survey would identify the level of interest in the general concept and the reaction to the specific elements outlined above;

2 a survey of public health organisations and related bodies would determine whether potential funding sources would be made available to the project.

During the second phase, or implementation phase, detailed exploration of the types of exhibitory and display techniques would be completed. The implementative phase would also include:

fuller descriptions of the visitor experience;
operational management and space needs;
building costs and programme;
market catchment and revenues;
organisation and management;
project implementation.

APPENDIX C

Health promotion in England, Wales and Northern Ireland: a state of the art

[Madeleine Rendall and Bobbie Jacobson]

The concept of health promotion

Health promotion is slowly becoming accepted as the 'umbrella' term for a diverse process involving a wide range of activities and disciplines – the social, environmental, political, economic, legal, fiscal and cultural – all of which have a potential contribution to make towards improving health. Professionals in a wide range of spheres are now arriving at a consensus that education, while an essential component, is not synonymous with the broad health promotion process. This growing awareness of the scope of health promotion is evidenced in the increasing number of multi-disciplinary health promotion teams that now form an integral part of the work of health authorities around the UK.

The development of priorities in health promotion – a brief history

The promotion of health through education dates back to the nineteenth century and owes much to the voluntary organisations – especially in the field of maternal and child welfare. When the National Health Service was established in 1948, the importance of the educational role in promoting health was strongly reinforced within the community nursing structure, with the newly-created health visitors devoted at that time solely to the promotion of maternal and infant health. By the 1960s, increasing postwar affluence had contributed to improved life expectancy, perinatal, maternal and infant mortality. But it had also become clear that much current ill-health was associated with a style of living which was not conducive to good health.

This marked the emergence of a new public health movement,

which emphasised the impact of 'lifestyle' on health. This philosophy was given public expression with the creation of the Health Education Council and the Scottish Health Education Unit. In its early years, the HEC's emphasis was on educational approaches related to school curriculum development, and later to high-profile, mass-media campaigns on specific topics such as smoking, family planning, dental health and immunisation. It is often argued that it was this 'education period' which created a climate sympathetic to the use of mass-media approaches.

At that stage there were no nationally-agreed priorities for health education. The HEC's smoking and health programme received – and still receives – top priority; this was both in line with government policy and in response to the successful, high-profile anti-smoking campaign launched by the first report on smoking from the Royal College of Physicians in 1962, and followed by the establishment of the pressure group 'Action on Smoking and Health'. HEC's early mass-media campaigns, together with fiscal and other measures, have resulted in an impressive downward trend in cigarette smoking.

The 1974 reorganisation of the NHS saw the introduction of two potential sources of support for health promotion – the health education officer and the community health council. Their full impact, however, has yet to be realised: even now not all districts have a health education service, and the power of the consumer voiced by the CHCs is still more theoretical than real. The advancing economic stringencies of the 1970s led government increasingly to view health education and the prevention of disease as a means of saving money. Nineteen seventy-six saw the publication of the first major government statement on health promotion in a discussion document entitled *Prevention and Health: Everybody's Business*, which set out the scope for disease prevention but laid the responsibility firmly with the individual. Since then it has published a series of shorter documents on alcohol, occupational health, and diet; none has offered a comprehensive prescription for action. The government has expressed its continuing commitment to shifting the focus from cure to prevention, but spending on prevention represents only 0.5 per cent of the total NHS budget, a figure which has remained constant for some ten years. More recently, the gradually increasing number of health promotion officers have stimulated increasing awareness amongst both health profesisonals, community groups and the public of the scope of promotion, and the way in which organisations and individuals may contribute.

The World Health Organization has played an important role in identifying the shift in emphasis, from primary 'medical' care to primary 'health' care. Along with the other 32 European member states, Britain has endorsed the principles enshrined in the WHO's 'Health for all by the year 2000'. As part of this initiative, the European region of WHO has set out a comprehensive strategy for member states with 38 objectives relating both to direct health indices and to social and economic targets. Implicit in the WHO approach is the philosophy of reduction of inequalities in health rather than improvement in health *per se*. A limited number of health authorities have adopted this approach as central to their own plans. In Britain as a whole, however, there is little evidence of either a real shift from hospital to primary care, or of government commitment to act on the WHO initiative.

The most recent reorganisation (1982) of the NHS aimed at producing a more streamlined managerial structure; at this early stage there is little evidence that the newly appointed general managers are as committed to the promotion of health as to cost-effectiveness.

The last decade has seen increasing dissatisfaction with a health service which shows little accountability to consumer needs. However, the consumer, women's health, and self-help movements have all had an impact on existing practice – particularly within the obstetic and primary care fields. There is now increasing awareness that training in medical technology is not enough; in order to promote well-being amongst their patients, health professionals need to be trained in the art of communication.

The state of the art

There is still lively debate as to what constitutes good health, and what methods should be used to pursue it. The growing diversity of practitioners in the field, both within and outside the NHS, has led to a similarly diverse number of approaches being adopted. These include:

legislative and fiscal initiatives;
high-profile, mass media campaigns and marketing approaches;
community-based initiatives;
educational initiatives;

individual and group counselling;
self-help groups;
holistic approaches;
information and publications.

There is some tension between the proponents of different methods, but all fall legitimately under the health promotion 'umbrella', and none is mutually exclusive.

National initiatives

While the government is on record for its commitment to the promotion of health, it has no clearly stated policy or objectives. This leaves Britain significantly behind other nations such as the USA, Canada and Scandinavia, which have well-defined goals for health promotion. The HEC does, however, have established priorities, which are reflected in major programmes on smoking and health, and coronary heart disease (HEC 1984 Annual Report provides full details). HEC's total budget reflects some 0.01 per cent of the total NHS budget.

While other issues – such as women's health, mental health, inequalities in health, and the health of ethnic minorities – are recognised areas of concern and have received some attention, they are politically sensitive areas for action, and often remain unaddressed on the grounds of their 'unquantifiability'. Increasing public concern over the growing incidence of AIDS, leading to pressure on government to act promptly, has resulted in the allocation of some extra funding.

Local initiatives

WITHIN THE NATIONAL HEALTH SERVICE

England and Wales are divided into 14 regional and 192 district health authorities; the chair of each authority is a political appointment, and there is increasing evidence of central government intervention in the appointment of the newly-created general manager posts. Authorities are serviced by community physicians with a training in epidemiology and public health; many of these, however, also see themselves in a primarily managerial role. There is currently tension and uncertainty between the two, and responsibility for improving the health of the local community is ill-defined. Although both clearly have a role to play, a growing number of community physicians have

been dismissed by the new managers. A number of regions have specifically allocated funds for health promotion: the North West now has a comprehensive health promotion strategy and has an administrator with specific responsibility for prevention; Stockport has followed suit and now has a management unit devoted to 'prevention'; Merseyside was the first region to appoint a health promotion officer (part funded by the HEC), part of whose work has been to develop high-profile initiatives including the use of touring 'health promotion' buses, which use the long-term unemployed as health promotion assistants.

The extent to which health promotion has become an integral part of the work of *primary care* doctors and nurses is difficult to assess, although the major part of community nursing – health visiting, midwifery, district nursing – is devoted to this area. There is undoubted commitment on the part of the Royal College of General Practitioners to the promotion of health, and it has produced a number of reports delineating the opportunity that GPs have for promoting health in the following areas: family planning, antenatal care, immunisation, fostering mother-child bonds, discouragement of smoking, detection and management of raised blood pressure, bereavement counselling. It has also produced a seminal document on the promotion of mental health – an area often neglected by others in the field, possibly because the problems which may occur are unlikely to lead the premature death.

There is some evidence that general practice is beginning to recognise its role in preventive medicine and health promotion. Though it is traditionally a demand-led service, it serves a registered population, 70 per cent of whom consult in one year, and 90 per cent in five years. The development of primary care teams has encouraged the participation of other disciplines, notably health visitors and practice nurses, and in some cases social workers and counsellors. Efforts have focused initially on the provision of preventive medical services, for example child health, well-woman clinics, and the prevention of arterial disease. Increasing emphasis is also being placed on using each encounter to develop individuals' understanding of, and responsibility for, their own health. The Oxford RHA project, aiming to stimulate GPs to record risk factors for stroke and arterial disease, is being coordinated through the appointment of a 'nurse facilitator, and is currently being evaluated. Questions still remain, however, as to whether it is possible to achieve population coverage through general practice.

Almost every health district now has a health education department, many of which have become the focus for new, multidisciplinary initiatives in health promotion. Many have had a real impact on the adoption and implementation of policies within the NHS (for example, on healthy nutrition).

THE INTERFACE BETWEEN HEALTH AND EDUCATION

Traditionally, school health education was very much a peripheral concern dealing chiefly with hygiene, with perhaps an occasional venture into what was narrowly defined as 'sex education'. During the past decade, some aspects of health education have become a major part of the school curriculum. Health education for young people – in school, further education, and in the informal sector – is now based on a broad definition of health, ranging from single topics such as smoking and drugs to much broader concepts of health, such as personal relationships and 'life skills'.

The aims of the Health Education Council's programme for young people include the following:

> to promote and maintain health education as a central component of the school/further education curriculum;
>
> to stimulate debate concerning the position, scope and organisation of health education in educational institutions;
>
> to assist teachers to compile programmes based on assessment of local need, and to provide in-service and pre-service training.
>
> to promote the use of active, non-didactic, participative teaching methods.

Large sums of money have been spent on curriculum projects, many thousands of teachers have attended HEC inservice courses, Her Majesty's Inspectorate reports separately on health education, and over half of all British secondary schools have a senior staff member designated as a health education coordinator. There is, however, at times a divergence between the views of the Department of Health and the Department of Education which has affected the work of the HEC, particularly in the field of sex education.

Trends in the UK point to the continuation of large-scale unemployment, especially amongst 16–20 years olds, with more and more young people spending the latter part of their teen years

in the non-statutory and informal sectors of education, and on government training schemes.

OUTSIDE THE NATIONAL HEALTH SERVICE

At national level, there is some recognition of the contribution to health to be made by government departments such as those of employment, environment, and agriculture. Many *local authorities*, however, now work with health authorities on health promotion, and several have formed their own health strategy groups. In Sheffield, this has led to the formulation of policies of food and health which have potential wide-ranging implications for the health of school children. Over 150 local authorities recently collaborated with the HEC in the 1984 Great British Fun Run in which teams of runners linked around 100 health fairs held throughout England, Wales and Scotland. Local mayors signed a 'health charter' committing themselves to the aims of the HEC's coronary heart disease prevention programme. The event was also sponsored by a major bread manufacturer, with bread wrappers carrying both nutritional information and details of local health events.

One expanding area of activity which is attracting increasing interest is that of *community initiatives*. These represent a variety of ideas and approaches, and include large-scale community-based programmes such as the Welsh Heart Programme (or the USA Stanford Project), which tend to have a particular topic focus and to that extent may be seen as 'directive'; and smaller scale local initiatives which attempt a less directive approach, usually on a patch basis (for example, a housing estate) or particular client group basis (for example, elderly people). This latter group includes, firstly, the large number (*c*10,000) of what are termed community health initiatives, which generally have non-statutory origins and include many voluntary, community and self-help groups; and, secondly, some local authorities and health districts, from the basis of a statutory agency, are developing specific community development projects which utilise community work methods for health education.

The HEC's Look After Yourself! *workplace* project has its roots in classes for the general public run throughout the country by HEC-trained tutors, most of whom have an adult education or health background. Classes develop to meet local need, but focus on a broad lifestyle approach, with emphasis on giving up smoking, healthy nutrition, regular exercise, and relaxation. The LAY! network began in certain regions in 1981, and classes have

now spread throughout England, Wales and Northern Ireland, and into the workplace. The package can be tailored to suit the needs of particular companies, enabling employers to create and maintain a healthy environment, with obvious benefits in terms of reduced absenteeism, improved morale and so on; for employees, LAY! offers a focus on well-being rather than disease, and provides the opportunity for personal advice on general health status; for health professionals, the LAY! package offers direct access to specific groups at risk, together with access via these groups to families, peer groups, and so on.

The *mass media* in Britain regularly carry news, features and information on health issues. Health educators themselves also publish, print and film material and commission advertisements. Links between health professionals and media professionals, however, are historically rather fragmented, but there is a growing realisation that where there are shared objectives the advantages of closer cooperation are considerable. Recent years have seen a steadily increasing number of joint projects on such issues as accident prevention, smoking, fitness, nutrition, and mental health. These collaborative projects have taken advantage of the high visibility and penetration of the media, and have combined back-up programmes, print materials, telephone referral services, and occasionally self-help groups and local action. These developments have been helped by growing public interest in 'health' rather than 'medical' issues, and there are now regular health programmes on all the four national networks (BBC 1, BBC 2, ITV and Channel 4). Local television is not as well established as local radio, but both offer opportunities for community-based initiatives. The biggest problem that remains, however, is how to contain the potentially damaging impact of the media representations of alcohol, tobacco, unhealthy foods, and other 'lifestyle' images portrayed both in advertisements and in entertainment.

Although difficult to evaluate, the media has undoubtedly had a role to play in increasing public awareness of health issues. It is clearly a double-edged sword, and numerous analyses now exist showing that press coverage of issues such as smoking is sometimes compromised by dependence on advertising revenue from tobacco companies. Despite this, sensible coverage of health has always been part of the responsibility of women's magazines, and there are a growing number that give health topics increasing prominence. Some now refuse advertising for products such as tobacco, alcohol and even butter. *Just Seventeen*, a new and highly

successful magazine for teenage girls, not only has a clear anti-tobacco policy, it has with the HEC recently produced as entire supplement entitled 'Pacesetters' promoting the idea that non-smoking is the norm through a series of interviews with sports and rock personalities. The magazine has been incorporated into a teaching pack, and has been disseminated to every school in the country.

The process by which health is covered as a news issue is complex, and not often determined by the 'worthiness' of the subject. Much of the current media coverage of AIDS centres not on a disease which kills a growing number of young people, both homosexual and heterosexual, but on accusations of immorality or perversion.

Progress in health promotion would undoubtedly not have been so rapid without strong pressure from voluntary organisations and consumer groups. Alongside ASH, there are now a growing number of pressure groups such as Action on Alcohol Abuse, Maternity Alliance, the Coronary Prevention Group and the Community Health Initiatives Research Unit, all of whom are pressing for more action in their respective fields. The women's health movement has forced health policy makers and the medical profession to provide safer and more effective contraception, as well as alerting the public to the abuse of psychotropic drugs.

Individual initiatives

There is growing evidence of a new health consciousness among British people, but this is both hard to quantify and has been poorly researched. Certainly opinion polls show the the public considers expenditure on health as top priority, over education and social services, and way above defence. In the relatively well-researched field of smoking, a majority of both smokers and non-smokers would like to see more action to control smoking; indeed, cigarette consumption itself has shown a steady decline in the last decade among people from all social classes. Public attitudes and behaviour in other fields related to health remain to be documented as fully.

The dilemmas

HEALTH PROMOTION, DISEASE PREVENTION AND HEALTH EDUCATION

Health promotion and disease prevention: are the approaches compatible?

What is the relationship between health education and health promotion?

Whose responsibility

OBJECTIVES AND EVALUATION

What are the priorities, and who establishes them?

Setting goals: what assumptions do we make?

What are the relative merits of setting shorter- or longer-term objectives?

How do we quantify both health and ill-health?

PUBLIC PARTICIPATION

How can policy makers respond to consumer needs?

METHODS

Single-issue programmes or holistic approaches?

What are the pros and cons of methods currently in use at national, community and individual levels?

What do community development approaches have to offer? How can they complement other health education initiatives?

How can priorities be translated into effective action?

INEQUALITIES IN HEALTH

What contribution can health promotion make?

APPENDIX D

Detailed summary of sample comprehensive projects for older people in the USA

[Robert Anderson]

Project	*Sponsor*	*Community*	*Goals*	*Methods/topics*
The Wisdom Project	American Red Cross in Greater New York with Queens Hospital Center	Low income multiracial persons age 60 years and older who have had three consecutive HPB readings or are taking anti-hypertensives	One-one comprehensive health education; control of HBP; promote wellness and independent living; self-responsibility for health behaviour	Ombudsman programme, referral services, health appraisal, risk analysis, transportation; weekly medical screening, follow-up care; individual health education; to relay information needed to make decisions about own health needs. Group Health Education Program: medical system utilisation; signs and symptoms of disease; exercise to improve infirmities; nutrition; HBP (overview, diet, medication)
Augustana Seniors Health Program	Augustana Hospital and Health Care Center	Groups of adults 60 and over; health professionals	Provide information, physical and emotional self-care; challenge attitudes about aging and medical consumerism and teach health-promoting behaviors	Medication safety; coping with common physical problems; Exploring issues of self-image and assertiveness; participating in health-promoting activities; relaxation techniques, massage, exercise, nutrition; living and stress; hypertension; other topics upon request
People Care for People	Division of Gerontology, Office of Urban Affairs, NYU Medical Center	Friends and family of elderly in the Murrary Hill and Midtown communities. Maids in SROs participated	To extend the informal support networks for frail elderly and create ongoing support groups	Coping and old age; health care; physical and mental problems; service; community service benefits; legal rights; feeling about caring for older friends or relatives; health-education classes 6 sessions (exercise, HBP, nutrition, sex, attitudes, and so on)

Recruitment/ information dissemination	*Evaluation*	*Funding source*	*Replication*
Senior recruitment; advertise in senior citizen newsletter; announcements at membership meetings; brochures, flyers, announcements sent to churches, synagogues, community groups, supermarkets, post offices, and so on	Columbia University Teachers College doing evaluation via research design	Red Cross in Greater New York funds from voluntary contributions	Upcoming publications: Wisdom Project Health Education Modules: large-print, replicable, senior citizen health education booklets are being developed – will be available nationally
Publicity flyers to mailing list and to senior neighborhood centers; hospital bulletin board; media coverage	Direct feedback; written evaluation forms; unsolicited comments; universities use program for research data. At early stage of evaluation, utilization of medication cards	State of Illinois; Augustana Hospital; donations	Large print flyers; wallet size medication record (English, Spanish, Polish); posters; videotapes – 'To Your Good Health', 1980 by R Skeist RN, Contact: Rob Skeist RN, Augustana Hospital, 411 W Dickens, Chicago, Illinois, USA.
Courses at university through continuing education; leaflets, pamphlets; letters; door to door visits; meeting with professional and paraprofessionals in key agencies; newspaper coverage; attended meetings of Council on Aging; church group; senior groups; nutrition sites. Videotape – 'What Can you Expect at Your Age' – at senior centres, nutrition sites, church groups, self-help groups, medical nursing/social work, schools		Administration on Aging; fees	

Project	*Sponsor*	*Community*	*Goals*	*Methods/topics*
Wallingford Wellness Project	University of Washington's School of Social Work in conjunction with Senior Services and Centers Inc	Intergene rational mix from 13–93 years, 75 per cent over 60, median age 71	Improve health and well-being of participants through education and training. Provide people with tools to make choices and structure in which to make change	Nutrition; physical activities; stress management; environmental assertiveness 21-week course
AHOY	North Carolina Division of Aging	Community leaders statewide from aging and related fields	Provide centralization of resources available to leaders of groups for aged. Functions as a catalyst and training resource	Improve strength, flexibility and circulatory-respiratory endurance through safe movements
Self Care for Senior Citizens	Dartmouth Institute for Better Health Catholic Medical Center in Manchester, NH; South Shore Hospital in Miami; University of Miami Medical School, Dartmouth Medical School	Senior citizens who function independently in the community	Promote intelligent self-reliance in health and social areas; help the elderly to help themselves achieve better physical and mental health, make judicious use of the health and social service system, and maintain the capacity for independent living	1) Medical self-care; acute illnesses, chronic illness, medications, emergencies. 2) Personal prevention lifestyles; physical fitness, nutrition, emotional wellbeing. 3) Appropriate use of health and human services; available resources in community; gaining access to services. 13 two-hour classes

Recruitment/ information dissemination	*Evaluation*	*Funding source*	*Replication*
Introductory workshops, presentations and phone contacts by project; TV, radio and newspaper, Speakers Bureau	Research data collected from participants and comparison group to assess changes	Administration on Aging	*A Healthy Old Age: Sourcebook for Health Promotion with Older Adults* by Stephanie Fallcreek, Haworth Press, NY. Contact: Stephanie Fallcreek, Department of Social Work, Box 35W, New Mexico State University, Las Cruces, NM 88003, USA
Community coordination, workshops, mini-presentations, media coverage, presentations at regional, state conferences	Formal evaluation undertaken in 1983. Informal evaluation has been in place since programme's inception through reports, field visits, various survey instruments and office records	Administration on Aging; TVA grants; North Carolina AOA to develop 7 modules and films	*Add Health to Our Years Workshop Training Manual* by Margot Raynor $4.00, available from: North Carolina Department of Human Resources, Division on Aging, 708 Hillborough Street, Raleigh, NC 27603–691, USA
Advertisements at senior centres; informational 'teas', brochures hand delivered or placed in key stations; personal letters from primary physician or hospital administrator followed by phone call to promote registration; peer recruitment; newspaper, radio, posters	Controlled research design has been developed to measure the impact of the programme on seniors' functional health status, illness behavior, lifestyle and use of services. Quasi-experimental design used since autumn of 1979. Full set of results available	The Administration on Aging and DHHS awarded 3-year grant to Dartmouth Medical School for development of SCSC programme	Self-care instructor manual *Give Yourself A Break:* a book on leading exercise breaks for teachers; *Self Care Planner* (participant's workbook); *The Family Medical Handbook*, Sehnert and Eisenberg, Contact: Dartmouth Institute for Better Health, Dartmouth Medical School, Hanover, NH 03755, USA

Project	*Sponsor*	*Community*	*Goals*	*Methods/topics*
Growing Younger	Healthwise Wellness Center, Boise, Idaho	People 60 years or over	To enrich the lives of of people 60 and over	Four two-hour workshops: 1) physical fitness; 2) nutrition; 3) stress management; 4) medical self-care. Each is integrated into each session. Neighbourhood support for fitness, nutrition, relaxation, medical self-care decisions and activities is encouraged by informal neighbourhood groups meeting outside of workshop schedule to take walks, share meals, practice skills
Healthy Lifestyles for Seniors	Meals for Millions/ Freedom from Hunger Foundation	Aim recruitment at 55–75 year group whose physical and mental health can be improved with lifestyle change – must be motivated to make change	Attitudinal and behavioural changes; build on strengths of older people; enable older people to pursue a healthier old age through lifestyle modifications	4–6 months course; nutrition, exercise, stress, management, self-assessment skills. Candidates are screened via interview (phone or person) and health screening by nurse practitioner. Need consent from participant and MO

Recruitment information dissemination	*Evaluation*	*Funding source*	*Replication*
Neighbourhood recruitment approach. Objective: enroll 10% of 60 and over population; target area divided into neighbourhood units of 1000–1600 resident 60 plus; 16 individuals recruited to host in their home neighbourhood information parties. Each neighborhood covered twice over 1–2 year period. Demonstration at informational parties. Public service announcements in media	Test achievement of objectives in: 1) logistics; 2) biometrics; 3) medicare; costs – being compiled by Idaho's medicare intermediaries, analysis using 2nd year participants as comparison group for 1st year participants. Quasi-experimental design-control for historical trends, self-selection bias	Initial funding from Centers for Disease Control Risk Reduction Program. 1982 funding transferred to State of Idaho. Participants fees for materials	Has been documented for use in other communities – replication package includes: TV spots, recruitment brochures, workshop scripts, teaching aids. *Growing Younger Handbook* for participants, in large print, by Donald W Kemper, E Judith Dennen, James V Ginffre, $10.00: available from Healthwise, Box 1989, Boise, ID 83701, USA
Short presentations to senior groups; newspaper articles; referrals from past participants and local health clinics, radio and TV, flyers; posters are less effective. Brochures sent to announce training manual availability	Nurse practitioners monitoring; pre-post intervention data gathered; participant self assessment; pre-post intervention questionnaire; staff assessment and observation; biometrics; knowledge tests. Measure: knowledge, attitude, behaviour, physiological objectives	Meals for Millions/ Freedom from Hunger Foundation	*Health Lifestyles for Seniors:* a programme development manual which includes lesson plans, evaluation instruments, results of programme. Available from: Meals for Millions/Freedom from Hunger Foundation, 815 Second Avenue, Suite 501, New York, NY 10017, USA, $22.50 plus $2.50 shipping and handling.

APPENDIX E

*Organisations visited in North America**

USA

AIDS Foundation, San Francisco, California	Mitch Bart
Andrus Gerontology Center, University of Southern California, California	Dr James Birren
Californians for Non Smokers' Rights, California	Stanton Glanze, Founder
Department of Public Health, Bureau of Health Promotion and Education, San Francisco, California	Dr Glen Margo
ESSI System, San Francisco, California	Dennis Jaffe
Exploratorium, San Francisco, California	Bob Grill
Gray Panthers, San Francisco, California	Miriam Blaustein

*Listed by country, alphabetically by State (or province) and by organisation.

Huntington Park High School, Huntington Park, California	Ric Long
Institute for Health Policy, San Francisco, California	
KQED, San Francisco, California	Nat Katzman, Head of Programming; Beverley Ornstein, Head of Current Affairs
Office of Senior Information, San Francisco, California	Terri Dowling
Pacific Bell Telephones, San Francisco, California	Director of Health Education and Health Promotion
Prevention Research Center, Pacific Institute for Research and Evaluation, Berkeley, California	Larry Wallack
Rehabilitation Research and Training Center for Aging, Downey, California	
San Francisco General Hospital, San Francisco, California	Andrew Moss
Senior Health and Peer Counselling Center, Santa Monica, California	

School of Nursing, San Francisco, California	
Department of Social and Behavioral Sciences	Dr Carroll Eates: Dr Gay Becker; Dr Anselm Strauss; Dr Virginia Olesen; Marj Bogaert-Tullis
Department of Mental Health and Community Nursing	Dr Mary Duffy Dr Shirley Laffrey
School of Public Health, University College, Berkeley, California	Dr Meredith Minkler, Associate Professor of Health Education; Maurice Winkelstein, Professor of Public Health
School of Public Health, University College, Los Angeles, California	Professor Al Karz Dr Shehendu Kar
Suicide Prevention Center, Berkeley, California	
University of California, Department of Public Health, Berkeley, California	Len Duhl
University College, Department of Epidemiology and National Health, San Francisco, California	Virginia Ernster
School of Medicine, Denver, Colorado	Professor Miriam Orleans

The Geriatric Assessment Clinic, Yale New Haven Hospital, New Haven, Connecticut	Dr Alan P Siegal; Robert Wood Johnson, Clinical Scholar; Cynthia Sava; Ruth M Griffin, Consultant, Occupational Therapy
Yale University, Department of Epidemiology, New Haven, Connecticut	Dr Lowell Levin
CDC, Atlanta, Georgia	Dr Denis Tulsmer, Convenor; Fred Kroger
Turner Broadcasting System, Atlanta, Georgia	Tom Knott, Executive Producer
Bethel Holistic Health Center, Chicago, Illinois	Jackie Reed, Director
Center for Educational Development, University of Illinois, Chicago Illinois	Dr Barbara Sharf, Faculty Member
Center for Urban Affairs and Policy Research, Northwestern University, Evanston, Illinois	Professor John McKnight, Associate Director; Dr Steve Whitman, Research Associate; Dr Robert Crawford
Health and Medicine Policy Research, Chicago, Illinois	Dr Quenton Young, President

The School of Speech, Northwestern University, Evanston, Illinois	Dr Paul Arnston, Professor of Communication Studies; Dr James Etma, Faculty Member
The Self Help Center, Evanston, Illinois	
South Shore Community, Unemployment Union, Chicago, Illinois	Reverend Gregory Jones, Director
Betty Cox Associates, Baltimore, Maryland	Betty Cox
Center for Health Education Inc, Baltimore, Maryland	Dr Carmine Valente, Executive Director
Johns Hopkins Medical Institutions, Baltimore, Maryland	
Division of Internal Medicine, The Johns Hopkins Hospital	Dr David Levine, Professor and Director of Behavioral Research in Cardiovascular Disease
The Health Service Research and Development Center School of Hygiene and Diabetic Health	Dr Donald Steinwachs, Director
Department of Behavioral Sciences and Health Education School of Hygiene and Public Health	Dr Debra Roter

National Institute on Aging, Bethesda, Maryland	Dr Franklin Williams, Director; Ann Zimmer; Suzanna Porter, International Coordinator
The Sheppard and Enoch Pratt Hospital, Baltimore, Maryland	Dr Emile Bendit; Dr Robert W Gibson, President and Chief Executive Officer; Edith Hanson; Dr Sheldon Miller, Director, Division of Acute In-patient Services
Springfield Senior Center, (Springfield Hospital Center, Sykesville, Maryland	Carole Hays, Director of occupational Therapy
University of Maryland, (Department of Pharmacy Practice and Administrative Science), Baltimore, Maryland	Madeline V Feinberg, Clinical Assistant Professor; Director, Elder Health Programs
Waxter Center for Senior Citizens, Baltimore, Maryland	Dr Carole Cox, Director
Department of Public Health, Boston, Massachusetts	Dr Bernard Guyer
Education Development Center Inc, Newton, Massachusetts	Millie Solomon
Everett Family Practice, Everett, Massachusetts	Dr Michael Glenn, Family Practitioner

Harvard Medical School, (Primary Health Care Programme), Boston, Massachusetts	Dr John Stoeckle, Professor of Medicine
WGBH, Boston, Massachusetts	Peter McGee, Head of Network Programming; David Fanning, Executive Producer 'Frontline'
Catherine McAuley Health Center, Office of Health Promotion, Michigan	B Burkholder, Director
Dept of Health Behaviour and Health Education, University of Michigan, School of Public Health, Michigan	Professor Marshall Becker
School of Public Health, (Minnesota Health and Heart Programme), Minneapolis, Minnesota	Dr Maurine Mittlemark; Dr Phillip Kofron; Jacqueline Admire; Dr Richard Grimom
Adolescent Health Center, New York	Sue Cohen
American Cancer Society, New York	Arthur Holleb, Vice President: Medicine; Irving Rimer, Vice President: Public Affairs; D Burton, Director: Adult Education
American Lung Association, New York	Stephanie Miller; Roger Schmidt
Brooklyn Catholic Charities, Brooklyn, New York	Sister Barbara Suessmann, Project Director

CBS, New York	Dr Frank Field, Health, Medical and Science Features
Elderplan Inc, Brooklyn, New York	Dr George N Braman, Primary Care Physician; Suzanne Rapisarda, Nurse Coordinator; Margaret Nyalka, Administrator; Judy Seewald, Physicians Assistant; Doris Simon, Director (Case Management); Carole A Snyder, Director of Special Projects; Joan Stabiner, Case Manager; Helen Weinraub, Director (Health Education)
Fresh Air Fund, New York	Emily Moore
Gouveneur Hospital, Department of Paediatrics, New York	Dr Wendy Keyman
Hunter College, School of Social Work, New York	Dr Terry Mizrahi, Associate Professor of Social Work
Lifestyle Cable TV, WNET, New York	
Lifetime Cable Network, New York	Mary Alice Dwyer, Head of Programming
Louis Harris and Associates Inc, New York	Humphrey Taylor, President
Metropolitan Life Insurance Co, New York	Dr Charles Arnold, Medical Director

Mount Sinai Medical Center, New York	Professor Bess Dana, Professor of Community Medicine; Suzanne Field; Malvin Schechter, Senior Teaching Associate
Mount Sinai School of Medicine, Department of Geriatrics and Adult Development, New York	Dr Robert Butter
National Center for Health Education, New York	Clarence Pearson, Chairman; Stephanie Letterman
National Self-Help Clearinghouse, New York	Frank Riessman, Director
New York Public Health Department, Teenage Pregnancy Programme, New York	Alice Rudosh
Population and Family Health Programme, New York	Judy Jones
WNET, New York	Peter Foges, Director of Public Affairs; Roger Weisberg, Public Policy Programme Unit
Center for the Study of Creative Leadership, Greensboro, North Carolina	

Duke Center for Aging, (Duke Family Support Program), Durham, North Carolina	Lisa Gwyther, Program Director
Duke Hospital South, Gerontology Building, Durham, North Carolina	Linda George
Duke University Medical Center, Durham, North Carolina	Dr Noel List
Center for the Study of Aging and Human Development	Dr Harvey Cohen, Professor of Medicine, Chief of Geriatrics Division;
Geriatric Evaluation and Treatment Clinic	Dr Robert Sullivan, Medical Director
Health Services Research Center, University of North Carolina, North Carolina	Gordon H DeFriese, Professor of Social Medicine and Director; Thomas Ricketts, Research Assistant
School of Journalism, North Carolina	Jane Delano Brown
School of Public Health, University of North Carolina, North Carolina	Nancy Milio, Professor of Health, Policy and Administration
Senior Games Inc, Raleigh, North Carolina	Margot Raynor, Executive Director
University Council on Aging and Human Development, Duke University, Durham, North Carolina	George L Maddox, Chairman

Cleveland Health Museum, Cleveland, Ohio	Bernard Cowell
Dorchester Family Practice, Summerville, South Carolina	Dr Walter Leventhal, Family Practitioner
Mount Pleasant Family Practice Associates, Mount Pleasant, South Carolina	Dr Papadopoulos, Family Practitioner
American Association of Retired Persons, Washington DC	Barbara K Herzog, Manager of Health Care Campaign; Edna Kane-Williams, Project Manager; Helen Savage, Director, Health Maintenance Organisations
American College of Obstetricians and Gynaecologists, Washington	Bonnie Connors; Morton Lebow
American Heart Association, Washington DC	Scott Ballin, Representative from Smoking or Health Lobbying Coalition
Center for Youth Services, Washington DC	Irene Addlestone
Children's Hospital, Washington DC	Dr Lawrence D'Angelo
Corporation for Public Broadcasting, Washington DC	Doug Bodwell, Head of Education
Institute on Aging, Work and Health, Washington Business Group on Health, Washington DC	Carol Cronin, Director; Willis Goldbeck, President of WB Group

National Cancer Institute Washington DC	Rose Mary Romano, Chief, Information Projects Branch; Bill Morrison, Media Adviser
National Heart, Lung and Blood Institute Washington DC	Mike White, Director, Office of Prevention
Peace Corps, Domestic Peace Corps, Washington DC	Ron Defroe; Don Bonner
PBS Headquarters Washington DC	Gail Christian, Director of Public Affairs; Sandy Heberer and Joanne Kaufmann, Associate Directors
Senate Special Committee on Aging, Washington DC	Dr Steven McConnell, Special Assistant; Mary Naylor, Research Fellow
US Office of Disease Prevention, Washington DC	
US Office of Health Promotion and Disease Prevention, Washington DC	Dr M McGuiness

Canada

Canadian Broadcasting Corporation Toronto Ontario	James Murray, Head of Science Unit; Darce Fardy, Head of Public Affairs

Community Health Promotion and Advocacy, Toronto, Ontario	Ronald Labonte, Community Health Educator; Diana Baxter, Health Planner; John Garcia, Coordinator of the 'Smoking Prevention Programme'; Maria Lee, Community Health Officer
Department of Public Health, Toronto, Ontario	Dr Trevor Hancock, Associate Medical Health Officer
Health Promotion Directorate, Toronto, Ontario	J Johnston, Regional Director; Patricia Hayes
Health Promotion and Health Advocacy, Toronto, Ontario	Bill Shannon
Home Care Programme, Toronto, Ontario	Marie Lund, Executive Director
Immigrant Womens Center, Toronto, Ontario	
Ontario Health Coalition, Toronto, Ontario	Michele Harding, Executive Director
Partners for Employment, Toronto, Ontario	Bev Barbeau; Katherine Piggot

Parkdale Community Health Centre, Toronto, Ontario	Alison Sterling, Health Educator; Bonnie Heath, Health Educator
Parkdale Community Ministry, Toronto, Ontario	Mary Anne Whittall; Lynn Connell
Public Health Association, Toronto, Ontario	Peter Cole, President
TV Ontario, Toronto, Ontario	Carol Burtin Fripp, Executive Producer; Don Kelly, Head of Adult Education; Kate Adelman, Producer
University of Toronto, (Department of Behavioral Science), Ontario	R Love, Assistant Professor; Alan Best
Canada World Youth, Montreal, Quebec	John Cawley
Katimavik (National Office), Cite Du Havre, Quebec	Ken Delabarre

References

1 World Health Organization. Health promotion: a discussion document on the concept and principles. Copenhagen, WHO, Regional Office for Europe, 1984.

2 Dennis J, Draper P and others. Rethinking community medicine. London, Unit for the Study of Health Policy, Guy's Hospital Medical School, 1979.

3 Ashton J R. Towards prevention: an outline plan for the development of health promotion teams. Community medicine, 4, 1982: pp 231–237.

4 Department of Health and Social Security. Inequalities in health: report of a research working group. London, DHSS, 1980.

5 United States, Department of Health, Education and Welfare. Healthy people. Washington DC, US Government Printing Offices, 1979.

6 United States, Department of Health, Education and Welfare. Promoting health/preventing disease: objectives for the nation. Washington DC, US Government Printing Office, 1980.

7 United States, Department of Health, Education and Welfare. Promoting health/preventing disease: public health service implementation plans for attaining objectives for the nation. Washington DC, US Government Printing Office, 1983.

8 Lalonde M. A new perspective on the health of Canadians. Department of national Health and Welfare, 1974.

9 United States, Department of Health and Human Services, Center for Disease Control. PATCH: planned approach to community health. Washington DC, US Government Printing Office, 1985.

10 Board of Health. Public health in the 1980s: report of the health planning committee. Toronto, Board of Health, 1978.

11 Department of Public Health. The unequal society: a challenge to public health. Toronto, Department of Public Health, 1985.

12 Crawford R. A cultural account of 'health': control, release and the social body. In: McKinlay J B (editor). Issues in the political economy of health care. New York, Tavistock, 1984: pp 60–103.

13 Whitman S and McKnight J L. Ideology and injury prevention. International Journal of Health Services, 15, 1985: pp 35–46.

14 Blackburn H and others. The Minnesota Healthy Heart Program: a research and demonstration project in cardiovascular disease prevention. In: Matarazzo J (editor). Behavioral health: a handbook for enhancement and disease prevention. New York, J Wiley and Sons, 1984.

15 Grimm R H. Should mild hypertension by treated? Medical Clinics of North America, 68, 1984: pp 477–490.

16 Morisky D E, Levine D M and others. Five year blood pressure control and mortality following health education for hypertensive

patients. American Journal of Public Health, 73, 1983: pp 153–162.
17 Stoeckle J D. The role of the academician as a teacher of patient care. Bulletin of the New York Academy of Medicine, 61, 1985: pp 144–154.
18 Sharf B. The physician's guide to better communication. Illinois, Scott Foresman and Co, 1984.
19 Davis R and others. Comprehensive school health education: a practical definition. Journal of School Health, October, 1985: pp 335–339.
20 United States, Department of Health and Human Services. Executive summary: aging and health promotion, market research for public federation. Washington DC, Office of Desease Prevention and Health Promotion, 1984.
21 Aging Health Policy Center. The health of older people: a framework for public policy. San Francisco, University of California, 1983.
22 Aging Health Policy Center. Health promotions for the elderly: program and policy issues. Policy Paper no 11. San Francisco, University of California, 1984.
23 Somers A R and Weisfeld V D. The challenge of health promotion for the elderly. Business and Health, November, 1983: p 10.
24 McKnight J and Kretzmann J. Community organising in the 80s: towards a post-Alinsky agenda. Social Policy, winter, 1984: pp 15–17.
25 United States, Department of Health and Human Services. Making PSAs work: a handbook for health professionals. Washington DC, National Cancer Institute, 1984.
26 McAlister A. Progress in developing effective communications. Public Communication Campaigns, Rice and Paisley Sage Publications, 1981.
27 Farquhar J W, Maccoby N and others. The Stanford five city project: design and methods. American Journal of Epidemiology, 122, 1985: p 323.
28 Gerbner O, Gross L and others. Health and medicine on television. New England Journal of Medicien, 305, 1981: pp 901–904.
29 Wallack L, Breed W and Cruz J. Alcohol on prime time television: findings from the fall 1984 season. Berkeley, California, Prevention Research Center, Pacific Institute for Research and Evaluation, 1984.
30 Wallack L. Mass media, youth and the prevention of substance abuse: towards an integrated approach. Journal of Children in Contemporary Society (forthcoming).
31 Teachman and Daggan. Health and the environment: an examination of utilisation in post-secondary school environment. Ontario, Education Communication Authority, 1979.

The tour of North America on which this report is based gave health professionals from the UK an opportunity to study the ideas and practices of countries with different health care systems and an extensive experience of health promotion initiatives. The conclusions of the members of the tour reflect the optimism and success achieved in the USA and Canada.

There are no short and precise definitions of the new public health. This movement challenges the basic definitions of health, accepted views of who should be included in decisions affecting health, and the nature of a society which will promote and protect health.

Even allowing for the differences in culture, ideology and health service provision between the UK and North America, the implications for this country contained in this book are impressive and will stimulate the growing debate on the role and directions of health promotion – particularly into areas like health service planning, primary care, elderly people, community development and the media.

£7.50