Encouraging trends in health promotion in the United States

Although the United States has long been a leader in many fields of biomedical science and medical technology, it has been slow to assume a similar role in promoting health. However, in the past two decades, particularly the last 5 years, two major developments have led to an expanded focus on health promotion in this country.

The first development was an evolutionary change in the concept of health promotion. Early in this century, following the successful use of population-based approaches to assure clean air, clean water and safe food, the challenge to public health was to control infectious diseases. Efforts concentrated on medically driven technologies such as vaccinations and screenings, with follow-up medical treatment with a focus on disease prevention to reduce mortality and morbidity. In short, epidemiologic methods and data drove the practice of public health. Although community and school health programs existed, health education was seen only as a complementary strategy to the practice of clinical preventive medicine and the implementation of disease-specific public health programs.

As the disease burden shifted from infectious to chronic diseases, public health continued to focus on disease prevention, and epidemiology remained as the principal science. However, in the 1970s an important change took place in health education: this discipline broadened from patient education to include intervention strategies designed to produce individual behavior change. During this decade a number of early governmental policy decisions were made recognizing that health behaviors were related to social and environmental issues. As a result, the goal of health promotion came to be defined as the absence of disease, with an emphasis on reducing risk factors by changing behaviors.

Health education and health promotion were, however, not vigorously embraced by the United States government, but two events are changing the federal perspective. One was the advent of HIV, with no medical intervention available to prevent or control the infection. Only health education and health promotion strategies are effective in preventing the spread of the virus. The second event is the increasing realization that most deaths in the United States are preventable. For example, in a paper published in 1993 that received considerable attention from federal, state and local public health officials, McGinnis and Foege argued that the real causes of death are related to behavior or the environment. Tobacco and diet/inactivity account for more than 700,000 deaths, or 30% of total deaths, annually in the United States. Sexual behavior, use of antimicrobial agents, firearm use, drug and alcohol use, toxic agents, and motor vehicles are the other culprits. Indeed population-wide approaches aimed at reducing the effects of these behavioral or environmental factors could prevent as many as 70% of early deaths. Acknowledging and accepting the role that behavior and the environment play is a critical first step away from the medical model for those who are entrenched in that framework if they are to design comprehensive, multi-strategy intervention programs that will prevent disease and death.

Fortunately, in recent years, there has been greater recognition in the United States that the goal of health promotion is more than merely preventing disease. The World Health Organization (WHO)'s definition of health—"Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity"—is heard more frequently (WHO, 1946). In addition, public health strategies are expanding to include widespread community involvement and the formation of public policy measures leading to a healthful environment and the empowerment of individuals to make choices.
for healthy living. The focus for implementing change is shifting from individual to community behavior. A case in point is the effort to reduce tobacco consumption in the United States: from emphasizing individual tobacco cessation, the focus has changed to community efforts such as the formation of state and local tobacco prevention coalitions, the use of public policy such as restricting access to sales to minors, enacting clean indoor air laws, taxing tobacco products, and using the media to counter the influence of advertising by the tobacco industry.

Even more promising than these changes is the emergence of a dialogue that the goal of health promotion should be about creating health for all people by achieving environmental and social equity. Last year, the World Health Organization announced that poverty is the leading cause of death worldwide. In the United States there is a growing recognition of the role that poverty, both by itself and through its effects on employment and educational attainment, plays in promoting ill-health and causing disease in the United States. Although poverty rates in the United States have remained relatively constant over the past 30 years, they are three times higher among African Americans and Hispanic Americans than among whites; unemployment is two times higher and 15% fewer African Americans and 30% fewer Hispanic Americans graduate from high school. These poor, social conditions have serious effects on health. People of low income suffer a 25% higher risk from heart disease (the leading cause of death in the United States) than the overall population. Various cancers, HIV infection, tuberculosis, and diabetes are disproportionately suffered by the poor. Children are most susceptible to the effects of poverty; infant mortality and injuries, for example, are higher among the poor than in the remainder of the population (Department of Health and Human Services, 1991).

At the community level, public health efforts embracing a broader view of health are underway, going beyond preventing disease to creating health. In tandem, there is the increasing acceptance of the concept that both community and self-empowerment are integral to health. Thus, the definition of health promotion is expanding to include strategies, interventions, and techniques that provide people with equal opportunity to make decisions that create health.

Many such health promotion efforts are currently under way in the United States. Very soon, as many as half of the states will have initiated Healthy Cities or Healthy Communities projects. Foundations such as Robert Wood Johnson and W. K. Kellogg have funded community development projects that involve many elements of the community, including multiple sectors and multiple interventions. In addition, traditional public health programs such as tuberculosis control, HIV prevention, and immunizations to prevent childhood diseases are incorporating community outreach as an important way to improve health in communities where the prevalence of these diseases are high.

The second significant development leading to a greater emphasis on health promotion is actually twofold. First, the science base for public health practice is moving beyond epidemiology to include the social and behavioral sciences. Second, in part because of this first event, the fields of health promotion and health education have matured, winning greater recognition from other health professions. For example, the quality of research in support of health education and health promotion has improved significantly in the past two decades, perhaps partly due to the recognition that the scientific basis for health education and health promotion practice comes from the social and behavioral sciences.

At the same time, there is agreement that health promotion activities have measurable outcomes, and that those who carry out these activities can be held accountable to produce changes in health status. Unfortunately, this is no easy task, as health promotion requires a multi-strategy and multi-sectoral approach that does not readily lend itself to current evaluation methodologies. But with sufficient planning and funding, appropriate evaluations of health promotion programs can be implemented.

Ideas of what constitutes an appropriate research paradigm for health promotion are changing. The methodologies of epidemiology and clinical research cannot be the standard for evaluating health promotion; randomized clinical trials, for example, are of little use in determining whether a health promotion program is effective. Qualitative methodologies, including new research paradigms such as participatory research, are much more likely to elucidate the relationship between health promotion interventions and outcomes. Only the most skeptical public health physician would question the reliability and validity of methods such as focus groups or process evaluation.
Perhaps before the end of this decade, we will see appreciable funding for health promotion research. It is therefore incumbent upon scientists in our field to define an appropriate research agenda for health promotion. Toward that end, the Centers for Disease Control and Prevention and the Society for Public Health Education cosponsored in 1994 the first research meeting from the public and private sectors to address a broad range of health education and health promotion research needs. Papers presented at the meeting, which were published in Health Education Quarterly, addressed theories, intervention strategies, settings, underserved and special populations, and evaluation. The agenda emanating from the meeting should provide the basis for building a strong foundation for determining future research.

Yet we have a long way to go in the United States before we can deliver quality health promotion programs to all people. Not only do the principles of health promotion need to gain greater acceptance, but an expanded science base is also needed to inform practitioners of effective health promotion intervention strategies, approaches, and models. Many questions about community capacity and mobilization, policy interventions, appropriate evaluations for health promotion programs, and other important issues, remain unanswered. In today’s environment, answers to these questions are eagerly sought.

However, the health promotion community in the United States does not need to develop its own scientific knowledge before implementing health promotion programs. Health promotion programs abound in other countries such as Canada, Australia and countries in Western Europe. As a nation, we are ready to look globally to solve our health problems. By taking advantage of electronic mail, satellite distance learning, and journals such as Health Promotion International, we in the United States can build on the interest and capacity of colleagues in other countries. It is this exciting prospect that leads me to accept with pleasure the opportunity to be the North American Regional Editor for the Journal.

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REFERENCES
