Health promotion and the vocabulary of the internal market

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The paper by Craig and Walker (1996; this issue) provides a useful corrective to some of the more overstated claims of our polemic against the role of health economics in the evaluation of health promotion interventions (Burrows et al., 1995). However, our argument was not that health economics would continue to play a limited role in the evaluation of health promotion interventions. On the contrary, we argued that even though the application of frameworks derived from health economics was largely inappropriate to the evaluation of health promotion, the discourse of health economics as a conceptual frame (or as a linguistic repertoire) was likely to increase in importance. Indeed, since the original paper was written almost 2 years ago, Sarah Nettleton (also at the University of York) and I have been carrying out qualitative fieldwork examining changes in the health promotion function (Nettleton and Burrows, 1997), and this has confirmed that the language of health economics is increasingly impinging upon the work of health promotion specialists.

In essence, it has become clear that there is developing an elective affinity between the discourse of health economics and the ‘contract culture’ within which health promotion (along with most other health care services) has to operate. The specification of contracts for health promotion services within the internal market increasingly requires such services to rearticulate what they do in terms of a vocabulary which largely derives from health economics. This rearticulation of practice in terms of aims, objectives, inputs and measurable outcomes is one which is now a common feature of so much health and welfare work. However, it is a template within which health promotion is finding it especially difficult to accommodate itself.

Although priorities for health promotion can be determined by purchasers by comparing local needs assessments statistics with Health of the Nation targets, how best to tackle these priorities once they have been identified is highly problematic. Although there is evidence for the efficacy of major public health interventions based upon legislative action for health, the evidence of efficacy demanded by health economics for health persuasion techniques, personal counselling for health or community development work for health at a local level (Beattie, 1991) is much less clear (NHS Centre for Reviews and Dissemination, 1995).

Does anyone know how best to reduce smoking? Or the number of young male suicides? Or rates of teenage pregnancy? Or the incidence of mental health problems in a population? To the extent that efficacy is not measurable (either because the intervention does not work or because it is not possible to operationalize it in a manner to measure it satisfactorily) any attempt to ascertain the relative cost effectiveness of interventions will obviously fail.

The solution to this has been to construct a currency for contracts which can be measured. However, this currency does not relate to outcomes but to inputs. A common measure is the concept...
of 'service delivery days'. The work of many health promotion provider units has been restructured around this currency. Contracts specify how many days throughout the year health promotion staff will work on particular areas of work. Although many health promotion specialists may feel uncomfortable with this sort of arrangement, it is recognized by many that in order to compete for scarce resources they must be able to at least begin to utilize this sort of language to express what it is that they do.

The rise of 'evidence-based' medicine and the concomitant increase in the prevalence of evaluative frameworks influenced by health economics has meant that health promotion has had to begin to draw upon the linguistic repertoires that these discourses provide in order to justify itself. In so doing it is likely that the nature of health promotion practice will be transformed as those interventions better able to conform to dominant contractual templates will be given priority. So, to restate, although health promotion practice is unlikely to be influenced by the findings of economic evaluations of health promotion (which are still mostly largely inconclusive) it is being transformed by the vocabulary health economics provides. In conclusion, this quote from a health promotion specialist working in a purchasing setting summarizes the argument very clearly:

When you are purchasing you need a currency or preferably two, and this is what health promotion has not got. I mean we can’t say we want 75 coronary artery bypass grafts or 58 hip replacements. So what we have devised and it’s not uncommon ... is the concept of 'service delivery days'. I know we are measuring input and that it is crude and it is not what health promotion likes, but to be honest unless you’ve got some kind of currency health promotion will be massacred when it comes to a race for money.

References


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