Health promotion was conceived in the 1970s, born in the 1980s and matured in the 1990s. It built on the work of health education in the 1960s but offered a radically new concept to the development and enhancement of health. Health promotion brought together a range of disciplines and professionals who realized that there needed to be major changes not only in the way people lived but also in the conditions in which they lived. Action at individual and environmental levels are both required if there is to be a truly healthier future. This realization was the starting point for a new public health movement. Health promotion has established and consolidated its position by building on and drawing from ideas, theories and principles in other fields and subject areas, and by incorporating and accommodating changing approaches and themes into its practice (Bunton and Macdonald, 1992).

This process has meant that health promotion, much like evolution, has kept those ideas that have proved useful and with time, discarded concepts or areas of practice no longer of value or use. The search for new and more appropriate theories and practices over the last 20 years has been a source of strength and sustenance. Since the mid-1960s health education and latterly health promotion have experimented with a variety of techniques and themes considered helpful at the time. One only has to scan through the editorials of the major health education and health promotion journals over this period to see the changes in emphasis occurring, and the massive strides that have been made. In the same way that health promotion seeks change so must it also learn to adapt to change itself and test new ideas and practices.

The paramountcy of education
In the 1960s education was considered the driving force behind social change (Arnot and Weiner, 1987). Investment in, and the consequent expansion of, education provision was based on the premise that educational establishments—in particular schools—were the engine rooms for innovatory thinking and change. Health education was therefore housed firmly and deliberately in schools. The view was that only through the process of curriculum innovation, teaching methodologies and pupil-centred learning could education concerned with behaviour change happen.

This emphasis on school-based education continued into the 1970s with the development of major curriculum projects in the UK, the USA and in The Netherlands (Becher and Maclure, 1978). Unswerving support was given by local education authorities, education advisers and inspectors, and in most countries in the developed world by the government itself. However the knowledge–attitude–practice (KAP) model was increasingly perceived as somewhat simplistic in determining the relationship between education and lifestyle. As a result, work was strengthened by developing skills-based learning in the second half of this decade. For the first time schools were actively encouraged to explore the concept of experimental and peer-led health education.

The birth of health promotion
At about the same time, the concepts of health promotion, until then only a vague and ill-defined term was becoming more attractive. The Lalonde report (1974) crystallized the thinking of some of the early pioneers and emphasized the need to go beyond lifestyles, when considering the causes of ill health. Human biology, the organization of health care and the environment were also co-determinants and required different responses if action was to be fully health promoting. This wider vision challenged the dominance education had enjoyed and highlighted the importance of inter-sectoral working. This shift in thinking did not deny an important role for education. Rather it emphasized the need for the active support of a
wide range of agencies and professionals, as well as people themselves, in a truly collaborative venture for better health.

In tandem with this drive towards inter-sectoral action was a growing awareness that the media could be a powerful delivery mechanism for health information even if, as research indicated, it only provided a public agenda for discussion (Leathar, 1988). Unfortunately preoccupation with media based activities which were 'high profile' gave health education and, by association, health promotion, a bad name. This judgement was largely due to a misunderstanding and a misconception of the principal features of health promotion which, at its heart, concerns enabling, mediating and advocating but not directing. The five key themes of the Ottawa Charter, for example, make no specific reference to the role of the media. Like educational approaches, media information can support and assist action. Nevertheless inappropriate use of the media did alienate many in the health education and health promotion fields. Shortly afterwards community development approaches to health promotion, much in evidence in developing countries in the 1960s, became popular in the industrialized world and helped to forge strong working alliances with groups outside conventional health systems. It strove to demonstrate the need for long term, process-oriented work in direct contrast to the more high impact, short term media-focused approach.

Three conferences
Ottawa, Adelaide and Sundsvall provided further momentum to the health promotion movement. These three international conferences shifted the focus away from the individual by building on the inter-agency concept and highlighting the healthy public policy approach. All public policy should have a health dimension it was argued, thus allowing the healthy choice to be the easy choice. This wider interpretation of the health promotion remit gave legitimacy to the new skills of health promoters in the field of policy analysis and advocacy, evident in the concept of the Healthy Cities programme. Sundsvall took the public policy approach one step further by aligning health promotion with the environmental movement. The greening of health promotion opened the door to issues concerned with sustainable development. These three conferences moved health education on from health behaviours, seen by many in a vacuum, to the much wider issues concerned with social policy and social structures, now commonly associated with health promotion theory and practice. These trends and developments in ideas and concepts are to be welcomed. However, they need to capture the imagination and support of commentators, practitioners and academics if health promotion is to move into these new areas. Otherwise there is a danger that the principles and practice of health promotion will be perceived to be so large and all consuming that real, everyday practical issues will get lost. That is not to say that health promotion does not need visionaries and theorists; of course it does. However, their ideas have to be based on sound, sustainable precepts and realistic ideas if health promoters are to accept and feel comfortable with them. The saying 'think globally act locally' is as true for health promotion as it is for environmental care.

Many countries are experiencing a period of rapid change which will accelerate as we move towards a new century. As health promoters we should accept changes, even welcome them and use them to best advantage. They allow us to innovate, create and motivate. As early health promoters drew on the experiences of others we can, in turn, now offer other disciplines and professionals new insights for building a healthier future. But we must be wary of trends or fashions that are simply gimmicks. If health promotion is to sustain itself and continue to develop as it has done in the last decade, then it has to avoid bandwagons and evolve on the basis of sound sustainable practices and theories.

An ironic and apt footnote to this short sketch is that schools, the original vehicle for much early health education have now borrowed back some of the contemporary thinking and applied them to the goal of creating 'health promoting schools'. Schools themselves can develop the concept of inter-sectoral action and environmental change for health through increased links with the community. This means that teachers will think beyond the classroom when developing curricula and may provide further impetus for sustainable developments in schools and health promotion into the next century.

Gordon Macdonald
Associate Editor
REFERENCES

