Health-promoting environments: the next steps

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'The only thing that looks good on me is you'
Bryan Adams

ONE of the key prerequisites for action is a vision of where one would like to be. One of the key challenges is to transform that vision into manageable steps that support the intention and the direction of the vision. Health promotion strategies have aimed to link vision and action through a unique approach to health-promoting environments, the 'settings for health' projects. We can now look back on about 10 years' experience with such projects, both in the developed and in the developing world. A range of publications and case studies in many languages has set out the experiences gained, has proposed indicators and has strengthened the theoretical and conceptual base of the approach. The contributions to this special issue of the *Australian and New Zealand Journal of Public Health* describe progress, show gaps and make many important conceptual and strategic contributions. Here I will pick up some of the themes raised and discussed, ranging from the theoretical underpinnings to the strategic priorities.

The essence of the settings for health approach is stated clearly in the article by Harris and Wills: the required 'shift away from defining goals and targets in terms of populations (people) towards goals that look at changes in organisations and systems'. This will imply—as stated in several of the articles—new program perspectives and new ways of measuring results. Let me begin with outlining the three premises that led to the development of the settings for health approach and continue to guide its further progress. They also indicate—very much along the lines of the articles in this issue—what gaps remain to be filled.

The theoretical premise: what creates health

The most crucial defining factor of any health promotion strategy is that it starts out from health creation. 'Health is created where people live, love, learn, work and play.' This could seem like a trivial statement—actually it is a revolution in health thinking. It was pioneered by Aaron Antonovsky and is best reflected in his seminal work *Unravelling the mystery of health. How people manage stress and stay well.*[1] Antonovsky argues convincingly that the key question health research must ask is, 'What creates health?' It is the interaction between environments and people in the course of everyday life that creates a pattern of health—in the individual, the family, the community, the nation and the globe. Antonovsky went on to develop a scale called 'the sense of coherence', which links a person's sense of comprehensibility, manageability and meaningfulness to health status, and his research indicates that a high sense of coherence tends to correlate with good health.

While Antonovsky restricted his research to the sense of coherence of individuals, others, such as Evans and Stoddart, have indicated that it might apply to communities, even nations.[2] A key challenge for health promotion based on a salutogenic model, therefore, is to develop strategies that strengthen the sense of coherence of individuals and social groups. This leads to a vision of environments that are supportive to health: a healthy school, a health-promoting hospital, a healthy workplace, a healthy city, to name just a few. This theoretical underpinning needs to be further strengthened and developed in health promotion research.[3,4]

The public health premise: which investment creates the largest health gain?

Public health is concerned with population health, so a key premise for health promotion clearly follows: the best public health investment, with the largest impact, is change that affects large population groups. What this means for health promotion strategies has been argued succinctly by Leonard Syme in an overview that is as valid today as when it was written, which was in the year of the Ottawa Charter, 1986.[5] Research results consistently indicate that 'systems interventions' are more efficient than individually oriented prevention programs. Therefore health promotion (as a social health strategy) must prioritise strategies that focus on social environments. This knowledge goes back as far as Emile Durkheim's seminal work *Le suicide* (1897) but has gained only minor acceptance in a health system dominated by a biomedical paradigm.[6] A case in point is the recent Australian health goals and targets, as described in the article by Harris and Wills in this issue.

The production of health is seriously neglected in the 'health reform' debate in many countries. Decisions and debate focus on the financing and organisation of the curative services—that is, on the consumption of medical care. A few exemplars exist which understand the importance of creating environments that are supportive to health as the essence of a 'new' public health approach: the 'Quebec policy on health and wellbeing', the 'Copenhagen healthy cities policy', the strong support for a settings approach in the English 'Health of the Nation'.[7–10]

These documents illustrate how intervention priorities emerge through identifying the 'patterned

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consistency' of health status, building upon research results on the relationship between health and socioeconomic status, marital status, occupation, education, ethnicity, race, age and sex. Of concern is the fact that the challenge which Leonard Syme posed to health promotion research in 1986 has not been met—the challenge to develop an alternative classification system that builds on a systems–environmental perspective. This would be essential to obtain support for a new policy base. The present 'noncommunicable diseases' classification both restricts innovative research into the creation of health and the pattern of disease and hampers innovative interventions that start from common root factors. There exists a wide research base that supports the settings for health approach but it is frequently not found in the shelves labelled 'epidemiology'. Health promotion researchers must become more informed on, and adept in, using existing research results from other disciplines. And they must give the matter of 'classification' a priority. Too frequently health promotion research slips into the noncommunicable disease or behavioural epidemiology mould.

The practical premise: community development and organisational development

Community development has been a key element of health promotion, following through from the Alma Ata Declaration on Primary Health Care and the basic policy principles of the World Health Organization (WHO). A new component was added in making use of the practical approaches to organisational change as developed in the management literature of the 1980s and early 1990s. Most important for the development of the 'settings for health' approach was the concept of the learning organisation. Five 'component technologies' of organisations that continually improve their capacity were put forward by Peter Senge: systems thinking, personal mastery, mental models, building shared vision, team learning.[11] Like health promotion, these approaches aim to combine vision, context and meaning. Following from this the 'settings for health' approach builds on the premise that there is in practically every organisation and community a health development potential which can be fostered through a series of defined strategies and applied across a range of settings, just as the management approaches apply to a wide range of very different companies. The article 'Health promotive Aboriginal communities' by Wise et al., and the points put forward by Harris and Wills, clearly illustrate this.

The health of an organisation or community is more than the aggregate health of its citizens. This fact stretches the measurement of progress beyond the health of populations to include the health of systems. It is also clearly a measure of sustainability: the constant influx of 'new populations' into the systems more efficiently calls for intervention at the environmental level. Just as in the private sector 'benchmarking' has become a key evaluation tool of settings projects, indicators developed in the various projects—healthy cities, health-promoting schools, health-promoting hospitals—make sense only if settings are compared with each other: how well is our school doing on various parameters, how is it that others are doing better, what can we learn from them, what must we do to improve our ranking, how can we become the best? Particularly the WHO's pilot hospital in Vienna for the health-promoting hospitals project has tested and evaluated the organisational development approach using project management methods and involving outside consultants as advisers and supervisors of the process.[12–14]

Resulting from such work are several 'how to' guides, as developed, for example, by the Healthy Cities project: *Twenty steps for developing a healthy cities project* or the 'practitioners' guide' to a healthy city'.[15–17] Many more such practical toolboxes need to be developed and disseminated widely. A Tom Peters type of book, with a title like *In search of excellence in health promotion*, would be the kind of thing we need if we are to get out of the health professional ghetto.[18] The WHO is at present exploring such a publication.

Bringing the premises together

The settings approach has combined the three premises outlined above into a vision that can be translated into manageable steps towards a solution. The articles in this issue clearly show this. They also illustrate—as Dwyer summarises—what the approach has in common across the settings.

Let me just stress the following:

- The approach builds heavily on motivation and commitment of all actors within a system.
- While asking a simple question, 'What creates health in our setting?', it opens the way for a diversity of solutions, with different meanings for those involved. For the participants in settings for health projects the 'health' question can be framed in quite different ways and is usually oriented towards wellbeing and improved performance: does it make me feel better (about my role in the setting) and does it increase the quality of my performance? The two are absolutely essential in settings that are based on service work, communication and empathy, such as schools and health care.
- That is why many of the 'first step' solutions are organisational rather than linked directly to health behaviour: change of shift plans in the hospital, change of pupil–teacher interaction in schools. Focus groups, committees and quality circles are established, participatory decision making and team work are developed—sometimes a long and painful process as the experiences show. Top level commitment is absolutely essential for success, but if the health development process is not participatory it is doomed to failure. Again the experiences gained in Aboriginal health programs illustrate this in an exemplary manner.
- The shift of perspective is sometimes difficult for health professionals because it follows a non-medical logic. The settings approach is not 'health promotion in ...'. Health-promoting schools are

therefore as much about teachers' health as about developing the health skills of children, and health-promoting hospitals are as much about nurses' health as about reduced hospital infections. Most importantly it is all about the health of the system, so that the wheel does not need to be reinvented with each new generation of workers, teachers, nurses.

The settings logic follows Leonard Symes's argument that the presence of environmental stressors would predict the likelihood of people getting sick, but not what disease they get. The appropriate public health response is a health-promoting setting which builds health potential and creates buffers, intermediary support and protection factors. It is these that need to be identified, measured and evaluated.

Settings for health world wide

Settings for health projects are being implemented all over the world, some linked officially to WHO networks, others working independently in the spirit of a new public health approach. Over a thousand cities are working to the healthy cities principles, and, in addition, many communities, small towns and localities have adapted the settings approach to their needs. Healthy villages initiatives are being developed in Africa with the support of the WHO regional offices, as are healthy island projects in the Caribbean and the Western Pacific. The health-promoting hospitals principle has spread from Europe throughout the world, with a network of several hundred hospitals reaching as far as Thailand. The settings approach of the health-promoting schools project was recommended by the WHO expert committee on school health in 1995, and all WHO regional offices are committed to contributing to a Global WHO School Health Initiative.[19] Partners in this are organisations as diverse as the Council of Europe, the European Union, UNESCO, UNICEF, Education International, the World Bank, Centers for Disease Control, Atlanta, Johnson and Johnson, and many more, particularly at the national and local level. An initiative on health in prisons has been piloted in one European Union member state and has now motivated six other countries to move in the same direction. 'Healthy marketplaces' is an approach taken up by many developing world cities, with a focus on food safety and hygiene.

These networks and projects are being supported by initiatives on policy development that aim to develop strategies for priority setting and investment in health. An example is the 'Investment in Health: Creating Healthy Public Policies' initiative of the European office of WHO, which has run two demonstration projects—one in the autonomous provinces of Trento and Bolzano, Italy,[20] and another in the autonomous region of Valencia, Spain. A third one is starting in Chemnitz, Germany. Australia has pioneered the work on and in settings such as sports and the arts, as described in this issue of the Journal. And finally many private companies have implemented 'healthy companies' approaches, such as the companies that belong to the Washington Business Group for Health. A WHO collaborating centre in Essen, Germany, is collecting models of good practice on a regular basis. At present they still concentrate on the developed world, but the recent launch of the WHO Global Strategy on Occupational Health will lead to an increased involvement of companies in the developing world.[21]

Partnerships and innovation

At the centre of a 'settings for health' approach are partnerships. Increasingly these partnerships reflect a public–private mix, either through sponsorships or through 'business in the community' involvement.[22] The philanthropic organisations of major companies are increasingly showing interest in settings based strategies, rather than disease-by-disease approaches. In fact, it frequently seems that organisations and individuals outside the health sector find it easier than the health sector itself to understand and accept the settings based approach. These partnerships should be expanded to move us into other types of settings approach that respond to the organisation of everyday life in consumer societies. We could rephrase 'where people live, love, learn, work and play' to include 'where people shop, get their hair done, have a drink, go out to have fun.' Elements of this are illustrated in the contribution by Corti et al. in this issue.

This also means facing up to some ambiguities and trade-offs. For example in most cities parents can be reasonably relaxed if they know their children are in a certain burger place: it is nonsmoking, it does not serve alcohol, it's a clean and safe environment, it has high food safety standards. Yet the same parents do not feel good about fast food, eating beef, and the streamlining of cultural experiences. A car-racing idol is very active in promoting safe driving and child safety in cars—but is plastered all over with cigarette advertising.

We need new types of standards and indicators that allow for new types of evaluation and comparison. For example, an index for a health-promoting supermarket or a health-promoting shopping mall could include factors such as the hygiene level, shelf space for healthy products, price range of healthy products, working conditions of staff, 'temptation levels' (e.g. refusal to place sweets at the height of kiddies' grubby fingers), nonsmoking policies, noise pollution etc. The index could indicate how easy the healthy choice is within the respective environment.

Another type of environmental index could compare, in different communities, the number of square metres dedicated to tobacco and alcohol advertising, or to clothes advertisements showing anaemic-looking young girls. We could begin to define the media and marketing as an environment that is allowed to invade public space without any organised possibility of public response. The next step is to expand our understanding of 'supportive environments' to settings or communities that are not classic institutions or buildings with walls around them. This is all the more important because that is where the young people dream, where the unem-

ployed wait, where the families shop.

In summary, I see two big challenges relating to environments supportive to health. On the one hand we need to move the existing settings projects out of their status as models and turn them into standards. This means accepting that 'health technology' is more than pipes and drains, medical equipment and computers. It must include the social technology of creating supportive environments for health. Just as we have standards for water quality and food safety, we should have standards for health-promoting settings.

On the other hand we must widen the settings approach into innovative areas of non-traditional, non-institutional settings. This might allow us to reach some of the really difficult target groups, young males in particular, and live up to the challenge of reducing health inequities. Public health, says the WHO, in its definition following Winslow, is the science and art of preventing disease, prolonging life and promoting health through organised efforts of society. Despite pressures to the contrary in a society with a fixation on short term measurable results, we must put much more effort into developing the art. This includes the art of alliance building across sectors, in particular between the public and private sectors. While health promotion is attacked on all fronts within the health care system, it is a successful big business 'out there'. We need to draw a new health promotion map and adjust our strategies and approaches accordingly. We hope that the Fourth International Conference on Health Promotion, due to take place in July 1997 and entitled 'New players for a new era', will help this process along.

So as not to be misunderstood: I do not want to preach a totally sanitised environment which would make life even more restrictive than it frequently is. When I started working in health promotion I always kept a quotation from Aldous Huxley's *Brave new world* on my wall.[23] The Savage from the old world protests that he doesn't want comfort: '... I want poetry, I want real danger, I want freedom, I want goodness, I want sin.' Mustapha Mond from the new world responds by outlining what this means in terms of pain, suffering, illness and insecurity: 'In fact, you are claiming the right to be unhappy.' The Savage thinks for a long time after having heard the list (which, having been written in the early 1930s, includes typhoid rather than AIDS) and then responds, 'I claim them all.'

I urge everyone involved in health promotion to read that dialogue regularly. Have it on your bathroom mirror. It describes the dream of every new teenage cohort and the 'boring' adult response. It covers the whole ambiguity of our professional task. But most importantly it reminds us that health is only one dimension of the human condition.

So in case you were wondering what the Bryan Adams quote at the beginning meant ...

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