

# Integrated health promotion resource kit



### 3. Foundations for integrated health promotion

This section outlines the foundations of, and gives a historical background to, integrated health promotion practice and principles. It provides an overview of the broader determinants of health that reflect a social model of health (fundamental to integrated health promotion practice), the link to social capital and community development and the policy context for integrated health promotion.

#### 3.1 The determinants of health

*The primary health care sector aims to achieve positive outcomes for consumers by working with the community to improve health and wellbeing.*

The primary health care sector aims to achieve positive outcomes for consumers by working with the community to improve health and wellbeing. To achieve these outcomes, practitioners need to understand the broad determinants of health and wellbeing<sup>19</sup> and apply a **social model of health** to service planning and provision.

A social model of health is a framework for thinking about health. Within this framework, improvements in health and wellbeing are achieved by addressing the social and environmental determinants of health, in tandem with biological and medical factors.<sup>20</sup> Underpinning and supporting this conceptual framework is the Alma Ata declaration and the World Health Organisation definition of health:

Health is a complete state of physical, mental and social wellbeing, not merely the absence of disease or infirmity.<sup>21</sup>

Planners of services that aim to improve health and wellbeing and reduce the burden of preventable disease, need to be concerned not only with the individual context or factors, but also with the context of broad public policies and environmental influences, group and family influences and the community context.<sup>22</sup> It is not possible to decide how best to support the improvement of health without understanding this context as illustrated in Figure 1.<sup>23</sup>

**Figure 1: The context of health**

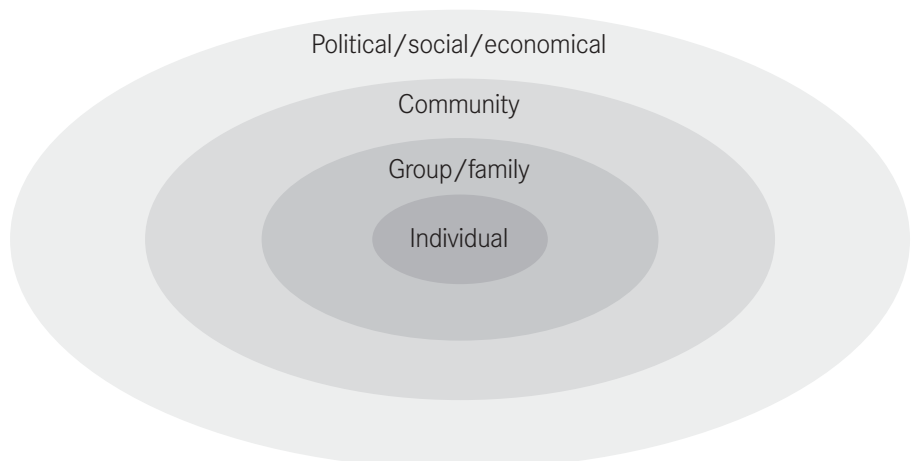
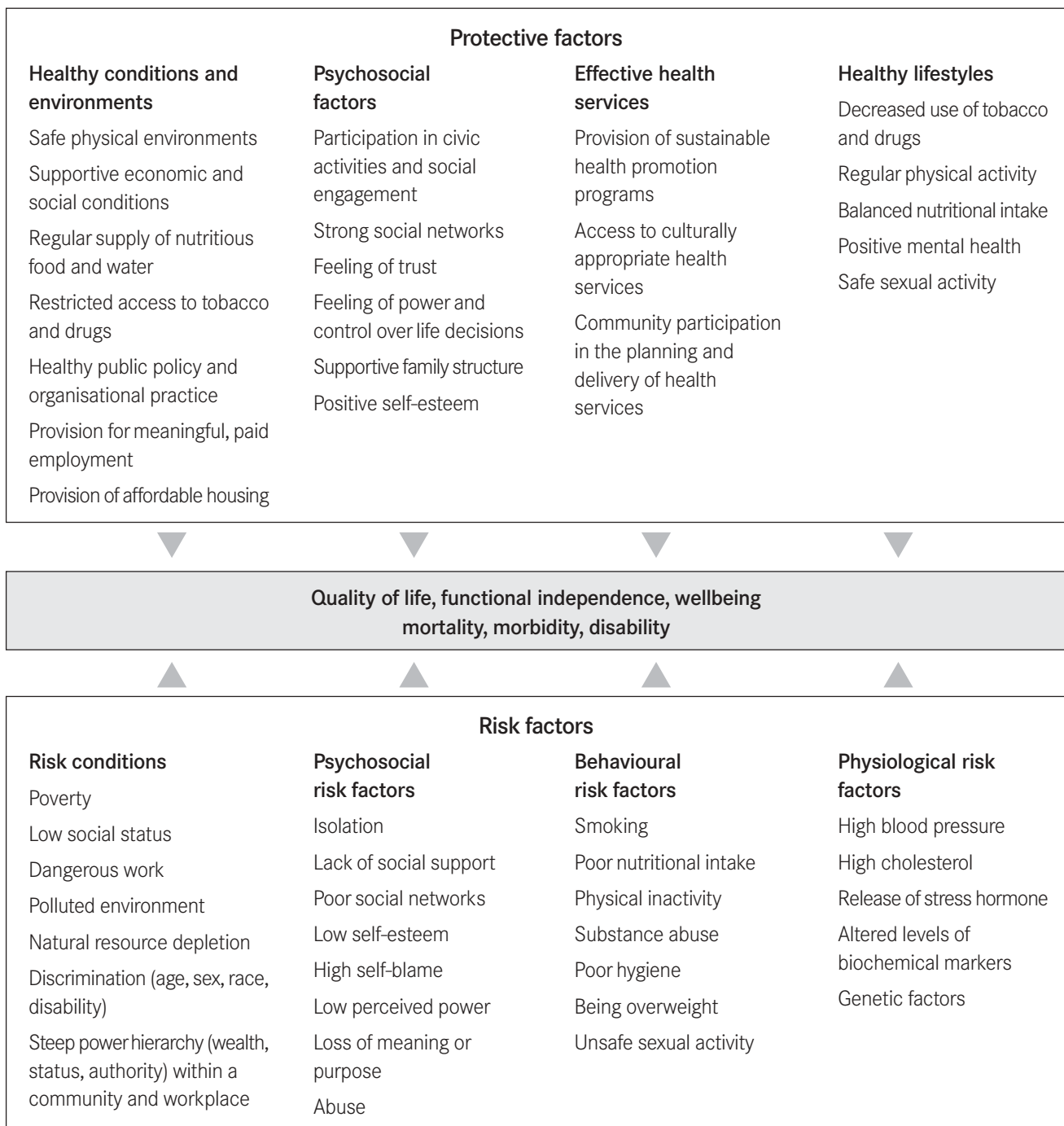


Figure 2 lists examples of the relationship between the determinants of health (grouped as protective and risk factors) and health and social outcomes, further illustrating the importance of applying the social model of health to service delivery.<sup>24</sup>

**Figure 2: The factors affecting health and wellbeing<sup>25</sup>**



*There is a growing consensus on the importance of systematic differences in exposure to health hazards and risk conditions in the population.*

There is a growing consensus on the importance of systematic differences in exposure to health hazards and risk conditions in the population. This means some groups in society have a much poorer chance of achieving their full health potential as a result of their life circumstances – including political, social, economic and environmental conditions as illustrated in Figure 2.

Differences are observed in the health status of groups according to a range of socioeconomic indicators. The most disadvantaged groups have the poorest health and the highest exposure to health-damaging risk factors.<sup>26</sup>

There is evidence that poorer socioeconomic groups tend to have poorer nutrition, less physical activity in leisure time, greater prevalence of smoking and more damaging patterns of alcohol use. However, each factor should not be considered separately. The life circumstances or determinants of health (including people's social and economic circumstances, indigenous status and ethnicity, stress, gender, early life development and experiences, social exclusion, work and unemployment, and social supports)<sup>27,28</sup> of people experiencing disadvantage highlight the greater restrictions on 'making healthy choices the easy choices'.<sup>29</sup> Further, cultural diversity and the failure of the system to address issues of access to appropriate services and programs for diverse groups can create inequalities in health status. Integrated health promotion attempts to close the equity gaps by supporting social networks; developing and advocating healthy public policies; and strengthening community capacity.<sup>30</sup>

Inequity and inequality are often used interchangeably, but have very different meanings. If one person lives longer or suffers less sickness and disability than another, then inequalities in health status exist—but not necessarily as a result of inequity. These differences may not have arisen from living conditions, but from genetics, personal lifestyle choices or particular accidents. However, if differences in health status result from different living conditions (such as reduced access to nutritious foods, inadequate housing, lack of access to appropriate health care, lower income levels, stressful work conditions and frequent periods of prolonged unemployment), then inequalities in health status are the result of social inequities.<sup>31</sup>

#### **Toolkit: the determinants of health<sup>32</sup>**

In practice, working within a social model of health means investigating what determines health and wellbeing or the determinants of health, including:

**The social gradient:** People's social and economic circumstances affect health throughout life. A continuum exists from the disadvantaged to well off rather than a binary effect at the extremes.

**Stress:** The individual response to stress can cause physiological changes, which affect health. It is recognised that people's social and psychological circumstances can affect health through stress.

**Early life:** The effects of early physiological and psychological development, both negative and positive, last a lifetime. The infant is dependent on their circumstances and significant others for both physical and emotional experiences.

**Social exclusion:** This may be imposed by law, result from economic circumstances or from failure to supply social goods or services. Groups that are socially excluded include the unemployed, ethnic minorities, homeless, pensioners or people with disabilities. These groups experience worse health outcomes than the general population.

**Work:** Stress in the workplace increases the risk of disease. An imbalance in two aspects of workflow control when work demands are high and an imbalance in effort in relation to reward (income, self esteem or status) – have been identified with negative health consequences.

**Unemployment:** Unemployment and job insecurity have a negative effect on health. Psychological and social resources are likely to increase in employment and decline in unemployment.

**Social supports:** Friendships, good social support at home, at work and in the community improve both physical and mental health.

**Addiction:** While individuals use alcohol, drugs and tobacco, their use is influenced by a wider social setting. Addictive behaviours are generally detrimental to health.

**Food:** Strong links have been established between nutrition (both under and over nutrition) and a range of diseases.

**Transport:** Healthy transport means reducing driving and encouraging more cycling and walking, backed up by better public transport.

**In all of the checklists, key questions have been included to prompt practitioners to continually consider their role in affecting these determinants.**

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### 3.2 Social capital and community development

Participating in social and civic activities, such as community group meetings, child care arrangements with neighbours, neighbourhood watch schemes and voting, all work to produce a resource called social capital. Social capital is critical to the health, wealth and wellbeing of populations.<sup>33</sup> It is a key indicator of the building of healthy communities through collective and mutually beneficial interaction and accomplishments.<sup>34</sup> Recent research has linked these types of activities to improved health outcomes.<sup>35, 36, 37, 38</sup>

*A focus on social capital supports a balance of strategies that address behaviour and those that focus on the settings in which people live, work and play.*

The notion of social capital represents a way of thinking about the broader determinants of health and about how to influence them through community-based approaches to reduce inequalities in health and wellbeing.<sup>39</sup> A focus on social capital supports a balance of strategies that address behaviour and those that focus on the settings in which people live, work and play. The implication for integrated health promotion is that more emphasis is needed on efforts to strengthen the mechanisms by which people come together, interact and, in some cases, take action to promote health. Simple measures, such as providing space for people to meet, may be as health promoting as providing health information in an effort to change behaviour.

Service providers can also enhance the social capital within a community by supporting community projects that bring neighbours together to achieve a mutually beneficial goal, such as beautifying the environment of a public housing estate, establishing a community fruit and vegetable garden or working with the local sporting club to encourage all parts of the community to participate in sporting activities.

It is important to note that the literature on social capital can present a romantic view of community and assumes that close-knit communities are necessarily healthy. It is, however, possible that a community can be socially cohesive but also exclusionary and distrustful of outsiders, and may in fact be unhealthy for those who are not a part of it or those within who disagree with the majority. Baum presents a range of factors that distinguish 'unhealthy and healthy' forms of social capital (see Table 2).<sup>40</sup>

**Table 2: Healthy and unhealthy forms of social capital<sup>41</sup>**

<b>Healthy social capital</b>	<b>Unhealthy social capital</b>
Trust	Distrust of strangers/difference
Cooperation	'Them' and 'us'
Understanding	Tight knit but excluding
Empathy	Fear of the unknown
Alliance across difference	Dislike change and new ideas
Questioning and open to new ideas	Racism

Community development, in very simple terms, is the process of developing social capital.<sup>42</sup> It is a process that emphasises the importance of working with people as they define their own goals, mobilise resources, and develop action plans for addressing problems they have collectively identified.<sup>43</sup>

**Toolkit:** Service providers are in a unique position to employ community development concepts when delivering integrated health promotion programs by understanding their role as a:

**Catalyst:** Stimulating other people to take action by assisting in the problem definition of shared concerns and helping to bring individuals together who may not normally meet, but share common issues.

**Teacher:** Increasing the capacity, knowledge and skills of people and organisations to deal with their own challenges and priority issues. There is an approach to teaching based on principles of adult education where teachers and students are partners who move between teaching and learning roles.

**Facilitator:** Supporting community organisations in decision making and implementing actions. This includes undertaking organisational tasks and contributing technical skills to planning, implementing and evaluating. In this process, the service provider is not the manager but has a role in facilitation with the community committee or project advisory group and the policy makers.

**Linking person:** The service provider is in a unique position to build good relationships between the key stakeholders involved in the program for example, community organisations, funding agencies and the local media.<sup>44</sup>

### 3.3 International, Australian and Victorian context

This section gives a brief overview of the key policy directions and activities for integrated health promotion in international, Australian and Victorian contexts.

#### 3.3.1 International

##### The Declaration of Alma-Ata (1978)<sup>45</sup>

The Declaration of Alma-Ata is regarded as an important milestone in the promotion of world health. The principles documented in the declaration are the blueprint for primary health care and later became known as 'Health for All by the year 2000'. The key to understanding primary health care is to realise that it is a philosophy of practice rather than just a particular type or level of health service. Several concepts stand out in the Declaration of Alma Ata:

1. Social justice.
2. Equity.
3. Community participation and maximum community self-reliance.
4. Use of socially acceptable and affordable technology.
5. Health promotion and disease prevention.
6. Involvement of government departments other than health.
7. Political action.

*The principles documented in the declaration are the blueprint for primary health care and later became known as 'Health for All by the year 2000':*

8. Cooperation between countries.
9. Reduction of money spent on armaments in order to increase funds for primary health care.
10. World peace.<sup>46</sup>

This declaration is reiterated in the *Health for All in the 21st Century* (1998) global health policy framework. See <http://www.who.int/archives/hfa/index.html> for further information about the process and the contents of this policy.

#### **Ottawa Charter for Health Promotion (1986)<sup>47</sup>**

The first World Health Organisation (WHO) International Conference on Health Promotion was held in Ottawa, Canada, in 1986. The Ottawa Charter for Health Promotion was developed as a clear statement of action for health promotion, aiming to increase the relevance of the primary health care philosophy for industrialised countries. Building on the Declaration of Alma-Ata, the Ottawa Charter defines health promotion as:

*Health is, therefore, seen as a resource for everyday life, not the objective of living.*

The process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living.<sup>48</sup>

The Ottawa Charter directs strategic health promotion thinking and planning to five action areas:

1. Building healthy public policy.
2. Creating supportive environments for health.
3. Strengthening community action.
4. Developing personal skills.
5. Reorienting health services.

#### **Jakarta Declaration on Leading Health Promotion into the Twenty-First Century (1997)<sup>49</sup>**

This declaration identifies the importance of health promotion as an investment and reiterates the need to address the significant social determinants of health. While emphasising the five action areas listed in the Ottawa Charter, the declaration goes further to set five priorities for health promotion in the twenty-first century:

1. Promote social responsibility for health.
2. Increase investments for health development.
3. Consolidate and expand partnerships for health.
4. Increase community capacity and empower the individual.
5. Secure an infrastructure for health promotion.

*In July 2002, Australian health ministers announced arthritis and musculoskeletal disorders as a new national health priority area in recognition of the major health and economic burden these diseases place on the community.*



**Toolkit:** The WHO Department of Non Communicative Diseases (NCD), Prevention and Health Promotion, works to reduce the incidence of NCD and promote positive health and wellbeing, with a focus on developing countries. Their website gives full details of these initiatives.

Go to <http://www.who.int/hpr/support.material.shtml>

The Ottawa Charter can be downloaded from:

[http://www.who.int/hpr/NPH/docs/ottawa\\_charter\\_hp.pdf](http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf)

### 3.3.2 Australia

As a signatory to the Declaration of Alma-Ata, Australia formally committed in 1981 to achieve the 'Health for All' goals by 2000.<sup>50</sup> Significant policy directions have followed, including the *Goals and Targets for Australia's Health in the Year 2000 and Beyond*<sup>51</sup>, the *Better Health Outcomes for Australians*<sup>52</sup> and the *National Health Priority Areas*.<sup>53</sup> These policies have highlighted the need for a consolidated approach to meet goals in the prevention of cancer, cardiovascular disease, injury, mental health, diabetes and asthma. In July 2002, Australian health ministers announced arthritis and musculoskeletal disorders as a new national health priority area in recognition of the major health and economic burden these diseases place on the community.

In 1995 the Commonwealth Government commissioned the Health Advancement Standing Committee of the National Health and Medical Research Council to conduct a review of health promotion activity and infrastructure needed to support health promotion in Australia. The review<sup>54</sup> recommended improvements to a range of areas, including improvements in health promotion capacity and in funding, implementing and evaluating health promotion programs. Subsequent national and State health promotion work has reflected these recommendations.

The National Public Health Partnership established in 1996 recognises the need for a more systematic national approach for health promotion to respond to the above recommendations. This partnership is establishing core competencies for the workforce; strategy coordination; accreditation standards for education and training in health promotion; and national data sets (such as indicators and intermediate review outcomes).<sup>55</sup> The partnership has emphasised the importance of integrated public health practice and key factors required to support integration. Its National Strategies Coordination Working Group is developing strategies and tools to support and facilitate integrated local public health practice.<sup>56</sup>

*The Department of Human Services has a leadership role for integrated health promotion, disease management and injury prevention strategies.*

### 3.3.3 Victoria

Integrated health promotion (including early intervention and prevention) were clearly identified in the 2002 Victorian Government's election policy – namely, *Healthy Communities: Labor's plan for seniors and community health*<sup>57</sup> and the Government's signpost document *Growing Victoria Together* – as an important component of the human services sector.<sup>58</sup> The policy adopts a social model of health to guide work in the human services sector, clearly recognising the effect of broader social determinants of health on the wellbeing of the Victorian population.

The Department of Human Services has a leadership role for integrated health promotion, disease management and injury prevention strategies. The international and Australian policy contexts discussed above are strengthened by Victorian policy initiatives such as the PCP strategy, municipal public health planning (as discussed in Section 2) and neighbourhood renewal. They reflect an emphasis on people, community-centred participation and service delivery.

**Case study:** Neighbourhood renewal is a new approach that offers a better deal for disadvantaged communities in Victoria. The strategy is an initiative of the Department of Human Services as part of the State Government's *Growing Victoria Together* agenda to build more cohesive communities and reduce inequalities.

Neighbourhood renewal is tackling health inequalities by narrowing the gap between the most disadvantaged neighbourhoods in Victoria and the rest of the State. Projects targeted to areas with high concentrations of public housing are promoting health and wellbeing by improving access to health services and programs and by tackling the key social determinants of health such as housing, employment, education, crime, transport and social inclusion.

Communities are being revitalised by tackling the multiple and interconnected causes of disadvantage. Local people are being empowered to shape their own futures by connecting to key decision makers across whole-of-government, businesses and service providers. An emphasis on 'neighbourhood' is refocusing government programs on local issues identified by communities in the places they live, work and play.

In a short period of time, houses have been upgraded, local environments improved, jobs have been created, educational opportunities improved, streets are becoming safer and residents are getting better access to key health and community services.

Neighbourhood renewal provides a unique opportunity for health service providers and integrated health promotion initiatives to join with other programs and agencies that are influencing the structural drivers of health inequality in Victoria.

For further information see [www.neighbourhoodrenewal.vic.gov.au](http://www.neighbourhoodrenewal.vic.gov.au)

