

# The Director's Message

*For an organization devoted to health,  
such as ours, the main strategies of health  
promotion can find application in almost  
all aspects of our work.*

# Promoting Health in the Americas

When I reflect, as I often do, on why I derive such satisfaction from looking for the historical antecedents of our concepts and practices in health, I sometimes hark back to my childhood. Where I grew up there was no electricity and, therefore, no radio, so we very much made our own entertainment. Many a night we listened to my father declaiming from one or other piece of literature or the Bible. I often remember his referring to the passage from Ecclesiastes, which ends, “and there is no new thing under the sun.” Of course, although that should not be taken literally, it has always made me look for the old things under the sun. Indeed, it makes me humble to be constantly reminded of how much has gone before, and that “the thing that hath been, is that which shall be.”

So it was with much pleasure that several years ago I heard Milton Terris,<sup>1</sup> in describing the dualities in public health theory, credit that great medical historian, Henry Sigerist, with being the first person to use the term “health promotion” with anything like its modern meaning. In 1946, Sigerist described the four major tasks of medicine as the promotion of health, the prevention of illness, the restoration of the sick, and rehabilitation.<sup>2</sup> No one

<sup>1</sup> Terris M. Concepts of Health Promotion—Dualities in Public Health Theory. Washington, DC: Pan American Health Organization; June 1992. Mimeograph.

<sup>2</sup> Sigerist HE. *The University at the Crossroads*. New York: Henry Schuman; 1946.

would disagree with that today. In an earlier work, Sigerist had defined health along similar lines to those later used by the World Health Organization (WHO), which said in its Constitution: "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." Sigerist's historical analysis of health and its relevance for human welfare, had led him to consider health in a social sense, and he wrote:

*A healthy individual is a man who is well balanced bodily and mentally, and well adjusted to his physical and social environment. He is in full control of his physical and mental faculties, can adapt to environmental changes, so long as they do not exceed normal limits, and contributes to the welfare of society according to his ability. Health therefore is not simply the absence of disease; it is something positive, a joyful attitude towards life, and a cheerful acceptance of the responsibilities that life puts upon the individual.*<sup>3</sup>

Obviously, there have been numerous attempts to define the kind of health that should be promoted and preserved, and almost all I have read have been rooted in a concept of wholeness or integrity. I have been particularly intrigued by Fritjof Capra's perception of that same wholeness in the systems approach to life in general and in the origin of this concept with respect to health, in contrast with the reductionist approach that has dominated Western thinking for 300 years.<sup>4</sup> He writes:

*Although everybody knows what it feels like to be healthy, it is impossible to give a precise definition; health is a subjective experience*

<sup>3</sup> Sigerist HE. *Medicine and Human Welfare*. New Haven: Yale University Press; 1941.

<sup>4</sup> Capra F. *The Turning Point: Science, Society and the Rising Culture*. Bantam Books; 1983.

*whose quality can be known intuitively, but can never be exhaustively described or quantified. Nevertheless, we may begin our definition by saying that health is a state of well-being that arises when the organism functions in a certain way.*

To Capra, “a certain way” means that the various systems are in “a dynamic balance that involves the physical and psychological aspects of the organism, as well as its interactions with its natural and social environment.”

Definitions such as those given by Sigerist, WHO, and perhaps Capra have been criticized as not being useful, because they approximate a utopian state of eternal happiness to which all humankind will probably aspire, but give little basis for quantification and are difficult to promote. I have always firmly held, however, that one of the great challenges for us mortals is to grasp those things that we know intuitively to be real and vital for our wholeness, but that we cannot see or touch or measure. I am often cheered by the anecdote that Einstein had a sign in his office that read, “not every thing that counts can be counted and not everything that can be counted counts.” A more useful approach would be to examine the proposals that can be made to improve what we know to be deficient, knowing that we have to be incremental in the major changes to be made.

Beyond the aspect of definitional precision, we accept that there is some intrinsic value to health itself, and that health is also valued for making it possible to work and to enjoy leisure. Let me refer again to Sigerist, who, in a lecture on health that was part of a series on “Religion in the Light of Sci-

ence and Philosophy,” examined the background to the notion of health as something valuable for itself and to be promoted, taking us back to classical Greek society. The health of individuals—free ones, at any rate—was one of the centerpieces of the Greeks’ existence, and represented the condition of perfect equilibrium. The attention they paid to their diet and exercise to maintain perfect health seems almost narcissistic to us today. But then came the Roman domination of the Hellenic culture, and this engendered a more utilitarian and pragmatic approach. Subsequently, Christian understanding and practice in health were founded more on hygiene and were certainly more catholic, as opposed to the aristocratic focus of the Greeks.

A plausible thesis might be that this catholic approach to health waxed and waned, but found its crescendo in the great movements of the eighteenth and nineteenth centuries, which saw men like Allison, Villerme, Virchow, and Chadwick emphasize the social origins of the poor hygiene that caused the illnesses of the underprivileged. The means of preventing ill health were to be found in social and sanitary engineering. It has been said that the growth of the germ theory of disease and the impressive advances in medical science and technology led to a decline in interest in the sanitary and social measures that are necessary for the people’s health, and there has been a virtual hijacking of care for the public’s health by an increasingly medicalized system.<sup>5</sup> This may well be so.

However, one of the most significant events of modern times that emphasized very much the social among the other dimensions of health was the landmark publication of the Lalonde report—*A New Perspective on the*

*Health of Canadians*—in 1974.<sup>6</sup> This has rightly been hailed as a watershed in our thinking about the public’s health, as the report focused on population health and those factors that influence it. It elaborated the “health field” concept with four components: biology, environment, lifestyle, and health care organization. These have been modified subsequently, but the basic concept remains: there are factors that influence or determine health beyond the capability of the health care services.<sup>7</sup> It is interesting that in putting forward the notion of health promotion, the report grounded the major strategy in the changing of lifestyles, and clearly focused this more on the individual.

The timing of this approach and its geographical origin are of interest. I wish to pose here a long historical sweep in which the world—at least the Western world—has moved from an aristocratic approach of the promotion of the health of the few, through the prevention of the disease of the many, to a stage in which we now advocate for the complementarity between the prevention of the disease of the many and the promotion of the health of the many. It is a matter of speculation whether this growth of interest in applying health promotion to the many would ever have taken place if there had not already existed a sizable portion of the world’s population that could afford to be less preoccupied with the prevention of diseases, although these still constituted a scourge for much of the world’s poor and socially marginalized. And it is perhaps not accidental that the impetus for the focus on health promotion for the many should have arisen in Canada, which is often credited with maintaining a more egalitarian approach in all health matters. The current

<sup>6</sup> Lalonde M. *A New Perspective on the Health of Canadians*. Ottawa: Government of Canada; 1974.

<sup>7</sup> Evans RG, Stoddart GL. Producing health, Consuming health care. *Social Science and Medicine* 1990; 31: 1347–1363.

force driving us to see the relevance of both approaches is undoubtedly the increasing interconnectedness that is characterized as globalization.

It is not uncommon to propose that the State be assigned the responsibility for health promotion as an integral function of public health. This view is not new, and Virchow, in his crusade for medical reform in 1848, wrote:

*[The State] must help everyone to live a healthy life. This simply follows from the conception of the state as the moral unity of all individuals composing it, and from the obligation of universal solidarity.*<sup>8</sup>

But today, even The State's competence to deal with those areas that are traditionally recognized as the very bread and butter of public health has been put in question. Laurie Garrett, in her book *Betrayal of Trust*, points out with gripping detail that the occurrence of recent epidemics and the possibility of even many others occurring are frightening proof that the nations of the world have betrayed the trust placed in them by their people, and that there has been a collapse of global public health.<sup>9</sup> There is inherent trust to protect the public, especially from the threat and reality of infectious disease. She writes:

*The only way to cope with the developing world's overwhelming problems is to build effective public health systems. Such services monitor the health and wellbeing of its citizens, identify problems in the environment and among the members of its community, and establish pub-*

<sup>8</sup> Rather LJ, ed. *Rudolph Virchow: Collected Essays in Public Health and Epidemiology*. Volume 1. Canton, Massachusetts, Science History Publication; 1995.

<sup>9</sup> Garrett L. *Betrayal of Trust—The Collapse of Global Public Health*. Hyperion: New York; 2000.

*lic health practices to address these problems, including the problem of whether proper health care is accessible to all.*

Given the numerous gaps that exist in providing even basic surveillance of diseases—such as of plague, which has been with us from biblical times—and the feeling that somehow some of the more fundamental bases of public health are being ignored, it is a major challenge to demonstrate the relevance of health promotion as a concept grounded in principles that are equally valid for those who still feel pressed to do battle against preventable diseases.

We have fortunately left behind us the stage in which there was a sterile polarization between the State's attention to the health of the population versus the health of the individual. There is no doubt of the applicability of the strategies of health promotion to individual behavior. And while there is no negating that the State has the responsibility to make the social environment as favorable as possible for individual behavior, or that individual behavior is facilitated and reinforced by the group's behavior, there is no avoiding the importance of individual volition and responsibility.

The Ottawa Charter still represents the essential formulation of what health promotion is about, and it says clearly that health promotion action means building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting the health services.<sup>10</sup> I will not discuss these in detail, as, except perhaps for the first, they are relatively easy to understand. I have always been intrigued by the concept of healthy public policy, however, and the Second Interna-

<sup>10</sup> Ottawa Charter for Health Promotion, First International Conference on Health Promotion, Ottawa; 1986.

tional Conference on Health Promotion, held in Adelaide, Australia, which dealt specifically with this, advanced our understanding considerably.

I understand public policy to mean the guide or framework for State action, and healthy public policy means for me those guides that seek to promote or restore health. One problem I face is that since the determinants of health are so expansive and touch almost all aspects of life, then healthy public policy would apply to almost all State policy. Indeed, the recommendations from the Adelaide Conference defined healthy public policy as one “characterized by an explicit concern for health and equity in all areas of policy and by accountability for health impact.”<sup>11</sup>

We note the reference to all areas of policy. Therefore, if income inequality is associated with poor health outcomes, for example, then healthy public policy would entail measures for income redistribution. With the current movement towards a system of social organization that favors increasing income inequality, a public policy to address this possible cause of ill health obviously becomes problematic. The political implications of policy formulation over such a wide range of issues are numerous, and many of them would clearly lie outside the purview of the traditional health sector. In addition, the possibility of convincing other sectors to adopt policies intentionally because of their impact on health, poses difficulties in the majority of our political systems.

The matter becomes more complicated when State action is called for in areas that lie outside of what may be called traditional public health but that are still focused on communicable diseases. Communicable diseases un-

doubtedly pose threats to the body public, and there is not likely to be any questioning of the State's responsibility here, as there are clear population interests.<sup>12</sup> But in those cases in which the externalities are minimal, it will be difficult to engage citizen interest, which is often one of the prerequisites for the generation of any public policy. Buchanan, in his theory of public choice, explains why individuals in their private capacity in economic terms seek to “maximize their utility function, but as voters acting in a political process have entirely different perceptions on what is appropriate.”<sup>13</sup> Thus, many of those health policies that do not have obvious individual benefit are unlikely to generate popular enthusiasm. In general, we in health have very little concept about how these political processes move towards the formation of policies and how to influence them.

From the perspective of an organization like ours, one of the most important decisions we can make is to advocate for specificity in addressing healthy public policy. We cannot address all the policy aspects of all the possible determinants of health. Similarly, it is obvious that the principal strategies of health promotion can find application in almost all aspects of the work of a health organization, and throughout this report there will be numerous examples of the health promotion focus. Health promotion is applicable to the actions taken to prevent and control noncommunicable *and* communicable diseases, although much of the very early focus was on the noncommunicable diseases—those that were supposed to be attributable to unhealthy lifestyles and practices. Health promotion finds application in the area of environmental health, as well, and some of the essential aspects of

<sup>12</sup> Marmor TR. Healthy Public Policy—What does it mean, who is responsible for it, and how would one pursue it. Program in Population Health; August 1989. Internal document.  
<sup>13</sup> Buchanan JM, Tollison RD, eds. *Toward Analysis of Closed Behavioral Systems in Theory of Public Choice, Political Applications of Economics*. Ann Arbor: The University of Michigan Press; 1984.

primary environmental care, for example, are grounded in the health promotion strategies. It was, therefore, a conscious decision to structure our Division of Health Promotion and Protection so that it would not have to deal with every application of the strategies of health promotion to every possible health problem. Our Division, in fact, is based on the logic that by concentrating on its three programmatic areas it could show most clearly the application of and results from the critical strategies.

Health promotion is very much here to stay. We have gone past much of the polemic that attended the characterization of any field of study and practice. It is for us to show that there is a practical application of the concepts embedded in health promotion and that, in the final analysis, the efforts in this field result not only in our populations enjoying health, but also in every citizen glorying in the health he or she enjoys. It may not be something new under the sun, but the sun may now be shining more brightly upon it.