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Modernity, Public Health, and Health Promotion
A Reflexive Discourse

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1. Introduction

Reflecting on the nature of evidence produced with regards to health promotion, one of us (McQueen, 2001) recently argued that health promotion could not yet claim the status of a scientific discipline. One symptom for this, McQueen noted, was the absence of a largely agreed upon corpus of theoretical concepts and propositions that would rally those who are engaged in the discourse or in the practice of health promotion. In established science, such a corpus makes the content of introductory textbooks and as a consequence of the large consensus about the objects and methods that constitute a discipline, the table of contents of most contemporaneous introductory textbooks are very similar. Such consensus and the accompanying uniform content are still lacking in health promotion, and it is certainly not our intention that this book should become one. Quite the contrary, our aim with this book is to offer for discussion a theoretical perspective for health promotion. Such a theoretical perspective, we argue, is necessary to support exploring the role of health promotion in contemporary society and to inform our response to the challenges facing the development of the health promotion knowledge base and practice. These are necessary conditions if health promotion is to evolve into a profession (see Pelikan, Chapter 6).

Over the roughly quarter century of its young history, the issue of a theoretical basis for health promotion has come up regularly. Interestingly, however, very few among those contributions seemed to be in associated with the theoretical discussions that were taking place in the preparation of the 1986 meeting in which the Ottawa Charter was adopted. As the codification of a field and the institutionalization of a given discourse, the Ottawa Charter,[2] with its five strategies for action does not make strong references to its own theoretical underpinnings. In addition

[1] The findings and conclusions in the report are those of the author(s) and do not necessarily reflect the views of the Centers for Disease Control and Prevention.

[2] The term Charter is itself a strong statement about the official and institutional nature of the propositions contained in the Ottawa Charter. It is a short document aiming at a broad and diverse audience with a clear goal of orienting action.

to the Charter itself that was a product of the conference, the group of scholars and public health officials involved in this endeavour also produced two major documents. The first one often referred to as the "Concepts and Principles" document is relatively unknown and was mostly circulated by the working group members.[3] The second paper was an article published in 1986 in *Social Science Medicine* (Kickbusch, 1986). Although it was available for a potentially larger diffusion than the "Principle" document, it is rarely cited in relation to the Ottawa Charter. Meanwhile, in the past two decades the Charter has acquired a life of its own.

Going back to these two documents twenty years later, one is struck by the fact that together they provide a solid foundation for the development of a knowledge base and a professional practice for health promotion with a strong emphasise on the paramount role of the social organisation of life in the making of health for both societies and individuals. "A new perspective is needed on lifestyles, one which places them firmly in the context of broad social trends and defines them as inherently social in origin and in growth" (Kickbusch, 1986, p. 124). The framework for health promotion actions according to the "Principle" document is formed by the health inequalities that follow from social inequities. The knowledge base for those actions should be multidisciplinary, making a large place for theories that help to understand the functioning of society and how change occurs and can be oriented. Finally both these documents situate health promotion in the continuity and a development of public health and conceived it as the public health answer to the challenges posed by our changing society.

In a sense, this book takes up where those two documents ended twenty years ago. Collectively reflecting upon the role and meaning of health and health promotion in our contemporary society, our group proposes that health promotion has been implicitly elaborating a discourse and a practice for public health in modernity. This book is about providing categories in which one can reflect that discourse and practice. Before doing so however, we felt a need to map out what, as a group, we agree to consider as the starting point of our search. This chapter presents what we believe the core of the field that we call health promotion looks like.

2. Health Promotion: Neither a Profession Nor a Discipline

For many in health promotion, the Ottawa Charter provides the founding characterization of the field of health promotion.[4] The World Health Organization's

[3] This document was produced and printed as a "taxi" document, meaning it was designed to be given out when someone, metaphorically traveling with one in a taxicab, would ask what health promotion was all about. Many copies were distributed, but few original copies of this printed document probably remain extant. We reproduce this document as an appendix of this book so it can be widely available and placed in historical context. The enormous progress of sociology regarding the structure/agency issue and the radical transformations of our society following the fall of communism and the acceleration of globalization could not be foreseen by the documents' authors.

[4] No doubt the Charter has gained wide currency since its formulation. It was the consensual product of a limited group of people, meeting in Ottawa, interested in health promotion. No

based Charter essentially offers an orientation for public health action along five strategies.[5] For us, the Ottawa Charter, together with its accompanying documents, represents the first attempt to codify an approach to public health practice that has been developing since the 1970's[6] in response to the profound transformations that Western societies were experiencing. In other words, we understand health promotion as a strategy for public health that reflects modernity. That strategy was developed and formally adopted in the beginning of the 1980's. Although initially it was rapidly infiltrating many government agencies and public health organisations throughout the world, this institutionalisation process has slowed down in many jurisdictions. It is not that the idea, principles, and strategies of health promotion are no longer relevant or implemented in public health practices, but rather that the term "health promotion" itself, as the denomination of a sector of activities such as government branches or agencies, seems to have become outdated in countries like Canada and the UK. So paradoxically, although a lot of the growth in health promotion has taken place in institutions, it has not yet developed into institutional recognition, neither as a science nor as a profession.

Of course some people would strongly disagree with this point of view, citing the establishment of departments of health promotion, offices of health promotion, and other examples of "names on the door." However this phenomenon appears to be rather short lived and in more recent years there have been concerns among many practitioners of health promotion that the budding institutionalization of the field is rapidly disappearing. To a large extent health promotion is being seen as a generalizing principle of approach that is literally a good thing when it operates across all the dimensions of a public health institution.

Although a fair number of people who claim the identity of health promoters would also legitimately declare that of scientists, in light of their fundamental training in a discipline-based academic degree, most would agree that health promotion itself is not a scientific discipline. There are still too many debates on what is health promotion about (topics and themes of interest), about the epistemological posture appropriate for developing the knowledge base of health promotion and about the methodological apparatus to be deployed to produce that knowledge. In addition, health promotion is still lacking the institutional tools that would make it recognized as a science. For example, there exist only a few health promotion

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document, no matter how carefully constructed, can claim to be all inclusive and capture every interest in an emerging field. Nonetheless, it represents the only document that is a product of several discussions, workgroups and deliberations held by groups of concerned individuals representing multiple disciplines and perspectives. In that sense it was created in the spirit of health promotion.

[5] For those readers less familiar with the Ottawa Charter, those strategies are: 1) developing personal skills, 2) fostering supportive environment, 3) strengthening communities, 4) reorienting health systems, and 5) developing healthy public policy.

[6] Indeed, the Canadian policy document entitled "Perspective on the Health of Canadian" that was presented by the then Canadian Minister of Health Marc Lalonde, is often cites as one of the important building block & for health promotion, together with the WHO Alma Ata Declaration of 1978 that established the global goal of "Health for All in the Year 2000".

departments in universities, therefore diplomas in health promotion, whenever they exist, are usually sub-specialties of other degrees, most often in public health but also in nursing or in psychology. Despite this lack of institutional credit, there are some indications that health promotion knowledge is gaining recognition. The number of scientific journals dedicated to health promotion continues to grow, as well as the number of research centres and academic units that use health promotion in their title. Those centres and units often include scientists from various university departments together with researchers appointed by organisations from the health system, reflecting the fact that the scientists engaged in the production of health promotion knowledge do so from a multi-disciplinary perspective, mainly found in the health or in social sciences. As an interdisciplinary field, health promotion has yet to reconcile the theoretical and methodological perspectives that were only rarely brought together to look at the same reality.[7]

In addition, we believe that health promotion is not strictly a profession per say, and several reasons support this assertion. Firstly, a lot of what we consider health promotion practice occurs totally outside of the codified professional world. In countries like Switzerland, Canada and Australia, private and public foundations fund cutting edge health promotion projects designed and implemented by community organisations that are composed of 'lay people' with little professional training. Interestingly, some of these projects have lead to real social innovations when properly nurtured by caring funding and/or research institutions. Secondly, there are few organisations dedicated to the professional advancement of health promotion. Those who engage in health promotion practice regroup either in special sections of broader professional associations such as in the Public Health Education and Health Promotion Section of the American Public Health Association (see www.jhsph.edu/hao/phehp), in associations where they are paired up with other professionals occupying overlapping fields, such as in the International Union for Health Promotion and Education (see www.iuhpe.org), or on a project basis in a loose network such as the Réseau francophone des intervenants en promotion de la santé (see www.refips.org). Thirdly, there is very little consensus on what would constitute a health promotion practice and this is evidenced by the persisting debate about whether health education is part of health promotion. It is also illustrated in the failure to establish licensure and professional practice guidelines for the field. In short, almost anyone, trained in any discipline, who wishes to take on the moniker of "health promoter" may do so without fear of censure or disapproval by a standardized professional body.

We think that it is important at this point in the evolution of our field to reflect on the meaning and consequences of this lack of a distinctive institutional structure for health promotion, and whether it is important to develop one such structure. The absence of a distinctive structure certainly makes health promotion more

[7] One could argue that sociology of medicine had brought together disciplines from these two fields. This is only partly true because they were not looking at the same object. In fact, in sociology of medicine the latter forms the object of enquiry of the former. This is a debate that goes well back to the 1960's debate on sociology "of" versus "in" medicine.

vulnerable to decisions made by others, particularly with regard to the power to dictate programmatic directions. The difficulty to secure funding for research and programs in health promotion is certainly a consequence of this vulnerability. The main response that health promotion has formulated to this threat has resulted in attempts to justify its existence by documenting the effects on some outcomes valued by policy makers and public health decision makers, from where most of its budget comes.

The absence of a distinctive institution also has certain advantages. The most obvious one is that those who engage in health promotion activities enjoy a greater freedom to innovate and experiment on new ways of addressing the problems raised by living in our society. In a little more than two decades, health promotion has been a formidable laboratory for designing and experimenting with new and innovative ways to address emerging and challenging public health issues. Some such programs that have been identified as inventive approaches such as healthy cities, healthy schools, health promoting hospitals have spread throughout the globe and have greatly contributed to the dissemination of the idea that health is produced and maintained in every day life. Moreover, these programs have also contributed to a profound reorientation of practice in the institution of public health. Instersectoral action, healthy public policy, population health assessment, public participation and the new governance, all those practices that are now integrated to various degrees into the institutional discourse of public health (see for example: The Swedish Health Policy Statement: Health on Equal Terms; The Québec National Public Health Program; The Pan Canadian Healthy Living Initiative), were initially introduced through health promotion programs and projects.

So if it is not a discipline, nor a profession, nor an institution what is health promotion? At the very least, health promotion is a structured discourse and a set of practices or what has been termed a "field of action" (McQueen, 2001). The increasingly numerous journals in which health promoters articulate a discourse and disseminate their ideas, together with the burgeoning number of conferences where health promotion issues are discussed and debated, is a sign that an original discourse is being elaborated upon and incorporated into other contemporary public discussions. Two features stand out from this dialogue: the emergence of a distinctive perspective on health; and a critical orientation towards action. It is notable that it took two outsiders from the field to identify these two gems in the crown of health promotion. Indeed, the epidemiologist Lester Breslow (1999) articulated the health promotion concept that health is a resource for everyday life and fuelled what he termed "the third revolution of public health". At about the same time, the sociologist-epidemiologist Len Syme, in a report commissioned by the Institute of Medicine, recommended that in order to improve population health, public health should modify its practice in a direction that has been widely advocated by health promotion practitioners (Smedley & Syme, 2000).

So as a discourse and a practice, although neither a scientific discipline nor a profession, it seems that health promotion has much to offer to the very well established field of public health. To take Breslow's words, it is nothing less than a "third revolution" and it is our contention that the renewal of public health that

health promotion is leading is much more profound than being only related to a conception of health.

3. The Third Revolution of Public Health

Several authors have used the revolution metaphor to describe the evolution of public health since the middle of the 19th Century (Susser & Susser, 1996; Terris, 1983), indicating that changes occurs in the field of public health through dramatic reorientations. To deserve the label of revolutionary such changes must affect the three fundamental dimensions that characterize systems of actions, such as public health: the direction or the finality of the system; its knowledge-base; and its practice (Potvin and Chabot, 2002). The finality establishes the target of the actions together with the set of objectives and goals that the system aims to achieve. The knowledge-base is both the substantive knowledge and the conditions that make possible the production of this knowledge about what constitutes the target of actions. The practice dimension encompasses the approaches developed to designing, implementing, and evaluating the actions that are necessary to attain the goals.

Terris (1983) identified two such revolutionary changes: the infectious disease and the chronic disease revolutions, and each of them can be described in terms of a dramatic change in finality, knowledge base and practice of public health. In addition to the traditional responsibility of the State to protect the health of its citizens, the infectious disease revolution pursued the goals of controlling and eliminating the threat posed by the great epidemics that had until then decimated human populations and prevented a steady and stable demographic growth. The knowledge base that fuelled this revolution was provided by the emerging and fast growing life sciences such as bacteriology, physiology and social statistics. While each of these disciplines was necessary to understand and address all aspects of transmissible diseases, one of the great achievements of the first public health revolution was to be able to integrate all these widely different knowledge into a coherent and comprehensive model of health and disease. In terms of practice, this first revolution was no less dramatic. Public health was no longer left to the initiatives of charity organizations or as an ad hoc answer to an emergency situation; it became integrated within the bureaucratic regulatory system that the nascent Nation-State was elaborating (Fassin, 1996; Porter, 1999). The complexity of the task at hand and the enormity of the means that were necessary for its completion required the mobilization of the resources of entire nations. This integration of the burgeoning scientific knowledge of life sciences with the population management capacity of the Nation-State provided to public health a jump start for the establishment of a practice founded on the authority of expert knowledge in the service of the common good.

Once transmissible diseases were mainly under control, chronic diseases became the leading causes of death, forcing a second revolution for public health. The fact that the majority of children lived to adulthood, and that women were surviving

childbirth were all incentives for embarking upon a new goal for public health, that of increasing human longevity through the prevention of chronic diseases. The knowledge base of public health grew with the integration of the rapidly expanding clinical sciences. The fight to cure chronic diseases has been stimulated by, and has stimulated in return, the development of experimental medicine and a plethora of bio-medical science sub specialties. The practice of public health has been transformed by a deep professionalisation movement. It became integrated in the established medical professions, such as physicians and nurses and a range of other emerging ones such as health educators, rehabilitation specialists, nutritionists and so on.

In a recent paper, Lester Breslow (1999) argued that the emergence of health promotion and the development of the Ottawa Charter for health promotion are signs that the field of public health is undergoing a third revolution. For Breslow, the fact that in many countries human longevity is reaching its upper limit and that individuals expect to live a long life relatively disease free, is demonstrating a shift in the public health agenda so that "some energy can now be devoted to advancing health in the sense of maximizing it as a resource for living," (Breslow, 1999, p. 1031). So health is no longer conceived simply as a "biological" feature of the human life, but a product that one should possess for as many years as feasible. Produced in everyday life, health encompasses all aspects of life. Defining health with such a comprehensive perspective requires an expansion of the current knowledge base, which is also characteristic of the third revolution (Potvin, Gendron, Bilodeau & Chabot, 2005).

If health is produced in everyday life then intervening on health requires knowledge about how individuals in society make decisions and act in a way that affects their health in their everyday life. Conversely it also necessitates an understanding of how societies change through the actions of, and inter relations among, those who constitute society. The production of health in everyday life also means that experts should come to a new understanding of their role. Their expertise has to become relevant in the management of everyday life. These new requirements regarding experts' role are reflected in the realignment of the knowledge base for public health. First, in terms of scientific disciplines, there is a greater integration of knowledge from a wider range of the social sciences, some even questioning the epistemological foundations of epidemiology (Potvin et al., 2005). Second, lay knowledge is also increasingly valued as a legitimate source of knowledge that should complement scientific knowledge in the construction of evidence to support or evaluate action (McQueen, 2001).

Finally, in line with the integration of lay knowledge, the third revolution of public health is associated with a change in practice that is characterized by: 1) a strong reliance on citizens input and participation in decision making regarding health and public health interventions, 2) an integrated approach that both targets a variety of interrelated risk factors and the social conditions with which they are associated, and deployed activities in a multiplicity of settings.

These changes in the definition of health, along with changes in the knowledge base that is the foundation for interventions, and in the practice of public

health have been heralded in the health promotion discourse since its inception. In all these, health promotion has been avant garde and leading the way for public health. The dialogue between health promotion and public health is well established in the field, and there are many examples of its fruitfulness. In its National Public Health Program for 2003–2012 for example, the government of Quebec identifies health promotion as one of four core function of public health, at the same level as prevention, protection and surveillance (Health and Social Services Québec, 2003). In its Pan Canadian Healthy Living Initiative, Canada has clearly defined both the improvement of health and the reduction of health inequalities has two equally important overarching goals (Secretariat for the Intersectoral Healthy Living Network, 2005). In addition, the strategies called for "integration" and for "partnership and shared responsibilities" as guiding principles for the Initiative. Finally, the "Health on Equal Terms" Swedish health policy identifies as the five priorities determinants of health that lie in the social realm (Swedish National Committee for Public Health, 2000).

We strongly believe that public health constitutes an obvious institutional niche for health promotion. There is increasing evidence that at least in its spirit, the health promotion discourse and practice have permeated deeply into the discourse and practice of public health. As a consequence, it should be clear that those engaged in health promotion should have a good understanding of public health in order for health promotion continue to be a rich field for innovation and experimentation for public health. Conversely, health promoters should also have a good grasp of what is distinctive about health promotion.

4. Conclusion

One of the main thesis underlying this book is that in its short history, health promotion has not paid enough attention to theories of the social science. The health promotion discourse has not been able to adapt and develop the proper tools to reflect upon the theoretical bases of what constitute its distinctive added value to public health. The third revolution of public health identifies that health is recognized as a social phenomenon as well as a biological and psychological one. Public health, therefore, should engage in a sustained dialog with social science and consider not only borrowing its methods and instruments, but also some of its theoretical understanding of the world, and how it shapes human action. One of the important roles for health promotion is to be the interface and to provide a space for this dialogue to happen between public health and the social sciences.

In the field of public health, social epidemiology also claims to set up bridges between social sciences and public health. Several influential social epidemiologists hold graduate degrees in sociology and health economists were instrumental in the elaboration of the population health discourse that many falsely attribute to social epidemiology. Our position is that there is a lot of room for diverse bridges between the social sciences and public health. We do not claim this land for the exclusive use of health promotion; neither do we think that it uniquely belongs

to population health or to social epidemiology. Our stand is that the same way that social epidemiology is ideally equipped to explore the role of the social determinants in the making of the population's health, health promotion is uniquely positioned to bring to public health a social science informed understanding of its practice, of its role as a social institution and on the significance of health in our contemporary society.

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