Concepts of health and health promotion

Critically analyse the concepts of health and health promotion and apply your understanding to the development of health work with young people/communities. Within this essay, I aim to discuss, critically evaluate and demonstrate an understanding of the concepts of health and health promotion and apply my understanding to the development of health work with young people and communities. The Cambridge Advanced Learners Dictionary (2006) gives one definition as ??? the condition of the body and the degree to which it is free from illness, or the state of being well???.

The perception of health as described by the World Health Authority in 1948 (citied by Naidoo & Wills 1994) ??? is a state of complete physical mental and social well-being, not merely the absence of disease or infirmity???. This definition, I believe, is impractical to achieve, as a ??? complete??? state of health means that all factors affecting one??™s health must be positive and in balance at all times. In 1986 the definition of health was expanded by the World Health Authority to include a community concept of health and stated that ??? Health is the extent to which an individual or group is able, on the one hand, to realise aspirations and satisfy needs; and on the other hand, to change or cope with the environment. Health is therefore seen as a resource for everyday life, not an object of living; it is a positive concept emphasising social and personal resources, as well as physical capacities ???, citied by Naidoo & Wills 1994. This definition places responsibility on individuals or the community to maximise, achieve and use resources effectively and demonstrate a strength of mind when facing new circumstances and I believe that this is a better-quality definition. Health in my understanding

concerns the physical, emotional and psychological aspects of well being within one??™s self.

Social issues surround the concept of health making it difficult to limit it to only one definition and perspective, as health is affected by the society and culture we live within. Dahlgren & Whitehead??™s model (citied by Adams et al 2001) demonstrates this clearly by illustrating the main determinants of health as socioeconomic conditions, living and working conditions, social and community conditions, individual lifestyle and age, sex and hereditary factors. This model is holistic and demonstrates properly, all of the factors that can affect a persons health, the implications of these for healthwork are that workers are focused on impacting all of these levels in order to improve health . Medicine has developed over time, the knowledge and practices of medicine has changed and expanded, in Barry & Yuill (2002) they describe the social construction of medical knowledge as ??? the degree to which medical knowledge is a product of those engaged in its practice???, this means that medicine and medical knowledge is limited to those who are educated and trained in those professions by those who experienced medical learning in the same way. This process creates a power imbalance as the knowledge stays with those who are privileged enough to access it, it is proposed by Barry & Yuill (2002) that ??? medical knowledge is a form of power, with the potential to control and influence the lives of its recipients???. Barry & Yuill (2002) describe that power is given through knowledge and there are various perspectives of health that include lay understanding, medical understanding and alternative understanding. The dawn of the scientific age saw society move away from religious and

superstitious beliefs to scientific ways, experiments were carried out and the knowledge was drawn together and taught to medical students.

Stacey (citied by Barry & Yuill 2002 p18) argues that the ??? developments that took place laid the basis from which biomedicine developed.??? Biomedicine is the traditional underpinning of health, based on a medical approach and is most frequently used. The development of biomedicine as the dominant perspective on health has occurred as the evidence developed was scientific and was seen as ??? unbiased, rational and purely descriptive of the natural word.??? Barry & Yuill (2002 p19). However, Naidoo and Wills (1994) describe assumptions of the biomedical view of health and state that the body is like a machine, it is connected in all parts but parts can be treated individually. Biomedicine in addition, assumes that health equals all parts of the body functioning correctly, this assumption does not allow for a disabled person to achieve health.

A biomedical view expects illness to equal a measurable malfunction, disease is caused by internal processes, individual failure to regulate lifestyle and pathogens invading the body. These assumptions can be criticised as they do not allow for other causes of illness and that all illnesses will have the same characteristics in every patient., this in turn could lead to patients being undiagnosed. The final assumption described is that medical treatment aims to restore normal functioning, the message here is that ??? normal??? equals good, again this discriminates and is critical of, various members of society because who decides what is ??? normal??? White 2002 describes how the scientific medical explanations are used to regulate personal behaviour by imposing compliance with social roles, sociologists came up

with the term medicalization to describe how scientific knowledge is being applied to human behaviour. Zola (citied by MacDonald and Theodore 1998 p10) who raised the issue of the medicalization of everyday life, argued that anything could be labelled an illness or medical problem if it affects the body or mind and causes illness. He states that ??? medicine, because it is concerned with the wellbeing of individuals, can intrude upon any aspect of everyday life it perceives as affecting health.??? Medicalization is a critical concept because it highlights the fact that medicine is not a purely scientific activity but a social activity.

This means that illness is not based on biology but on experience and illnesses are constructed. I believe that the medicalization of society reinforces anxieties about health and fears about disease. From considering the historic development of biomedicine and the concept of medicalization it is important to consider some of the critiques of biomedical model. (Gerhardt 1995) Archie Cochrane, during the 60??™s and 70??™s was concerned with the ??? untested assumptions??? of biomedicine, he called for the use of randomised controlled trials to evaluate the ??? effectiveness and efficiency??? of medical care, to challenge the assumptions. Thomas McKeown wrote in the 70??™s and argued that social processes made the biggest impact on infectious diseases and discussed living conditions and nutrition as key reasons. He also suggested that personal lifestyle choices had become a major determinant of health and medicine should be concerned with prevention as well as care.

During the 1980??™s Anne Oakley provided a strong critique of biomedicine and medical practice that argued that the male dominated medical

profession has manipulated and defined women??™s problems and roles, without considering women??™s experiences. I have considered the ways in which different social theorists have interpreted the concept of health, and the social activity and power structures involved . I will now provide a understanding of health education and of health promotion within a historical and political context. Davies and Macdowell (chapter in Lincoln and Nutbeam 2006) trace health education back to public health movements in the nineteenth century. Winslow 1923 (citied by Davies and Macdowell) stated that ??? education is the keynote of the modern campaign for public health???. His writing formed that basis for public health education to become a major tool in addressing health.

During the second half of the twentieth century, the existing efforts to promote use of the health services were accompanied by concern with ??? unhealthy lifestyles??? and individual and personal behaviour were the centre of attention. The politicians at the time found the concept of health education ??? irresistible ??? as it appeared to reduce the demand for health care and also tackle emerging health threats. Various national bodies were formed during the 60??™s and 70??™s in western countries and in 1972 the Labour government promoted the ??? development of community based integrated primary health care??? and by the end of the 70??™s many countries had developed ??? delivery of community based health programmes??? that has a deep focus on prevention and community participation (Davies and Macdowell 2006). In 1986 the Canadian document entitled ??? Achieving Health for All: A Framework for Health Promotion was

presented at the ??? International Health Promotion Conference??? in Ottawa and became known as the Ottawa Charter.

This charter gave an understanding of health promotion as it gave a framework for action that included building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorient health services. The World Health Organisation (1986) described health promotion as ??? the process of enabling people to increase control over, and to improve, their health.??? (Monash University 2001) The Ottawa charter gave a consensus on the definition of health promotion, the prerequisites for health and three key principles; reducing inequalities, increasing prevention and enhancing coping, that enabled organisations to plan health promotion within their societies and communities. (Lawton, and Cantrell 2004)Health promotion acts as an umbrella term to encompass traditional health education, health education was based on the individual biomedical model of health and health promotion is designed to tackle structural inequalities and aimed at population and communities.

The relationship between the two concepts is that they are both linked to health policies that governments set up, as health promotion has led to the development of national government agencies and local infrastructure for the ??? delivery of community based health programmes???. (Davies and Macdowell 2006). There are various models and approaches to health work I have selected two that represent different approaches to health promotion. The first model is proposed by Naidoo and Wills (1994) who describe five approaches, each approach has an aim, a method and a worker/client

relationship. The first is the medical approach, which identify those at ??? risk??? and is an expert led approach, the second is behaviour change, which asks people to lead ??? healthier??? lifestyles and take responsibility for their health, this approach is again expert led and the ideology is one of victim blaming. The educational approach is concerned with increasing knowledge and skills in regard to health, this approach may be expert led but the user may have some input.

Empowerment is listed as an approach to work alongside user??™s to address their needs, the expert acts as a facilitator in this process and users can become empowered. The final approach is social change, which tackles inequalities in health, this approach involves social policy and is a top down method. In 1991 Beattie proposed a framework for analysing health promotion and it identified ??? activities around the dimensions of authoritative/negotiated and individual/collective??? these four dimensions are set on lines at opposing ends to each other and are placed horizontally and vertically. Therefore the relationship between the ??? authoritative??? and ??? individual??? includes health persuasion techniques which could include behaviour change, the relationship between the ??? authoritative??? and ??? collective??? is one of legislative action, which is a top down approach.

The relationship between the ??? individual??? and ??? negotiated??? is a client centred empowerment approach and the ??? negotiated??? and ??? collective??? relationship is the community development approach, which is a bottom up approach based on the communities needs. I believe that Beattie??™s (1991) model is the most appropriate model to use for health

promotion as it allows practioners to move between the four relationships to map the practice that is taking place and make use of more than one method if required, as practice ??? rarely fits into a single one.??? Each model uses the term of ??? empowerment", empowerment is a process not a product, it is an ongoing process, by giving information I can act as a facilitator in this process to change power relationships.

Empowerment is based on the participation of the community, it was agreed that for the purpose of the presentation (see appendix) that community empowerment was the most appropriate model to use. Labonte (1994 s. l.) produced a community development empowerment holosphere that describes five overlapping spheres that start with personal care, leading to group development, to community organisation, coalition advocacy and finally political action. Laverack (2004) continues with this model and argues that community empowerment is an outcome and a process which ??? progresses along a dynamic continuum.

??? However there are sociological critiques of health promotion, MacDonald and Theodore discuss health promotion placed in a medical model context and states that it is aimed at individuals without addressing the ??? wider socio-economic and environmental determinants??? and leads to ??? victim blaming???. This is a structural critique and power relationships are still present in the health promotion work when it is placed in a medical model. Douglas (1995) argued that health promotion could not be disconnected from dominant ideologies and social policy, in regard to race and discussed the extent of social policies angle??™s during the past 50 years that include ??? assimilation???, ??? integration??? and ??? multiculturalists???

that have underpinned health promotion for ethnic minorities. This has meant that these groups have experienced racism within the health services provided for them, they have been expected to give up their cultural identity, stereotyped for their health through culture and currently there is not enough emphasis on racism due to multiculturalism. Daykin & Naidoo (1995) had difficulty with the ways in which sexism has prejudiced health promotion. They described that medical knowledge is based on a white middle class males perspectives, therefore women??™s health has been of secondary importance. They discuss the ??? medicalization??? of women??™s condition such as pregnancy and the menopause, what was one seen as a natural process has now become ??? treatable???. Women are also seen as providers of care within society therefore making them responsible for health.

Public policy in the UK is now characterized by an recognition that tackling inequalities requires complex steps, and that these steps are likely to be effective if they are based on aspiring to equalize social inequality through building community capacity, participation and consultation with communities. It is therefore imperative that politicians consider the sociological critiques when creating policy. When practioners consider carrying out health work there is a process to follow, this is demonstrated within the appendix but is commonly accepted that an aspect of health must be chosen as the focus, the needs for such work must be assessed, a set of aims and objectives have to be drawn up, the practioners decide which model or approach to health work will be used, the methods of the work agreed, measures in place to safeguard against discrimination and ensure

the work is ethical and a through process of evaluation designed to measure all outcomes. A vital aspect of health promotion is the importance of values in health work and the ethical principles involved in developing anti-discriminatory health work. Health promotion must always be carried out ethically, this applies to the collection, analysis practice and sharing of information. Ethics are generally understood to be a commonly agreed framework that encompasses personal and professional standards, including shared morals, values, and beliefs, within which to operate. ??? The bottom line of good youth work practice rests on the worker??™s values.??? (Young 1999 p98).

The ethical issues to consider within health work are the right to autonomy, people do not have to participate. The principles of beneficence and non-maleficence must be applied and upheld, justice, in a sense of resource allocation, respect for the individual and the group and common law. (Naidoo & Wills 1994) By creating a code of conduct that is open to review, has boundaries, sets guidelines for anti-discriminatory practice, discusses morality and exploitation, practioners can further establish a framework to work within. The hypothetical health promotion project that we carried out has its own code of conduct and it can be seen within the appendix. I believe it is imperative for all practioners to understand the ethical issues that can arise when carrying out health promotion and the tools that are available, such as the code of conduct should be included to ensure that the participants are protected. Within the essay I have referred to the hypothetical exercise that I took part which demonstrated my application of theory to practice.

An appendix is attached of the presentation which contains all details relating to the aim and objectives, model and methods and code of conduct. The appendix demonstrates my ability to translate theoretical understandings of health, professional power and health promotion to the development of anti-oppressive health work with young people and communities. I have examined health as an aspect of social action and believe that the concept of health is contested and health of the individual relates to all of the determinants of health.

Word count 2750Reference ListAdams, L; Amos, M & Munro, J (2002) Promoting Health. Sage. Barry, A. M & Yuill, C (2002) Medical Care or Medical Control in Barry, A.

M. & Yuill, C (2002) Understanding Health. Sage. Bunton, R; Nettleton, S; and Burrows, R (1995)The Sociology of Health Promotion. Routledge.

Cambridge Dictionaries Online (2006) Cambridge Advanced Learners Dictionary. Last Accessed 05/03/06. Available from http://dictionary. cambridge. orgDavies, M & Macdowell, W (eds) (2006)What is Health Promotion pp1 7 -14 in Lincoln, P & Nutbeam, D (2006) Health Promotion Theory. Open University PressDaykin, N & Naidoo, J (1995) Feminist Critiques of Health Promotion. In Bunton, R; Nettleton, S & Burrows, R (eds) The Sociology of Health Promotion. Routledge.

LondonDouglas, J et al (1995) Developing Anti-Racist Strategies. In Bunton, R; Nettleton, S & Burrows, R (eds) The Sociology of Health Promotion. Routledge. LondonLabonte, R. (1994) Community Development Model. (s. l.

)Laverick, G (2004) Health Promotion Practice: Power & Empowerment. Sage. London.

Lawton, S & Cantrell, J (eds) (2004) District Nursing. Providing care in a Supportive Context. Elsevier LtdMacDonald, T (1998) Health Promotions, Ancient and Modern and Their Relationship to Biomedicine pp. 1-10 in MacDonald, T (1995) Rethinking Health Promotion: a Global Approach.

Routledge. Monash University (2001) ??? Health Promotion??? ??“ What is it Last accessed 14/07/01. Available from http://www. med. monash. edu. auMoon, G & Gillespie, R , Eds (1995) Society and Health.

Routledge. Naidoo, J & Wills, J (1999) Practising Health Promotion. Balliere Tindall. Naidoo, J & Wills, J (1994) Health Promotion: Foundations for Practice. Balliere Tindall.

PAULO. (2002) National Occupational Standards for Youth Work. PAULO. Great Britain. p2. White, K (2002) An Introduction to the Sociology of Health and Illness. London.

Sage. Young, K. (1999) The Art of Youth Work. RHP. Cromwell Press.

Sheffield. p98.