

## Global health promotion models: enlightenment or entrapment?

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### Abstract

This paper suggests that there is a tendency for health promotion to be located within models that consider health to be a product of a range of forces, with practice itself assumed to comprise a similarly wide range of activities. This paper develops a critique of this tendency that is essentially accommodating, all embracing and 'neutral'. It is argued that this leads to the masking of tensions between the conflicting values contained within the different elements of the models. We suggest that for health promoters, this is neither conceptually appropriate nor practically sensible. These notions are developed in five main stages. We start by defining some of the key concepts in the piece, e.g. the nature of a 'model' and examples of 'global' models. We then examine some of the general reasons why global models are favoured, with respect to the emergence of the UK's strategy for health, *The Health of the Nation*. The third stage of the discussion identifies and considers, within the British context, professional and governmental factors perceived to have driven this choice. The fourth aspect of the paper will introduce a critique of the use of global modelling. The paper concludes by critically questioning this evolving relationship, and suggests that it will be essentially conservat-

ive and unproductive. We end by reviewing the implications for practice and suggesting a useful way forward.

### Introduction

Some recent health promotion work seeks to realign perspectives on health, from strict bio-medical and individualistic models to more holistic and comprehensive approaches. This is not only of interest to academics but also of significance for the development of health promotion policy and strategies, particularly those from the World Health Organization (WHO, 1981). Within Britain, this need for the realignment of views is confirmed by three developments: continued concern about the impact of environmental hazards on health (DoH, 1996), continuing work on the relationship between material deprivation and health (DoH, 1995; Wilkinson, 1997), and a growing recognition of the vital role of democratic participation in building health strategies from the convictions, beliefs and energies of communities (Summers and McKeown, 1996). These major health themes have all attained a degree of legitimacy and found their way, in some modified form, onto relatively influential British agendas (DoH, 1991, 1992, 1996).

Inherent in this is the notion that there exists an on-going struggle to define the nature of 'health promotion'. This task is made more difficult because of the tension between two competing paradigms. The dominant paradigm consists largely of a bio-medical orientation directed at individuals through formal service provision or education, while the counter-paradigm questions the appropriateness and effectiveness of such approaches,

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and suggests that more profound outcomes are possible via broad social and political change. The dominant paradigm underlies the view of health promotion set out in the original Health of the Nation strategy document which argued that 'initiatives should continue to ensure that individuals are able to exercise informed choice when selecting the lifestyles which they adopt' (DoH, 1992). A different view, reflecting the counter-paradigm, is stated in Donald Acheson's final report as Chief Medical Officer at the Department of Health where his perspective is that 'analysis has shown that the clearest links with the excess burden of ill health are: low income; unhealthy behaviour; poor housing and environmental amenities. Thus, where people are in a position to exercise greater choice in their housing, environment, employment, leisure activity, and consumption generally, this has tended to be beneficial to their health' (DoH, 1991). This difference of view reflects not only competing evidence but also different values.

Perhaps the most surprising result of this tension between competing perspectives is the *apparent* ease with which innovative concepts have been introduced alongside more established orientations. This is doubly puzzling when it is remembered that major UK policy documents dealing with these themes, including 'Inequalities in Health' and 'The Health Divide', were given a hostile official reception (HEC, 1987; DHSS, 1980). An explanation is required and this paper will offer one. It will be argued that one driving force behind this surprising realignment has been the use of frameworks that have emphasized the *inclusive and comprehensive* nature of health promotion. The recent Health of the Nation document on Environment and Health specifically states that 'everyone can play a part in improving the environment... Public health involves everyone... Joint or community action can provide an impact on health much greater than when individuals and organizations are working alone... It is essential that these efforts are combined' (DoH, 1996). Everyone is seen to be a health promoter at an individual, community or organizational level.

The fact that potentially incompatible values on

health are being willingly accommodated within such statements may seem to suggest that this is a profitable way forward, and that a genuine shift in policy emphasis and political commitment is occurring (Catford and Parish, 1989; French, 1990). The main proposition of this paper rejects both of these suggestions and warns that the creation of what we will term 'global' health promotion models could inhibit constructive debate around alternative perspectives on health.

Two definitional issues will now be briefly addressed. For the purposes of this paper, global models are assumed to be models or perspectives which focus on simple additions of different health promotion activities, approaches, agents and/or levels of intervention. We are also conscious of the potential difficulties in employing the globalized, short-hand term of 'health promotion' throughout this paper, as it may imply that the authors accept current global definitions of health promotion. They do not, and there is a strong case for further work to establish a simple and unitary 'definition'. That is a task for another article. This paper wishes to engage the attentions of those currently called health promotion specialists, practitioners and lecturers. Some of these individuals will define the concept differently and employ it variably. However, most use the term health promotion in a particular and generally consistent fashion that is congruous with our view of seeing health promotion as a broad and varied term. Their perspective is accepted for the sake of engaging in a meaningful discussion now. This acceptance simply deals with current realities. Hence, we offer 'health promotion' as a generic term that contains a range of elements, whether these be based around, for example, determinants of health (Lalonde, 1974), 'types' of activity (Draper *et al.*, 1980) or epistemological expectations (Rawson, 1992).

Given these definitions, the theme to be pursued is that, despite good intentions, global models serve to hinder the development of health promoting strategies, a point already raised by a number of commentators. As far back as 1985, Carol Buck was questioning the potential for Lalonde's 'Health Field Model' to bring about environmental change.

Caplan (1993), Rawson (1992) and Labonte (1991) have all subsequently questioned the conceptual appropriateness of global models, and French and Milner (1993) have recently linked the use of them to expectations that surround health promotion practice. This paper develops both of these themes: the conceptual appropriateness of global models and perspectives, and the implications of their adoption for health promotion in the field.

The central argument will be developed in five stages. It will start by defining some of the key concepts in the piece, e.g. the nature of a 'model', some examples of what we define as 'global' models, and our vision of the nature of the relationship between professionals and the 'government'. It will then examine some of the general reasons why all encompassing models are favoured, with respect to the emergence of the UK's strategy for health, *The Health of the Nation*. The third stage of the discussion will identify and consider the two sets of factors perceived to have driven this choice: the aspirations of some specialist health promoters to present a formal image and attain credible professional status, and a pragmatic and largely symbolic acceptance by policy makers of the legitimacy of 'alternative' perspectives on health. The fourth aspect of the paper will introduce a critique of the use of global modelling. In this respect, it is suggested that, within the medium of such models, a new type of mutually beneficial relationship between health promotion practitioners and state agencies may be developing. The paper then critically questions this evolving relationship, and suggests that it will be potentially conservative and unproductive. In the conclusion, the implications for practice are highlighted and a useful way forward is suggested.

This paper will focus exclusively on the British situation, although the central themes and issues should interest a wider audience. There is a debate around the issue of globalization, with much to be learnt from other countries. A recent paper which reflects on developments in Cuba is recommended (MacDonald, 1996). This paper will not stray beyond British shores.

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## Assumptions

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There are a number of initial points that need stating. Our critique of global models is not intended to suggest that they are of no value. Clearly, they have offered valuable support to those who wish to promote a more broadly based approach to health policy and as such are commendable. Nevertheless, recognizing this should not preclude the possibility of being wary of what we perceive to be specific misuses of the sentiments contained within global models. In this respect, the paper should be read as a constructive criticism of the *application* of the ideas contained within global models rather than a simple condemnation of them *per se*.

In addition, our views on the nature of professional motives and their interaction with 'government' expectations require qualification. Whilst suggesting that there is a *tendency* for some health promoters to be passively compliant to the wishes of 'government' expectations in return for political favour, we also recognize that there are others who actively reject this relationship in favour of a more critical and 'oppositional' stance. In this respect, we accept the diversity of views and approaches amongst health promoters, whether they be health promotion professionals or practitioners with a substantial health promotion role as an integral part of their job or specialist health promotion officers and advisers required to initiate, plan, coordinate, monitor and review health promotion projects and programmes. This paper is written with both groups in mind.

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## The attraction of inclusive modelling

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Whilst accepting the ambiguity of the use of the term 'model' and as such the varied and at times confusing application of it, a number of general observations can be made.

Firstly, one can suggest that the use of defined models in helping to explain the complexity of the world is a central and deeply ingrained part of a number of fields, including politics, economics and education. This may be at the level of organizing

and understanding the nature of reality via a simple *description* of existing circumstances through to more sophisticated and ambitious attempts to define the *values and relationships* that exist within any situation (Rawson, 1992). Whatever the intention, one can identify a tendency to progress by extending thought towards an all-embracing picture of reality called, by Lyotard (1984), the drive for a 'grand narrative'. These ambitions can be recognized in the evolution of what we call 'global models' of health promotion. Based on what Rawson (1992, p. 217) calls an 'eclectic' vision wherein, 'all approaches to health promotion are equally plausible, since no one criterion is possible', such models have tended to develop frameworks that imply a comprehensive and inclusive image.

Broadly speaking, two types of model can be identified. Firstly, in relation to modelling health '*determinants*', models are characterized by the view that health status is a product of social, environmental, cultural, economic, political, behavioural, biological and health service 'fields' (Lafambe, 1973; Lalonde, 1974; Hancock and Perkins, 1985; Hancock, 1986; Raeburn and Rootman, 1989; Hancock, 1993).

This is complemented by a second type of model which seeks to understand the practical consequences of such global thoughts in terms of health promotion *practice*. In this respect, creators of models have seen practice to be an amalgam of a *range* of interventions (Tannahill, 1985; French and Adams, 1986; Beattie, 1991). Such practices are seen to vary within a number of defining values systems, resulting in activity that spans a vast range, including authoritative and negotiated work, work oriented towards individuals and collectives, activity that addresses structural and political forces, and that which seeks to change individual behaviour. Common to both of these two types of models is their 'holistic' identity; Hancock (1993, p. 46) noting, 'a new understanding of the "wholeness" of health'.

Although the available models do not explicitly deny conflicts between different values and roles, the danger of accidentally or unintentionally mask-

ing tensions grows where there are aspirations to encompass the entirety of either health determination or health promotion action. This desire to develop a single encompassing explanation of reality is recognized by Barrow (1991) as a persistent feature of formal scientific exploration. That health promotion has sought to develop an identity around such a comprehensive approach rather than within more specialized areas of investigation merits attention. A consideration of both the reasons for this choice and the problems associated with it form the remainder of the paper.

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### The significance of global image

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Thus far, the tendency towards global models has been discussed within the context of the desire of many academic disciplines to pursue the drive for a 'grand narrative'. The focus now is on those influential factors that are peculiar to the discipline of health promotion. The argument moves from the general to the specific, with two groups of factors being seen to substantially enhance the attractiveness of global models. On the one hand, there are the 'formal' aspirations and expectations of a proportion of those within health promotion itself, and, on the other hand, there is the political context within which these expectations will be manifest.

### The aspirations of health promoters

From the perspective of specialist health promotion advisers, the adoption of a global image may be traced to a desire by some to see the specialism attain 'professional' status and thus be better able to achieve a more central role in health policy (Milio, 1986; Ashton and Seymour, 1988; Tones, 1990). Within the UK context, medicine has already been seen to fulfil this 'professional' status with its exclusive control of most acute medical care. A range of authors have been quick to identify the key criteria to be fulfilled before this highly prized professional status is attained (Flexner, 1915; Carr-Saunders and Wilson, 1933; Blaich, 1955). Despite the publication of many highly persuasive criticisms of this superficial and non-political

approach to the study of professions (Becker, 1962; Freidson, 1970; McKinley, 1973), there has been a concerted attempt to 'collect' the maximum number of these 'professional characteristics', with considerable energies being invested in the search for the development of unique, complex and robust 'bodies of knowledge' (Wilding, 1982) with the potential to encourage 'professional discourses' (Parker and Shotter, 1990). This push to improve the standing of the discipline in theoretical matters can be closely linked to the search for professional credibility and political influence. Many specialist health promotion officers and advisers may also expect to achieve some degree of control, or even monopoly, over official health promotion practice, leading ultimately to what Beattie (1991) has called 'occupational enclosure'.

As this journey towards 'professional' status proceeds, the acceptance and use of global models offers two crucial advantages. First of all, they tend to allow differing perspectives on health to be accommodated so that all approaches to health promotion can be placed somewhere within an agreed 'framework'. Secondly, as fundamental disagreements now appear to become just complementary views within a common vision, they tend to diminish debate and argument. This makes access to the political agenda potentially easier and substantially less threatening to all concerned.

This political point needs to be pursued further because it is impossible to make sense of current developments and debates without reference to the prevailing political climate. In the UK, the government set out its 'unequivocal' commitment to preventive medicine and health education as long ago as 1977 (DHSS, 1977), but it is only with the publication of the Acheson Report (DoH, 1988), the Working for Patients White Paper (DoH, 1989) and the Health of the Nation strategy documents (DoH, 1991, 1992) that health promotion has been given a significant role within the heart of mainstream health services. In this respect, health promotion is no longer peripheral to government policy. On the contrary, it has official backing for its desire to take a significant position in future service development (Dobson, 1993). The motives

of government and their relationship with global models thus become the next important considerations.

### 'Government' expectations

The sociological literature can be crudely divided into two schools. According to Caplan (1993), the first school is concerned with 'radical change' and seeks to find 'explanations which demonstrate the need for fundamental change' (Caplan, 1993, p. 150), while the second school focuses on 'social regulation' and attempts to explain why 'we live in a predominantly stable society which is integrated and holds together well' (Caplan, 1993, p. 150). It is this second phenomenon that is of direct concern here, for successive governments in 20th century Britain have worked hard to maintain the essential fabric of the 'status quo'. One tool at their command has been the use of what Bereano (1990) calls 'technological elites', including scientists, professionals, corporate managers, engineers and researchers, whose work practices uphold dominant ideologies. Thus the apparently 'neutral' professional activity of many groupings has hidden values which originate within the prevailing political environment. A close relationship between bio-medicine and 'state' functioning has thus been well documented (Foucault, 1975; Navarro, 1978; Doyal, 1979; Yarrow, 1986). Likewise, it has been argued that many within health promotion have fulfilled a regulatory role (Tones, 1981; Dorn, 1983; Patman, 1985).

Although this evidence supports the case for a close and supportive relationship between 'technological elites' and governments, there is little to explain why political agencies should increasingly favour global models. On the contrary, any shift towards such models would appear to fundamentally contradict existing thinking in this area. Official thinking might be expected to take the following line. Progressive or radical perspectives are politically threatening and will be suppressed or undermined by governments. For example, 'Inequalities in Health' (DHSS, 1980) was effectively undermined with a highly dismissive preface from the Secretary of State, and 'The Health

Divide' (HEC, 1987) was weakened by a delay in its publication and the 'forced' departure of the official who commissioned the work (Pattison and Player, 1990). These two examples illustrate how challenging perspectives are condemned to rejection by dominant political and professional groupings (Rodmell and Watt, 1986; Altenstetter and Heywood, 1991). The only safe and comfortable way forward for governments is the adoption of an individualized and medicalized view of health, and this can be illustrated from a range of British governmental reports on health education and promotion dating back to 1976 (DHSS, 1976). The perspective is *overt* and *simple*, with interventions appealing directly for individualized change in relation to 'single' behaviours or diseases.

A central argument of this paper is that the expected outright suppression and rejection of radical perspectives is being replaced by a move *in some respects* towards the adoption of more accommodating perspectives (DoH, 1996). This is a significant departure from the narrow and hostile approach described above, and there are clear implications for the relationship between the 'professions' and government. No claim is being made that this change is comprehensive, unconditional or absolute. Rather, we would like to explore what we consider to be *ideas* rather than certainties. The perceived nature of this change will be teased out throughout the rest of this paper.

In contrast to what was expected, UK government action adopted a different stance. The main characteristic was an *apparent* move towards a more expansive British government health policy perspective (DoH, 1987, 1991, 1992). These policies have sought to control not only the *scale* of services but also their *nature* (Small, 1989), confirming a desire to re-orientate services away from a narrow emphasis on diagnosis, treatment and rehabilitation.

Such policies are clearly a product of many forces, including the pressures of 'anti-welfare' ideology and cost containment (Klein, 1989). The argument here is that these policies go beyond a concern for mere cost cutting and contain a more creative element designed to appeal to, and deal

with, commonly held views on the problems facing narrowly constructed health services. To understand the dynamics of this, the broad nature of power and influence must be reviewed.

There is a tendency for power to be considered in rather crude and simplistic terms. The traditional notion of influence as a means of exercising one's will over somebody else, in an overt and uncompromising way, still holds much favour (Parker, 1992). Such a simple view must be questioned. Whilst not denying that there exists an element of coercive power, such limited ideas have tended to over-simplify the nature of influence and obscure more subtle, complex and sophisticated forms of expression.

In this context, Marcuse (1964) suggests a shift in the means of state control from one of open repression to a more subtle and persuasive form. Within this framework, he talks of a notion of 'repressive tolerance', meaning the *active* acceptance of views which may be at odds with dominant concerns. This acceptance of critique is, however, tempered by the framing of such views in language which moderates their strength. Thus, powerful agencies are seen to resist threats in a manner which is apparently accommodating and benevolent. Hence, the creative and duplicitous use of language can be seen as a means by which challenging perspectives are seemingly recognized but effectively quelled (Liggett, 1990).

These observations are offered as possible explanations of the apparent liberalization of UK government thinking on health. The reasons for such a shift may be seen to lie within an irresistible pressure to accommodate forms of health intervention other than traditional bio-medicine (Vuori, 1986). In other words, we are *notionally* seeing the accommodation of alternative perspectives on health. Nevertheless, the *actual* integration of such perspectives, and resultant shifts in policy and action, may be more symbolic than real (Le Grand, 1991).

Thus, global models lose much of their charm. Rather than being enlightening tools for progress, they potentially become a controlling straitjacket that creates a climate of bland inertia. To illustrate

this point, it is worth considering the use of global perspectives within the UK government's 1992 health strategy, *The Health of the Nation*.

Initial enthusiasm for the White Paper (DoH, 1992), as a fillip to health promotion, was based on evidence from a number of aspects of the document. Within the context of a more rational and strategic approach, the document 'emphasizes disease prevention and health promotion as ways in which even greater improvements in health can be secured' (p. 4). The paper presented an unusually broad vision of such work. It spanned a range of areas, including the importance of 'public policies considering the health dimension' (p. 13) and 'the active promotion of physical environments conducive to health' (p. 13). There is also a recognition that reductions in levels of infectious disease, 'essentially resulted from social and public health measures' (p. 7). These were significant developments in government thinking on health promotion. As such there appeared to be a move away from simple individualistic models of health promotion towards a more expansive vision.

Inevitably, criticisms of the paper soon emerged and this occurred at two levels. Firstly, the broad initial acceptance of the need for comprehensive approaches to the pursuit of health gain are offered alongside a practical focus that remained largely traditional, one-dimensional and individualistic. For example, the importance of 'increasing knowledge and understanding about how the way people live affects their health, and enabling families and individuals to act upon this' (p. 14) remains a central part of the document. At a more specific level, words are redefined and issues left unclear, e.g. health inequalities become 'variations' (p. 19), and the relationship between environments and health being considered as 'difficult to establish' (p. 30).

In summary, we suggest that *The Health of the Nation* is broadly drawing upon the notion of a global model of health promotion. Preceding discussion has suggested that such models may be problematic and the problems of *The Health of the Nation* delivering what it implies may tend to

support such a view. The concluding part of the paper will examine these limitations in more detail.

### A critique of global models

A questioning of the aspirations contained within global models has occurred both generally (Honeth, 1985; Moravcski, 1988) and specifically in disciplines such as sociology (Borgatta and Cook, 1988; Gurnah and Scott, 1992), history (McCrone, 1992), psychology (Parker, 1989) and health promotion (Altenstetter, 1987; Lincoln, 1990). Their criticisms are directed in two ways. They reject the simplicity and rigidity of the simple elements contained within efforts to model reality. They also dispute the notion that such encompassing creations can unite what they see as inherently disparate and conflicting components. Efforts by specialist health promotion officers and advisers to embrace global models need to be judged against the background of this analysis.

There may also be a related problem for these specialists in situations where they were formerly willing to open up critical debate by asking fundamental questions of existing perspectives and provision. There is now a tendency for such debate to be stifled because of the organizational and financial uncertainty surrounding their work. There is thus an incentive to embrace 'officially sanctioned' pronouncements.

A further constraining tendency may also be at work. This derives from the holistic structure of these models. It could be argued that their encompassing nature has created an impression of health promotion activity as an impenetrable 'whole', made up of activities of compatible form. In other words, they have largely smothered complex and potentially opposing elements in an all embracing whole. The scope for genuine debate is thus reduced and ultimately eliminated as different perspectives on health are accommodated and stifled. As such, there is then a possibility that it may become more difficult to distinguish the major different and competing perspectives on health. In turn, this could lead to the 'de-politicization' of the key issues in health promotion.

This tendency can be linked to Rawson's (1992)

idea of 'eclectic' health promotion. Debate may be inhibited by the tendency to see the comprehensive image of the model as implying *equal weight* to each component. This apparent levelling of perspectives as embodied within the image of the global model is additionally worrying in that it occurs in the context of existing differences in the prominence of perspectives. As such, it arguably acts as a means of maintaining the bias towards individualistic, bio-medical and service oriented approaches. This may thus allow the acceptance of differences to be used as an excuse for political indifference and inertia.

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### **The problems of neutrality**

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This relatively new policy of accommodating perspectives seems to offer both specialist health promotion officers and advisers and official policy makers important gains. For health promoters, there is some potential to defuse distracting disputes over the 'true' nature of health promotion that were threatening to become a damaging distraction during the mid-1980s (Baric, 1985; Catford *et al.*, 1985; Tones, 1985; Williams, 1985). For policy makers, the flexibility and imprecision of such a stance allows an image of progressiveness to be presented without any substantial requirement to fulfil it practically.

By seeking these benefits together, government agencies and some influential specialist health promotion officers and advisers can move towards a new and mutually convenient relationship, within what Rorty calls a 'normal' discourse (Rorty, 1980). The most important feature of such a relationship is the *degree* of compromise required to maintain it, and in this case, we would argue that specialist health promotion officers and advisers have most to lose.

For them, the accommodation required to achieve consensus stifles the potential to be actively critical of particular health promotion approaches. More importantly, such consensual relationships conveniently mask tensions and divergencies in approaches contained within the common framework. The practical consequence of any stifling of

debate is a gripping apathy which permits traditional practice to be selectively employed under the guise of approaches which are apparently holistic and comprehensive.

For government, the consequences are perhaps not so grave. The ability, through imprecise language, to appear to be progressive, whilst still defusing dissent and maintaining traditional practice, would appear to be an ideal outcome. In deciding upon the utility of global models, this shifts the initiative firmly back to specialist health promotion officers and advisers. Possible ways forward are discussed in the final section.

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### **Conclusion: the future of health promotion and global models, and an alternative way forward**

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This discussion highlights two separate though related issues: the need for a clear notion of the fundamental values that should define emergent health promotion practice, and the impact of the policy environment on arguments and actions driven by these values.

In relation to the former, this paper has argued that health promotion is currently moving from an insecure base to one which is characterized by a more formal and rational identity based upon the influence of global models. The enduring fixation with developing increasingly complex and definitive models continues with the UK's Society of Health Education and Promotion Specialists 2 Day Symposium to, 'discuss the history of the modelling of health promotion in the UK and agree a consensus statement on the definition and philosophy of health promotion appropriate to contemporary practice' (SHEPS, 1994).

We suggest that this tendency puts health promotion at risk of becoming caught up in a false sense of progress towards what Kolakowski (1972) calls 'the unity of science'. The process draws in a range of less mature disciplines towards a false vision where all investigative domains are linked by a common system.

This passive acceptance of 'truth', as suggested by accommodating models, is arguably contrary to

the radical traditions of health promotion. A highly persuasive radical literature has had two sources of inspiration. The first has been the various critiques of the effectiveness and relevance of mainstream medical practice carried out within the constraints of the medical model (Illich, 1976; McKeown, 1976; Kennedy, 1980). The second has been a growing body of evidence pointing to an intimate relationship between social, economic and political factors and health status (Le Grand, 1987; Townsend *et al.*, 1988; Wilkinson, 1990). The main thrust of this radical school has been to pose questions about existing arrangements and structures. Whilst acknowledged within the substance of global models, our contention throughout has been that, paradoxically, within this process, such views tend to be significantly quelled.

This may seem a slightly negative and pessimistic stance, and a case can be made that there is potential to operate more constructively within existing restrictions and not necessarily be passively drawn towards the predicted conclusions. The central question is, 'can health promotion control the tendency embodied within global models towards the continuance of an imbalance in the nature of practice and a suppression of debate?'

In this context, health promotion must clarify what is, and is not, possible within different modes of practice so as to avoid being judged upon criteria which are wholly unrealistic. However, the ability to do this is severely limited when health promotion has become so closely related to powerful political and professional forces and trapped by the high expectations inherent in global models. An appropriate strategy is required and a starting point is offered in the final part of the conclusion.

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### Moving forward

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This paper has presented a warning against being seduced by the attractiveness of global models. It is no accident or coincidence that the shift towards consensus and compromise exists both inside and outside academia. For example, within the wider political context, the blending of liberal free market

policies and welfare socialism has led to the marginalization of 'extreme' perspectives and a growing consensus around a preference for liberal democracy (Fukuyama, 1993). Just as conflict-oriented 'fundamentalists' are questioning the image of utopian consensus, we have suggested so too must specialist health promotion officers and advisers, and other health promoters, in relation to the nature of their practice.

We point out that the emergence of global models provides a dangerously moderate scenario wherein important tensions in perspectives may be lost in the image of consensus. Furthermore, to be associated with global models runs the danger of implying that the discipline itself will be in a position to control or influence a sufficiently large range of variables to ensure 'successful' health gain. Obviously, such a view would be grossly optimistic and there may be a danger that the failure of health promotion to steadily reduce mortality levels over the course of the decade (Brindle, 1993) could encourage attacks on the discipline itself.

We suggest that a more cautious relationship with global models should be encouraged. If health promoters believe that the use of such models offers scope to advance less prominent perspectives on health, then the tendencies outlined above should act as a warning against this.

Rather, we propose that if health promoters are to maintain their tradition of critical analysis, the doctrine of global models must be at least partly defused, and the search to rediscover 'difference' should be given renewed emphasis. As Andre Gorz recognizes, 'the beginning of wisdom is the discovery that there exists contradictions of permanent tension with which it is necessary to live, and that it is, above all, *not* necessary to resolve' (in Sawicki, 1991, p. 17).

But, where should initial energies be concentrated? Which 'permanent tensions' should be addressed? There is a persuasive case for initial energies to be concentrated in three areas: professional and political matters; technical and methodological dilemmas; and research questions.

The desire of many specialist health promotion

officers and advisers for professional status has already been critically discussed. What is urgently required is a shift of occupational energies from searching for the relative safety of official 'professional' status to recreating dynamic inter-disciplinary alliances which can co-ordinate focused lobbying, campaigning and advocacy on the fundamental determinants of health (McKeown, 1994). The need is for cohesion and agreement between professions if wider public health issues, such as continuing inequalities and the pollution of the environment, are to be effectively tackled. The perspective is a political one and guidance comes from the political science literature (Duverger, 1972.)

At the very heart of the Health of the Nation policy initiative is the introduction of health promotion targets. It may be believed that the price of gaining the protection of a high profile central government policy initiative like the Health of the Nation is the acceptance of governmentally identified behavioural and mortality targets. Any such passivity is dangerous. The tensions and dilemmas which underpin the Health of the Nation targets need to be explicitly addressed. Some specific targets may be unachievable because of a lack of political will, changing socio-economic circumstances, poor inter-professional cohesion, and a failure to apply effective methods of intervention at community and organizational levels. Specialist health promotion officers and advisers need to consider how targets can be adjusted, re-negotiated, recalculated, and made more relevant to the different local social, economic and political circumstances of communities, localities and districts.

This challenge to the Health of the Nation targets must address not only questions about what the targets should be and how they should be measured but also questions about the broader ownership of the targets, their implications for all decision makers and service providers, and the real reasons for variations in performance in achieving official targets. Disagreements will surface because the achievement of behavioural and mortality targets, especially in deprived areas, will need united and

continuing action. Even global models will fail to capture all the variables at work. A more honest and widespread dialogue about these difficult intellectual and practical matters, raised by the pursuit of the Health of the Nation targets, would help.

Out of this analysis comes both a range of research questions and a case for a closer dialogue between researchers, specialist health promotion officers and advisers, public health practitioners, and the general community of health promoters. Much is already understood, but evidence points to the link between researchers and decision makers being seriously fractured (DoH, 1993). Several questions might frame an agenda for a renewed debate. How has the political process behind the Health of the Nation operated and what can be learnt? How are models assimilated, understood and used by those making decisions about, or practising, health promotion? In what ways should the utility of models, especially global models, be assessed?

In the end, health promotion will be judged not only on its actions but also on its capacity to develop an appropriate agenda. This demands a clear appreciation of the forces driving current policy. Global models and perspectives logically require global action. Therefore, expectations of what health promotion practitioners can achieve in isolation may be falsely inflated. Health promotion should not allow itself to be manoeuvred into a position where it can be held to account for what it cannot, and should not, be expected to deliver.

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