HEALTH PROMOTION INTERNATIONAL
Vol. 17, No. 1
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Printed in Great Britain

Health literacy: a search for new categories

A series of papers have been published in *Health Promotion International* discussing the concept of health literacy. The starting point of the debate was a contribution by Don Nutbeam proposing 'health literacy' as a key outcome measure of health promotion, and suggesting that measures could be developed for three types or three domains of health literacy: 'functional health literacy', 'interactive health literacy' and 'critical health literacy' (Nutbeam, 2000). At a workshop organized on the occasion of the XVII World Conference on Health Promotion and Education in Paris in July 2001, a very stimulating discussion ensued trying to gauge the usefulness of such a concept. The challenge was put forward of whether it was really necessary to introduce yet another term and concept to the already complex itinerary of health promotion.

My unequivocal answer is yes. The issue at stake is not trivial and goes far beyond a discussion of health literacy to the very centre of health promotion development. The very explicit goal of health promotion is 'to increase people's control over their health and its determinants' (WHO, 1986). As a consequence, the task at hand is to identify and measure those factors that increase people's control over their health, both within the context of their everyday lives and within the health care system. This crucial focus is often forgotten as the health promotion debate gets entangled in evidence constructs that come from a medical, not a social-environmental, perspective. It leads health promotion proponents to prove how well they can swim in the water torrents 'downstream' rather than honing their 'upstream' skills of examining and regulating the water source.

Clearly health promotion must be able to show that it can make a difference. Since its primary objective is to increase resources for health (for example through empowering people and improving the environments in which they make health choices), health promotion must measure the difference it makes in strengthening those resources. Nutbeam has argued that we need to focus on 'health promotion outcomes' (Nutbeam, 1996), meaning those personal, social and structural factors that can be modified in order to change the determinants of health. The extensive literature that has been produced on social determinants of health [e.g. (Marmot and Wilkinson, 1999)] gives added support to this orientation; as does a recent report on intervention strategies from social and behavioural research published by the US Institute of Medicine (Institute of Medicine, 2000). The IOM report argues that research and intervention efforts should be based on an ecological model [see also (Kickbusch, 1989)], which is best operationalized by a social-environmental approach to health and health interventions. It requires a much stronger focus on populations and communities rather than individuals and on the dynamic interaction between determinants rather than causal streams. This is methodologically complex and requires different methods to individual-level research.

Lester Breslow has proposed that the Ottawa Charter approach of conceptualizing health as a 'resource for living' and shifting the focus of health promotion strategies to 'capacity building for health' is a timely, unique and revolutionary approach for public health at the beginning of the 21st century (Lester Breslow, 1999). Indeed, he terms this approach the third public health revolution. In this he mirrors other debates in philosophy, economics and development, which focus both on strengthening peoples' capabilities to act and the support-led development strategies that enable them to make choices (Sen, 1999; Nussbaum, 2000). Sen has argued that it is in the space of capabilities that issues about social inequality need to be raised. Nussbaum makes clear that:

> When we think of health for example, we should distinguish between the capability or opportunity to be healthy and actual healthy functioning: a society might make the first available and also give individuals the freedom not to choose the relevant functioning [(Nussbaum, 2000), p. 14].

Nussbaum's point is that where adult citizens are concerned, capability not functioning is the appropriate political goal. This directs us towards a set of critical voices [e.g. (Petersen, 1996)] who contend that health promotion contributes to an increased privatization of risk. They have warned that the Ottawa Charter definition of health promotion as increasing people's control over their health fits well with the processes of individualization underway in late modern societies and might mean no more than delegating what is a collective and societal responsibility to individuals (Lupton, 1999). This issue was also raised at the Paris workshop in relation to health literacy. The ensuing debate highlighted that we need much more discussion about the ambiguous 'fit' of health promotion strategies with the current wider social trends that define and structure everyday life. The three domains of health literacy proposed by Nutbeam (Nutbeam, 2000) allow us to take these ambiguities into consideration and reflect them further both as individual and as community characteristics (Kickbusch, 2001).

Health promotion has frequently been discussed as a new paradigm in health with a set of shared principled beliefs, shared causal beliefs, common notions of validity and a common agreed set of practices and approaches. But it is always in danger of being pushed from its population-based, social-environmental orientation towards a more individualistic, behavioural and disease-based model. This happens despite the fact that approaches based on the latter have shown themselves to be insufficient (Institute of Medicine, 2000). But the discussions at the XVII World Conference on 'evidence' indicated that the health promotion epistemic community is not yet fully secure in its common notions of validity; indeed it is sometimes singularly defensive. I see the debate around health literacy, social capital and social gradients (irrespective of whether these terms are perfect or not) as an expression of the search that is underway in the health promotion arena to emancipate itself from categories that belong to another era, another mind frame and another ontological tradition.

Leonard Syme has called continuously for a new categorization of health promotion interventions and outcomes that lead us away from the clinical classification based on disease to 'a comparable set of social and behavioral categories' (Leonard Syme, 1996). Health promotion should be at the forefront of this exciting exploratory process. It is time we seriously took up this challenge, perhaps as a key feature and section in this journal leading us up to the next IUHPE conference in 2004 in Melbourne.

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Chair, Editorial Board

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