The Ian Webster Health for All Oration 2018

Health education, health promotion, and health literacy – a personal journey

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THE UNIVERSITY OF SYDNEY

Structure of the presentation

- A bit about me
- Two important people
- Three important projects
- My current obsession

What values came with me into the workforce?

- Social, economic and environmental conditions significantly shape our lives and life chances
- Individual behaviour, personal choices and values matter a lot – but are significantly influenced by social conditions
- Positive role models are important
- Education can change everything

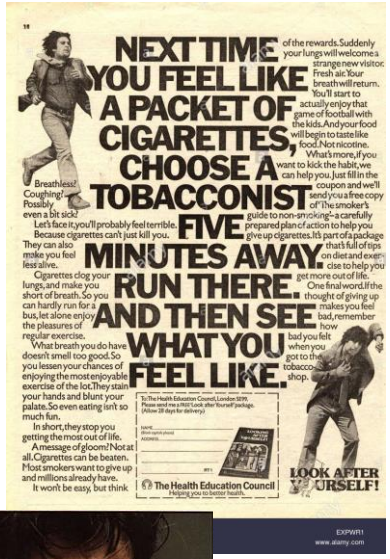
- I began my working career in 1978 in the NHS as a Health Education Officer in Portsmouth Local Health District – I quickly became frustrated

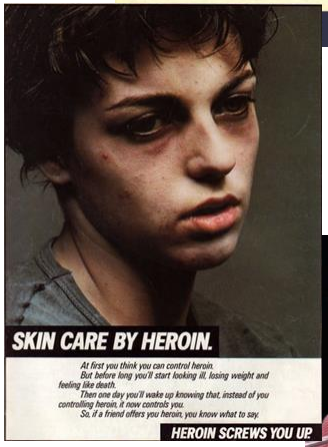
Health education in the late 1970's

Strong individual-behavioural focus

- "Look after yourself" key theme of health education programs
- Simplistic "Just say no" approach to complex problems of substance abuse
- Public education campaigns sometimes designed to reassure the voting population that "something" was being done
- Some more sophisticated understanding of media, and adaptation of social marketing techniques to health campaigns

This felt a long way from my personal life experiences





Health Education and Health Promotion – Two important people

- Searching for a “new public heath” brought me into contact with other likeminded thinkers interested in addressing social, economic and environmental determinants of health, and combining different forms of public health intervention to achieve greater impact and outcome

- I got to work with great thinkers and actors: - John Catford and Ilona Kickbusch

HEALTH EDUCATION

Four years ago the DHSS issued a circular on non-smoking in health service premises. Following this the local DMT of Portsmouth and South East Hampshire HD took action with a campaign of leaflets and posters. Health education officer Donald Nutbeam reports on the success so far.

A breath of fresh air

The National Health Service by its very existence will have an impact on the knowledge, attitudes and behaviour of the public in relation to their health. This point of view provides a particular challenge to health education officers as their ability to use, and even in some circumstances, control this situation is often very limited by their relatively subordinate position in the management hierarchy. However, in 1977 the DHSS circular on 'Non-Smoking in Health Service Premises' presented health education staff with 'an offer they could not refuse' — to attempt a specific programme within the NHS designed to further influence the general public's attitude and behaviour in relation to smoking.

The circular emphasised that: "hospitals, health centres and other health premises can be important places for health education, and district management teams are asked to encourage those working in them to see that this important educative role is not neglected . . . smokers often like to believe that many doctors still do not agree that smoking causes lung cancer and other diseases, and this misconception will be reinforced when they see doctors and other health workers smoking.'

Practical problems

The DHSS circular was issued nearly four years ago and what follows is a retrospective account of how one district dealt with the practical problems that the implementation of this policy presented. It is by no means intended to illustrate the only approach to the restriction of smoking; it is rather an attempt to share the experience of a relatively successful operation.

Following the distribution of the DHSS circular the local DMT issued its own policy statement which broadly reflected the content of the central circular. Using this policy document as the starting point the district health education staff were requested to implement the policy throughout the health district.

To facilitate this a small working party was established consisting of the district community physician, the district support services manager, the district HEO and another HEO as overall co-ordinator; in addition the active support of both the district nursing officer and the district fire officer was called upon. The implementation of this policy in a health district of this size (population 310,000) would not have been possible without the range of support that these senior staff provided.

The broad strategy adopted was to promote non-smoking as the norm in health service premises and correspondingly durable notices declaring 'You are now entering a no-smoking zone — please extinguish all cigarettes, pipes etc' were placed at all public entrances to NHS buildings in the district. In addition, in all waiting areas, main corridors and clinical areas reminder notices stating 'This is a no-smoking zone' were clearly posted.

Agreed areas

Once this had been established the aim was not to be entirely prohibitive, and thus encourage clandestine smoking, but to restrict smoking to certain agreed areas for staff and hospital patients. These were usually identified by individual unit administrators in liaison with the fire officer and HEO concerned and were clearly marked with notices stating 'This is a smoking zone'. These consisted mainly of staff rest rooms and, where possible, some ward day rooms, the only notable exception being a small area for visitors in one of the two district general hospitals.

Visitors, outpatients and patients attending clinics, it was argued, were usually attending for such a short period of time that it would not be necessary for them to smoke.

These notices were put up over as short a period as was practically possible (about two weeks) replacing older and worn out 'No Smoking' signs in all the health service premises. Once this blanket coverage had been dealt with an extensive media campaign attempted to achieve maximum support and understanding of the aims of this strategy.

All 6,000 NHS staff in the district were given a humorous explanatory leaflet, encouraging smokers to restrict their smoking to those designated areas

SMOKING ZONE?

. . . smokers often like to believe that many doctors still do not agree that smoking causes lung cancer and other diseases

Health and Social Service Journal, May 1, 1981

THE LANCET, JULY 9, 1983

Preventive Medicine

SMOKING IN HOSPITALS

JOHN C. CATFORD DON NUTBEAM

Wessex Positive Health Team, Wessex Regional Health Authority, Winchester

Summary Restricting smoking in public places is an important part of a smoking prevention strategy. To find out the extent to which smoking is restricted in health service premises a survey of 190 hospitals and health centres in the Wessex Region was done. It showed that the levels of smoking restriction were high, and that patients, visitors, and staff complied well with the restrictions. For ambulant patients the situation clearly favoured the smoker—for example, only 18% of acute hospitals could offer "smoke-free" day rooms to every patient who requested it, yet 92% could offer day-room accommodation to all smokers. Cigarettes were sold in a quarter of acute and maternity hospitals. Doctors played a small role in promoting non-smoking. Goals, based on percentage of floor space designated as non-smoking areas, should be set and their achievement monitored. Cigarettes should not be sold in hospitals, except perhaps long-stay hospitals.

INTRODUCTION

ACTION taken to protect the public from smoking would have more effect upon public health in Britain than anything else that could be done in the whole area of preventive medicine.[1] Cigarette smoking is responsible not only for at least 50 000 premature deaths per year but also for a considerable reduction in the quality of life for thousands of individuals with chronic, smoking-related diseases. The consequences of smoking are a major drain on National Health Service (NHS) resources, estimated to be at least £150 000 000 per annum.[2] Smoking prevention, therefore, is a challenge to doctors and other health workers. One aspect of this challenge must concern restrictions on smoking in public places, especially in health premises.

The need for smoking restrictions stems partly from the "rights" of the non-smoking majority[3] and from concern about the effects of passive smoking.[4] Restrictions also reduce the opportunity for smoking and may thus limit cigarette consumption. They can also act as a positive reinforcement to those who have already given up. These points apply particularly to health premises, since they are often viewed by many as a "shop window" for health.

A non-smoking policy in hospitals should not be entirely prohibitive but should promote non-smoking as the norm and restrict smoking to agreed areas for patients and staff. It can be argued that visitors, outpatients, and patients attending clinics usually attend for such short periods that it would be unnecessary for them to smoke and thus facilities for them to do so need only be minimal; but the situation for patients in hospital wards, and long-stay patients in particular, merits careful consideration, and a practical yet flexible approach needs to be adopted.

In March, 1977, the exemplary role of the NHS was emphasised in a Department of Health and Social Security

Health Education and Health Promotion, 1984

- Health education described as a limited tool for raising awareness, changing attitudes and promoting "voluntary changes in behaviour".
- By contrast, health promotion was cool, new and exciting.
- It not only included health education, but also an ambitious set of strategies that were intended to revitalise public health interventions by incorporating
  - environmental and organisational change;
  - economic and regulatory activities;
  - community development,
  - highlighting the importance of preventive health services.

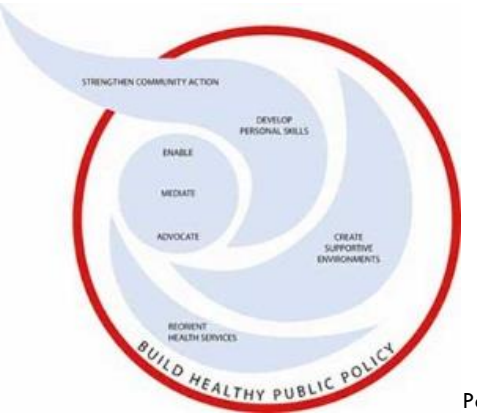
Towards a definition of health education and health promotion

John Catford,
Don Nutbeam,
Positive Health Team,
Western Regional Health Authority

Major Project 1: The Ottawa Charter 1986 – "the move towards a new public health"

- The *Ottawa Charter for health promotion* is a consensus statement on the "new" public health" developed by WHO at the first international conference on health promotion in Ottawa, Canada in 1986
- It uses the term "health promotion" to summarize new approaches to public health intervention.
- The *Charter* defines health promotion as: the process of enabling people to increase control over the determinants of health and thereby improve their health"

WHO, Ottawa Charter for Health Promotion, 1986



What did the Ottawa Charter say?

It established the underlying principles of health promotion

- a holistic and **functional** concept of health - beyond absence of disease
- directed towards **all determinants** of heath - operation in different sectors
- **multiple actions** combine to tackle multiple determinants
- Health promotion is a **process** - a means to an end
- health promotion is **enabling** - done by, with and for people, not on them
- health promotion is directed towards **improving control** over the **determinants** of health
- **Making healthy choices, easy choices**

Health Education and Health Promotion, after Ottawa – throwing the baby out with the bathwater

- "Health education" is conspicuously absent from the *Charter* - "learning opportunities for health", and "education for health" are used
- This absence contributed to an unhelpful breakdown in relations between people and organizations who were already deeply invested in health education, and those who were advocating for this paradigm-shifting "new public health"
- Health education was for some time portrayed as contributing to a "victim-blaming" culture in public health
- Was seen as unfashionable, and a poor relation to social and environmental interventions
- Danger of drift - doing things **to** people, rather than **for** people

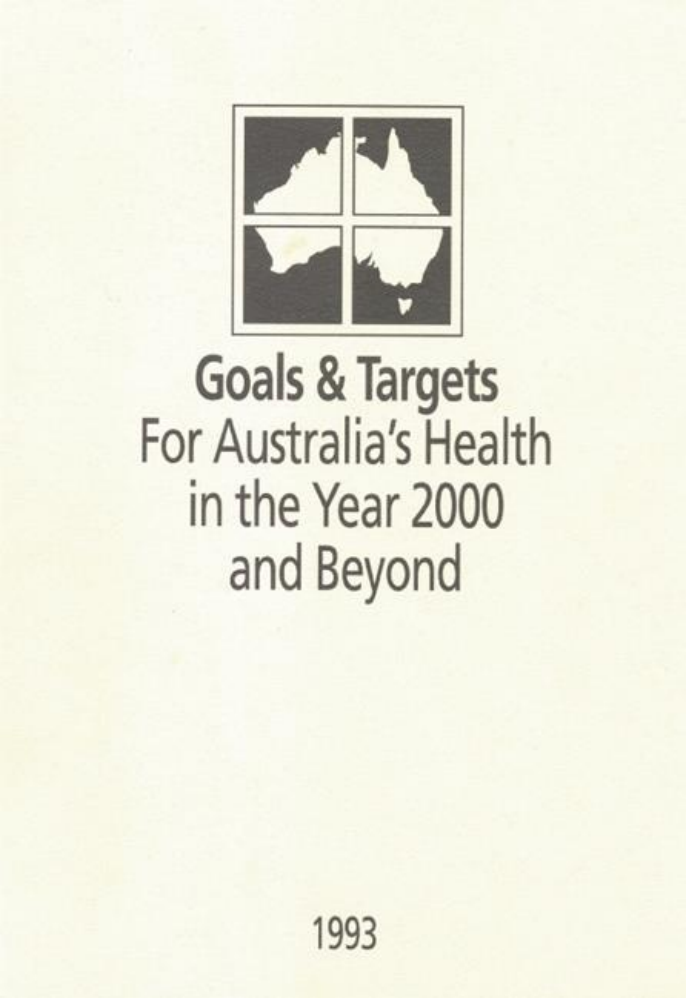
A sidebar – Don Nutbeam comes to Australia

- To attend the 2nd WHO Health Promotion Conference: Adelaide Conference on Healthy Public Policy, 1988
- Reported on progress with the Heartbeat Wales Programme
- Met Steve Leeder and heard about Australia's Better Health Commission
- Visited University of Sydney and School of Public Health
- Visited Western Sydney and learned about "Healthy Hearts West"
- Within 18 months was offered a Chair in Public Health at the University of Sydney

HEALTHY PUBLIC POLICY

Adelaide 1988

Major project 2: Reviewing and Revising Australia's National Health Goals and Targets



The "Dream Team"

Marilyn Wise

Adrian Bauman

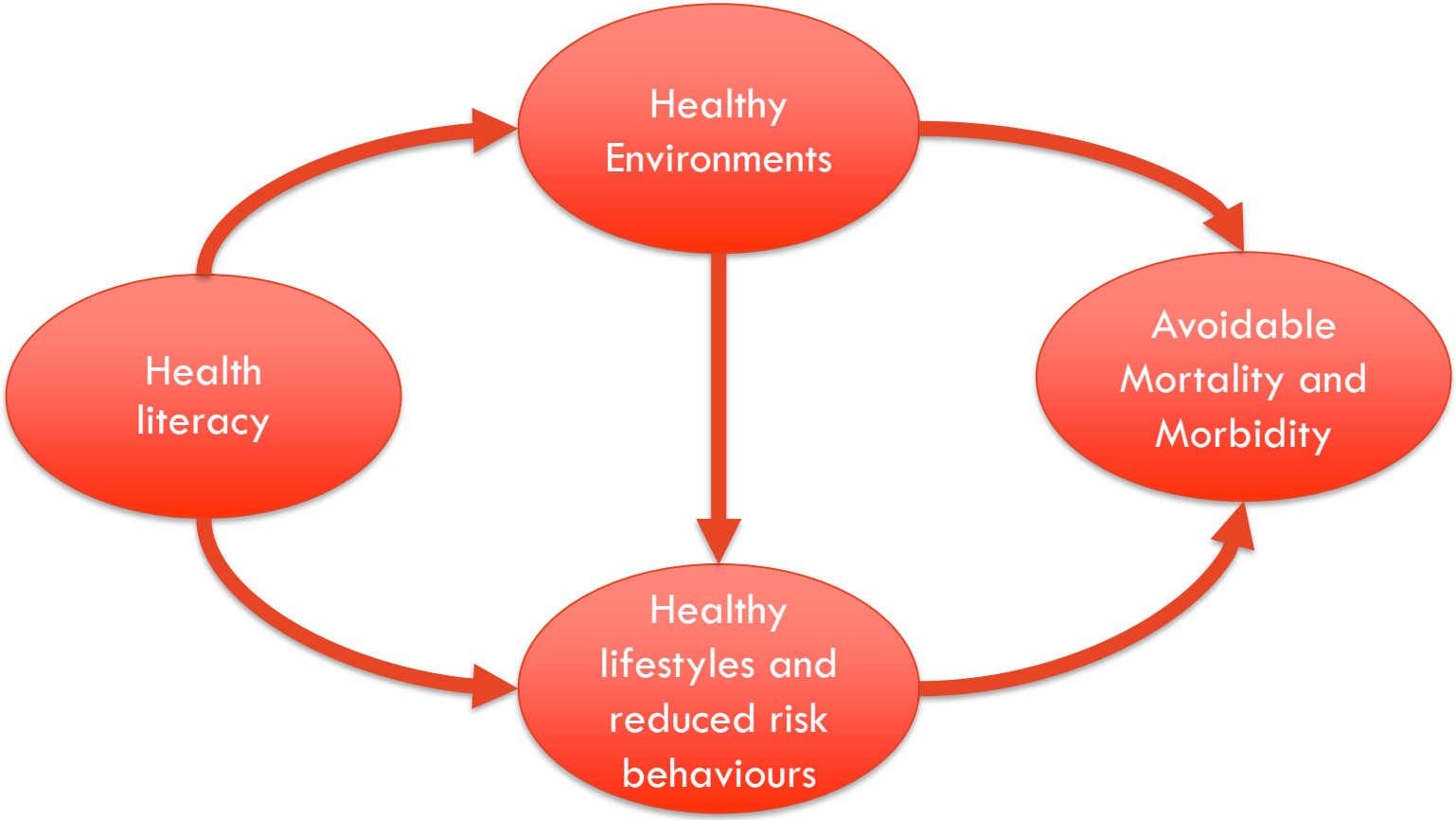
Steve Leeder

Liz Harris

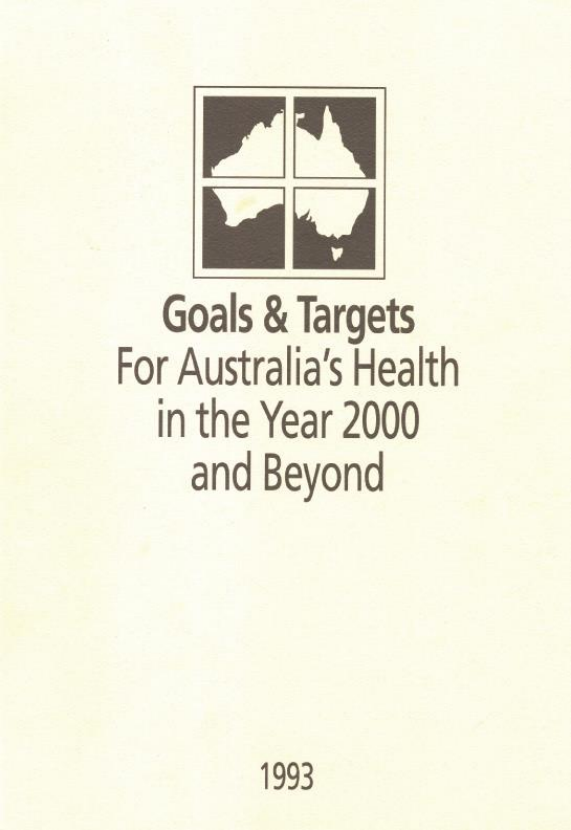
Relationship between the four groups of health targets

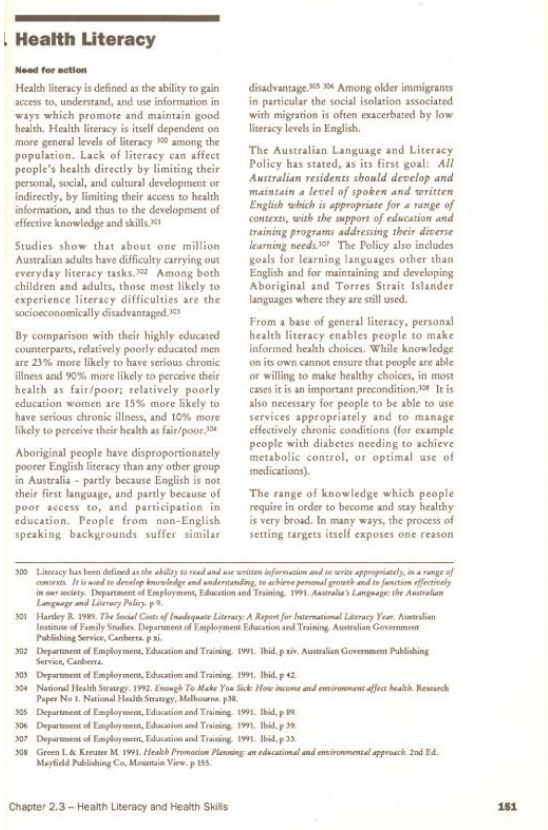
(from: Goals and Targets for Australia's Health in the year 2000 and beyond, AGPS, 1993)

Health literacy repositions health education at the heart of modern health promotion, complementary to and in partnership with addressing the social determinants of health



Re-invigorating health education
Health literacy in Australia – it's not a new idea





Health Literacy

Need for action

Health literacy is defined as the ability to gain access to, understand, and use information in ways which promote and maintain good health. Health literacy is itself dependent on more general levels of literacy [300] among the population. Lack of literacy can affect people's health directly by limiting their personal, social, and cultural development or indirectly, by limiting their access to health information, and thus to the development of effective knowledge and skills.[301]

Studies show that about one million Australian adults have difficulty carrying out everyday literacy tasks.[302] Among both children and adults, those most likely to experience literacy difficulties are the socioeconomically disadvantaged.[303]

By comparison with their highly educated counterparts, relatively poorly educated men are 23% more likely to have serious chronic illness and 90% more likely to perceive their health as fair/poor; relatively poorly education women are 15% more likely to have serious chronic illness, and 10% more likely to perceive their health as fair/poor.[304]

Aboriginal people have disproportionately poorer English literacy than any other group in Australia - partly because English is not their first language, and partly because of poor access to, and participation in education. People from non-English speaking backgrounds suffer similar disadvantage.[305 306] Among older immigrants in particular the social isolation associated with migration is often exacerbated by low literacy levels in English.

The Australian Language and Literacy Policy has stated, as its first goal: *All Australian residents should develop and maintain a level of spoken and written English which is appropriate for a range of contexts, with the support of education and training programs addressing their diverse learning needs.*[307] The Policy also includes goals for learning languages other than English and for maintaining and developing Aboriginal and Torres Strait Islander languages where they are still used.

From a base of general literacy, personal health literacy enables people to make informed health choices. While knowledge on its own cannot ensure that people are able or willing to make healthy choices, in most cases it is an important precondition.[308] It is also necessary for people to be able to use services appropriately and to manage effectively chronic conditions (for example people with diabetes needing to achieve metabolic control, or optimal use of medications).

The range of knowledge which people require in order to become and stay healthy is very broad. In many ways, the process of setting targets itself exposes one reason

300 Literacy has been defined as *the ability to read and use written information and to write appropriately, in a range of contexts. It is used to develop knowledge and understanding, to achieve personal growth and to function effectively in our society.* Department of Employment, Education and Training. 1991. *Australia's Language: the Australian Language and Literacy Policy*. p 9.

301 Hartley R. 1989. *The Social Costs of Inadequate Literacy: A Report for International Literacy Year*. Australian Institute of Family Studies. Department of Employment Education and Training. Australian Government Publishing Service, Canberra. p xi.

302 Department of Employment, Education and Training. 1991. Ibid, p xiv. Australian Government Publishing Service, Canberra.

303 Department of Employment, Education and Training. 1991. Ibid, p 42.

304 National Health Strategy. 1992. *Enough To Make You Sick: How income and environment affect health*. Research Paper No 1. National Health Strategy. Melbourne. p38.

305 Department of Employment, Education and Training. 1991. Ibid, p 89.

306 Department of Employment, Education and Training. 1991. Ibid, p 39.

307 Department of Employment, Education and Training. 1991. Ibid, p 33.

308 Green L & Kreuter M. 1991. *Health Promotion Planning: an educational and environmental approach*. 2nd Ed. Mayfield Publishing Co, Mountain View. p 155.

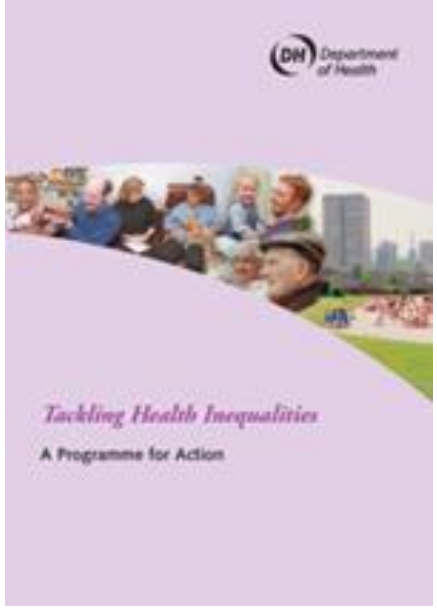
Chapter 2.3 – Health Literacy and Health Skills 151

A sidebar – Don Nutbeam goes back to the UK

Major project 3: Tackling Health Inequalities in England – A Programme for action

4 Underlying strategies

- The primacy of prevention
  - interventions to prevent the behavioural, economic and environmental causes of inequalities and minimise the consequences.
- Working through the mainstream –
  - to achieve the scale of change and sustainability of impact.
  - The use of 'floor targets' and national service frameworks in the NHS support this.
- Targeted interventions
  - to introduce innovation, tackle specific problems that are resistant to change, and/or provide outreach.
- Action at local level by engaging communities and individuals
  - Recognising that relevant and sustainable responses to health inequalities will come from locally determined and managed actions



http://webarchive.nationalarchives.gov.uk/20031220221853/http://doh.gov.uk/healthinequalities/programmeforaction/programmeforaction.pdf

All-government *Programme for Action*: 4 Key themes

Supporting families and children: addressing poverty, especially in families with children, healthy pregnancy, early childhood development through *Sure-start*, and educational interventions to close the attainment gap.

Engaging communities and individuals: working "with the grain" of the government's *Neighbourhood Renewal* and *Social Exclusion Strategies* to improving housing, create a safe environment, address the needs of socially excluded populations.

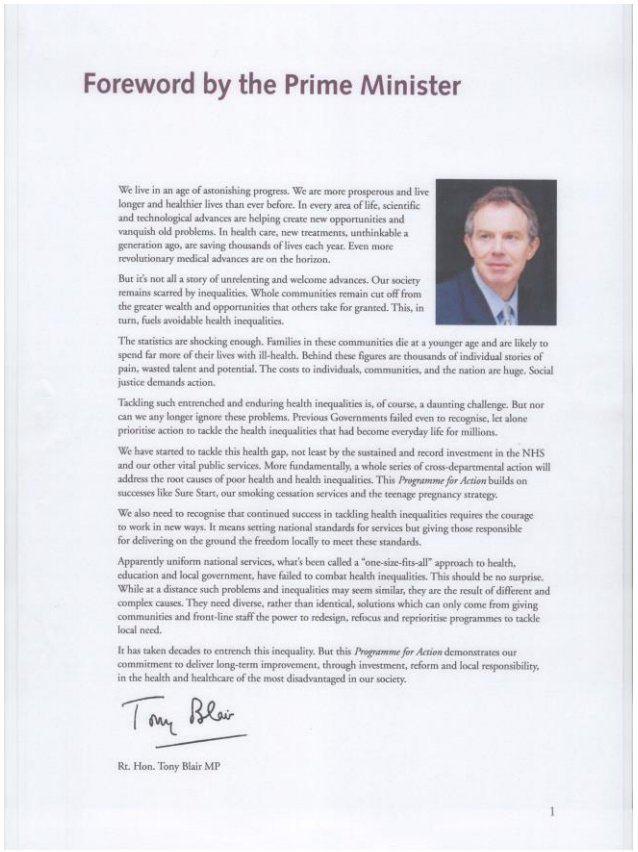
Addressing the underlying determinants of health:

tackling poverty, low basic skills, employment, low incomes

Preventing illness and providing effective treatment and care: a leading role for the NHS in addressing the social gradient in modifiable disease risks, in primary care access, in hospital quality and access

http://webarchive.nationalarchives.gov.uk/20031220221853/http://doh.gov.uk/healthinequalities/programmeforaction/programmeforaction.pdf

All-government *Programme for Action*:



Foreword by the Prime Minister

We live in an age of astonishing progress. We are more prosperous and live longer and healthier lives than ever before. In every area of life, scientific and technological advances are helping create new opportunities and vanquish old problems. In health care, new treatments, unthinkable a generation ago, are saving thousands of lives each year. Even more revolutionary medical advances are on the horizon.

But it's not all a story of unrelenting and welcome advances. Our society remains scarred by inequalities. Whole communities remain cut off from the greater wealth and opportunities that others take for granted. This, in turn, fuels avoidable health inequalities.

The statistics are shocking enough. Families in these communities die at a younger age and are likely to spend far more of their lives with ill-health. Behind these figures are thousands of individual stories of pain, wasted talent and potential. The costs to individuals, communities, and the nation are huge. Social justice demands action.

Tackling such entrenched and enduring health inequalities is, of course, a daunting challenge. But nor can we any longer ignore these problems. Previous Governments failed even to recognise, let alone prioritise action to tackle the health inequalities that had become everyday life for millions.

We have started to tackle this health gap, not least by the sustained and record investment in the NHS and our other vital public services. More fundamentally, a whole series of cross-departmental action will address the root causes of poor health and health inequalities. This *Programme for Action* builds on successes like Sure Start, our smoking cessation services and the teenage pregnancy strategy.

We also need to recognise that continued success in tackling health inequalities requires the courage to work in new ways. It means setting national standards for services but giving those responsible for delivering on the ground the freedom locally to meet these standards.

Apparently uniform national services, what's been called a "one-size-fits-all" approach to health, education and local government, have failed to combat health inequalities. This should be no surprise. While at a distance such problems and inequalities may seem similar, they are the result of different and complex causes. They need diverse, rather than identical, solutions which can only come from giving communities and front-line staff the power to redesign, refocus and reprioritise programmes to tackle local need.

It has taken decades to entrench this inequality. But this *Programme for Action* demonstrates our commitment to deliver long-term improvement, through investment, reform and local responsibility, in the health and healthcare of the most disadvantaged in our society.

Tony Blair

Rt. Hon. Tony Blair MP

1

The Programme for Action will be taken forward across Government.

OFFICE OF THE DEPUTY PRIME MINISTER

CABINET OFFICE

HM TREASURY

Home Office

dti

DWP Department for Work and Pensions

Department for Transport

defra

dcms

Department for Constitutional Affairs

department for education and skills

DH Department of Health

32366 1p 15k Jul 03 (OAK)

If you require further copies of this title quote *32366/Tackling Health Inequalities: a Programme for Action* and contact:

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www.doh.gov.uk/healthinequalities/programmeforaction

Health in all policies before the concept was invented……

Three projects – key lessons

- Addressing health inequity is hard, complex and sustained action across sectors
- Health promotion strategies offer the most complete response to this entrenched and complex problem
- Focussing only on the social determinants runs the risk of alienating those we seek to benefit
- Improving health literacy provides the foundations for meaningful, empowering engagement in health
- Bringing the two together provides a powerful platform for change

My Current obsession:
Health Literacy – where does it fit in?

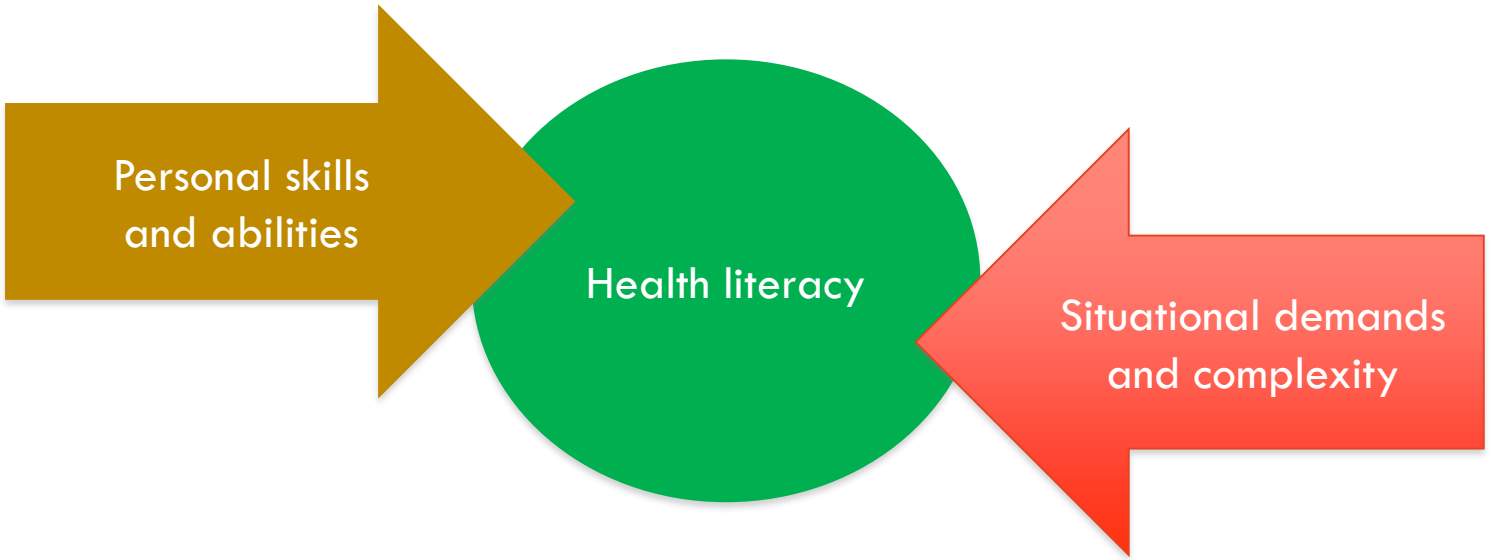
- Time to revisit the importance of health education alongside action on the social determinants

- Relationship between educational attainment and low literacy and a range of health related outcomes well established
- Relationship is both direct and indirect (through employment and income)

- Education addresses literacy
- Health education builds health literacy

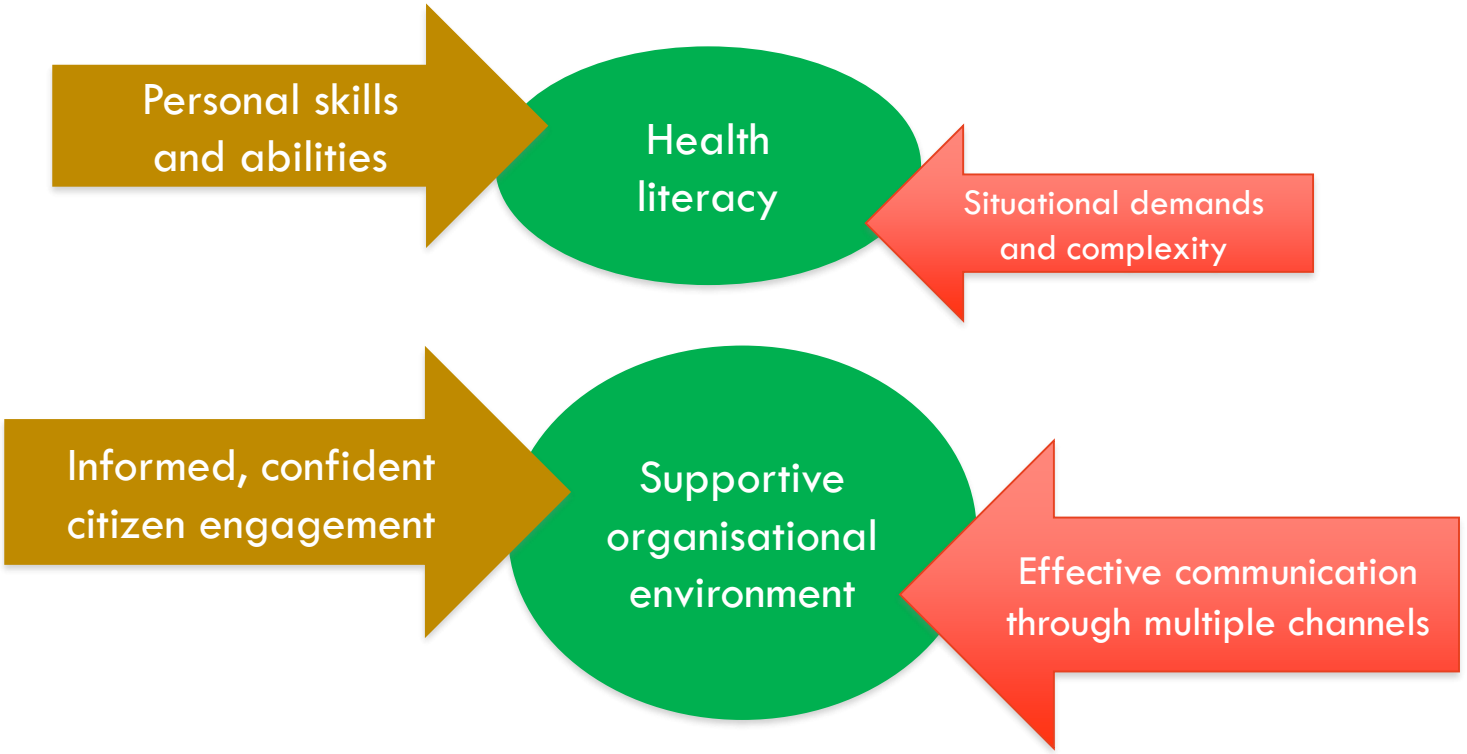
Health literacy describes the ability of a person to acquire, understand and act on health information

Health literacy is determined by personal skills and context in which those skills are to be applied



Adapted from Ruth Parker, Measuring health literacy: What? So what? Now what? In Hernandez L, ed. Measures of health literacy: workshop summary, Roundtable on Health Literacy. Washington, DC, National Academies Press, 2009:91–98

Health literacy describes the ability of a person to acquire, understand and act on health information in varying contexts – how do we change things?



Where does health education, health promotion and health equity come together – You can classify relative differences in health literacy*

Functional health literacy

- Basic health literacy skills that are sufficient for individuals to obtain relevant health information and apply that knowledge to a limited range of prescribed activities.

Interactive health literacy

- More advanced literacy skills that enable individuals to extract information and derive meaning from different forms of communication; to apply new information to changing circumstances; and to interact with greater confidence with information providers such as health care professionals.

Critical health literacy

- Most advanced cognitive skills which, together with social skills, can be applied to critically analyze information, and to use this information to exert greater control over life events and situations.

*Nutbeam D. (2001) Health Literacy as a Public Health Goal: A challenge for contemporary health education and communication strategies into the 21st Century. *Health Promotion International*, 15; 259-67

People move between categories of health literacy

Functional, interactive and *critical* health literacy are not static constructs

–Moving between categories of health literacy progressively indicates greater autonomy in decision-making, and personal empowerment.

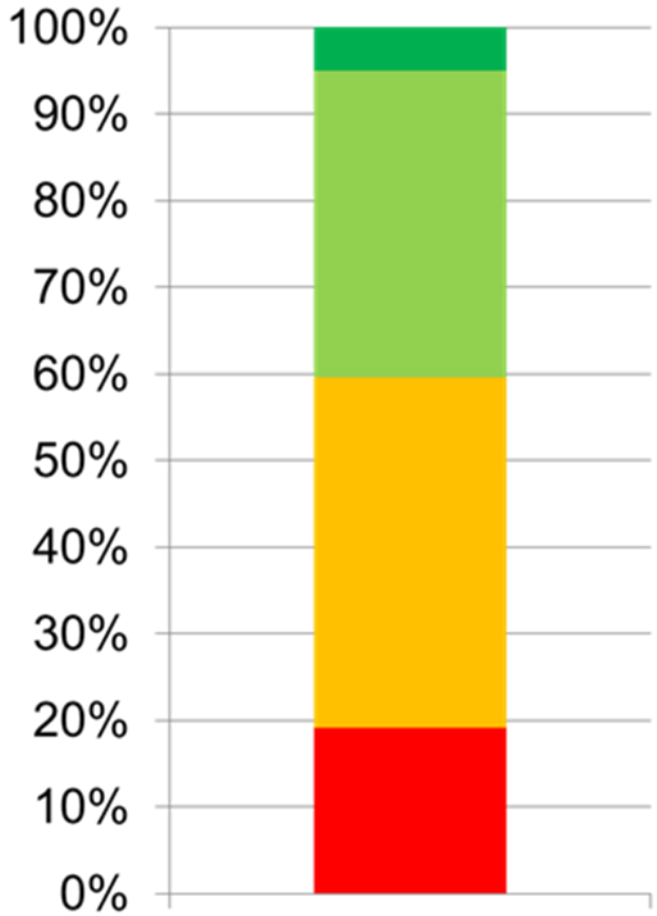
–Progression between categories is not only dependent upon skills development (reading, writing, numeracy), but also exposure to different forms of information (content, and media).

–It is also dependent upon a person's confidence to respond to health communications – described as *self-efficacy*.

–Both moderated by the context in which communication occurs (communication method)

Poor health literacy is more common that most people think

Australian Bureau of Statistics 2008



- 41% of adults were assessed as having **adequate or better health literacy skills,** scoring at Level 3 or above.
  - Able to perform tasks such as combining information in text and a graph **to correctly assess the safety of a product.**
- Around one-fifth (19%) of adults had level 1 health literacy skills, with a further 40% having Level 2. These people had difficulty with tasks like:
  - **locating information on a bottle of medicine** about the maximum number of days the medicine could be taken, or
  - drawing a line on a container indicating where one-third would be (based on other information on the container).

Health literacy matters

- in a health care system where there is
  - need for more effective prevention,
  - commitment to patient centred care, and
  - greater than ever dependence on patient self-management of chronic conditions.
- There is a strong social gradient in the population, with lower levels of health literacy much more common among the socially and economically disadvantaged.
- Those with greatest need are generally least able to respond to the demands of the health care system

Health outcomes can be improved through better communication

- In clinical practice, there is broadly consistent evidence* that comprehension of health information among individuals with low health literacy **can be improved** through modifications to communication, and changes to the clinical environment
- These deliver improved health outcomes including
  - Improved medication use
  - Improved self-management of conditions
  - Reduced reported disease severity,
  - Reduced unplanned emergency department visits, and
  - Reduced hospital use

*Sheridan et al. (2011). Interventions for individuals with low health literacy: a systematic review. *Journal of Health Communication*, 16(s3): 30-54.

Health literacy has become a priority for many countries across the world

We need to put into practice what works

Low health literacy can be improved through:

- Modifications to communication, for example by using **simplified text and pictures** in written communications
- Placing emphasis on building knowledge and cognitive skills, for example by using **teach-back methodologies**
- Modifications to **organisation of health services** to reduce the "literacy burden" on patients and visitors

*Sheridan et al. (2011). Interventions for individuals with low health literacy: a systematic review. *Journal of Health Communication*, 16(s3): 30-54.

Words to avoid in patient consultations

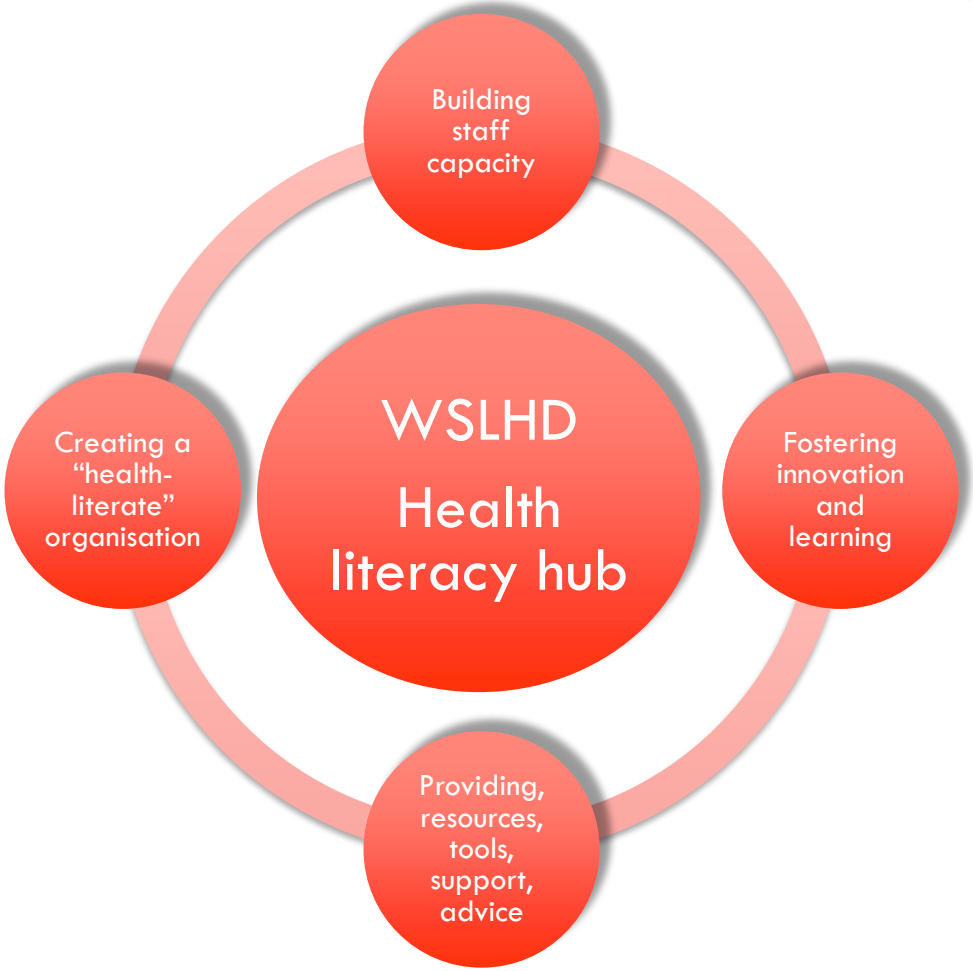
Word types to avoid	Definition	Example word	Alternative word
Medical words	Used to describe health	Condition	How you feel
		Dysfunction	Problem
Concept words	Used to describe an idea	Avoid	Do not use
		Wellness	Good health
Category words	Used to describe a group	Adverse	Bad
		High-intensity exercise	Use a specific example
Value judgment words	Require an example to convey their meaning	Adequate	Enough
		Significantly	Enough to make a difference

Created with information provided by the National Patient Safety Foundation.

Putting into practice what works in western Sydney - the "Health Literacy Hub"?

- The hub is a place to connect people interested in improving health literacy in Western Sydney – a community connected to best practice locally and the best in the world
- A resource to support rapid translation of best practice between and across primary (WSPHN-WentWest) and secondary (WSLHD) healthcare settings
- A source of tools and advice on how to improve communication with patients, relatives and carers, and members of the community
- A point of connection to the University of Sydney Health Literacy Lab – developing and testing innovations in health literacy

How does the Health Literacy Hub work?



Health Literacy Hub – supporting new ways of working

- Interactive "self-help" web portal
- Moderated "community of practice"
- Staff deployments – building a network of "health literacy ambassadors"
- Leveraging infrastructure developments to support WSLHD as health literate organisation
- Joint program of innovation, research and development with USyd Health Literacy Lab.

The health literacy hub: early priorities and current work

- **Successful transitions through healthcare**
  - improving communication, and ensuring optimal patient understanding at entry points (admission and pre-surgery) and discharge from hospital; and on enhanced communication in pharmacy dispensing
- **A healthy start to life**
  - optimising the existing communication and educational opportunities in ante-natal care and early childhood services
- **Prevention, early detection and early management of chronic disease**
  - supporting the partnership WSLHD/WSPHN priority in Diabetes; working with clinicians to improve patient self-management skills; and to optimise existing community oriented health education programs
- **Health literate hospitals**
  - to build health facilities that are sensitive to the variation in health literacy among our diverse populations

How to make sense of all this?

Some personal reflections:

I've led a charmed and privileged existence

Education has shaped my life chances

I've benefitted from great mentorship

Some professional reflections

Addressing health inequity is hard and complex – there is no single answer

Health promotion strategies offer the most complete response to this entrenched and complex problem

Focussing only on the social determinants runs the risk of alienating those we seek to benefit

Improving health literacy provides the foundations for meaningful, empowering engagement in health

Bringing the two together makes healthy choices, easy choices for all

Some recent reflections on past sins

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Towards a definition of health education and health promotion

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THE term 'health promotion' has come into common use over the last few years, and we have been keen supporters of this development. As a consequence there has often been lively discussion about the interrelationships between the terms 'health promotion', 'health education', 'disease prevention' and 'positive health'.

The translation of a concept into a definition has its problems. By their nature definitions are summaries, and will inevitably be unsatisfactory. Subtleties of the objectives and processes are often missed. Nevertheless, we think it important that some statement is made so that there is common understanding about these terms. Our current view is as follows.

Health education

- Seeks to improve or protect health through voluntary changes in behaviour as a consequence of learning opportunities. It can include personal education and development, and mass media information and education.
- Personal education and development concerns improving knowledge about health, offering health risk advice, and promoting self-esteem and self-empowerment. Examples include the opportunities provided through teacher-pupil and doctor-patient contacts.
- Mass media information and education tends to be non-personal, and concerns raising public awareness, creating a climate of opinion and offering health risk information and advice. It can take the form of public relations, advertising, marketing, news information, and distance learning projects, eg through radio, television, newspaper, other publications.

Health promotion

- Seeks to improve or protect health through behavioural, biological, socio-economic and environmental changes. It can include health education, personal services, environmental measures, community and organizational development, and economic and regulatory activities.
- Health promotion embraces the concepts of disease prevention as well as the notion of positive health - the promotion of a sense of physical and mental wellbeing. A major emphasis is to make the healthy choices, the easy choices. Health education is a core component, and it is unlikely that health promotion will succeed without it.
- Personal services designed specifically for health promotion comprise:
  - Preventive medicine services, eg immunization, family planning, hypertension screening and control.
  - Positive health services comprising individual and group programmes, eg smoking cessation, keep fit, weight reduction.
- Environmental measures concern safeguarding the physical environment and making it conducive to health, ie at home, at work, on the road, in public places. Examples of these often traditional 'public health measures include provision of clean water, safe sanitation, pollution control, fluoridation, fire precautions, industrial safety measures, better road design, non-smoking areas.
- Community development normally involves the mobilization of community resources, both human and physical. Activities might include the formation of self-help and pressure groups, and the development of local facilities and services.
- Organizational development usually concerns implementing policies within organizations which promote the health of staff and clients, such as the achievement of non-smoking areas, exercise and changing facilities and healthy catering services.
- Economic and regulatory activities are primarily concerned with creating a social and economic environment which protects or improves health. Examples include fiscal measures, legislation, voluntary codes of practice and the widening of the availability of services and products conducive to health.

We look forward to carrying further contributions to the debate about health education and health promotion. Letters or brief articles should be sent to the Editor to arrive by the beginning of October.

Retrospective

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Health education and health promotion revisited

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Abstract

Thirty years ago, the World Health Organization (WHO) Ottawa Charter for Health Promotion created a paradigm shift in addressing major public health challenges. Traditional approaches to health education focused on personal health 'risks' and lifestyle choices were quickly overshadowed by the attention given to more comprehensive policy and environmental interventions. Since that time health education has evolved in content, media use and sophistication of communication to fulfil a wider range of purposes. The concept of health literacy has been useful in sustaining this change. As the tools for communication have been transformed by digital communication, and the marketplace for communication has become more crowded and complex. Health education has continued to evolve to reflect these changes, enabling people to navigate competing sources of information and to engage meaningfully with social and economic determinants of health. Equitable access to quality health education and lifelong learning remain the cornerstones of modern health promotion.

Keywords

Health education, health literacy, health promotion, public health practice, theory

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A personal journey….

From this……..

to this