

Towards prevention—an outline plan for the development of health promotion teams

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Prevention of disease and the furtherance of good health are being universally promoted at the present time.¹⁻⁴ Partly this is in response to the cost-crisis associated with high technology and hospital-based health systems and to the economic recession. Partly it is also due to the growing realization that a rational approach to modern health problems requires that prevention and care should have a much greater emphasis relative to cure.⁵ However, there remains considerable confusion about how to proceed.

The DHSS publication *Prevention and Health, Everybody's Business* implied an understanding of the need for participation by the general public in matters related to their own health; in reality the approach advocated can be seen as a narrow exercise in victim blaming. It is now clear that to be successful an approach to prevention should be based on action at all three levels at which influence may be brought to bear. Such an approach should also take full account of the relative contributions of primary, secondary and tertiary prevention to the problem under discussion (*Fig. 1*).⁶

The origins of the public health movement in this country lay in a succession of inter-related problems in which effective central action by key people led to an immediate and obvious benefit to the public. The measures used were then usually widely accepted as being in the public interest. These problems were the dramatic ones associated with epidemic infectious disease against a background of squalor, poor housing, lack of sanitation and malnutrition. The main battles were often those involved in securing finance from the General Rate to pay for environmental improvements.⁷

The society of the times was highly ordered and paternalistic and ordinary people did not expect to take part in decision-making. The Medical Officer of Health had, at least in theory, considerable institutional authority. Even when public health expanded into personal health services at the beginning of this century there was no strong consumer lobby and the power of the Town Hall was considerable.

The situation is much different today. Contemporary health problems are almost inevitably multifactorial and the prevailing ethic at least until very recently has been a libertarian one. There are few examples where a single measure can lead to immediate results. The actions on tobacco, seat belts or fluoride may present themselves as such examples, but when examined closely the argument is seen to be fallacious; for an initiative to be successful the climate of opinion needs to be such that, in general, the public regards it as helpful and desirable and a measure which they wish to go along with and defend. The widespread flouting of the prohibition of cannabis gives some idea of what might be expected if similar legislation could somehow be manipulated through Parliament with respect to tobacco. Nevertheless, it has been possible through a concerted multi-dimensional approach

Level of Action	Level of Prevention		
	Primary	Secondary	Tertiary
Government			
Institutional			
Personal			

Fig. 1. A framework for constructing prevention programmes.

to achieve a major shift in direction of public opinion whereby legislation to control tobacco advertising and the extent of smoking in public places would attract widespread consent and the policy of a high tax on tobacco products has general support. Simultaneously, the climate of opinion is now right for anti-smoking health education on a personal level because the audience is becoming receptive.

The wearing of seat belts is almost impossible to police, and unless the public is more or less committed to the idea, there is little chance of the impending legislation being effective; it remains to be seen how the British respond to the legislation this year.

The fluoridation of water supplies seems to be regarded as an issue where all that is necessary is to lobby and win over key people on the community health councils, health and water authorities and the battle is won.⁸ It is worth pointing out that such an approach in modern Britain is not conducive to permanent change; the lobbying effectiveness of the Pure Water Association is well known and there is nothing to stop them from reversing committee decisions.

The achievement of lasting change in the factors affecting health and disease nowadays implies taking the public with you and if possible enabling them to take the initiative. The impasse over abortion legislation is probably a good example of a matter of widespread public concern where a large proportion of the public has actually thought about and formed a view. The result has been that even a well-organized pressure group such as Life, which has the backing of the Roman Catholic church, has so far been unable to overturn a piece of popular legislation.⁹

If the style necessary for modern prevention is participatory it must also be multi-disciplinary. Draper and his colleagues have made a strong case for the need for multidisciplinary health promotion teams to work in partnership with each other and with the general public.¹⁰ In their terms, in contemporary society there can be no more 'medical heroes' in the mould of the medical officers of health. Such teams need to be an independent resource to the community and capable of taking on vested interests without fear of losing their jobs, a condition of service which was recognized as necessary for the first medical officer of health, William Henry Duncan.⁷

The World Health Organization has taken the concept further and placed it firmly in the context of primary care.⁴ In the WHO strategy document the principles are clear—participation, intersectoral collaboration, education, team work and the development of appropriate health indicators are some of the keys to attaining the strategy goal whereby all people should be able to lead socially and economically productive lives by the year 2000. This strategy implies the adoption of a concept of primary care based on a public health model. Such a concept is not the prevailing wisdom among general practitioners in Britain whose practice remains firmly orientated towards the numerator of attenders and by and large ignores the denominators of the practice population, even though these exist in the

form of practice lists and even though many practices have age–sex registers. A model of practice based on a public health approach has been strongly advocated by Tudor Hart and has been well received.¹¹

THE WAY AHEAD

What then is the way ahead? Several English regional health authorities have now set up regional health promotion teams on the assumption that they are 'a good thing'. Some of those that exist have been formally constituted whilst others have not, and some have managed to obtain an independent budget. Probably the two that are most frequently talked about are those in the West Midlands and Wessex. Without doubt both have at least made an impact on their region in publicity terms. The West Midlands claims a major success with the fluoridation of water whilst Wessex played a key role in providing evidence and support for the seat belt legislation last year.^{8, 12}

However, both suffer from the same fundamental weakness; what they have done so far seems to have been very much from the top downwards, functioning in comparative isolation from the operational levels of primary care and health district and the active elements of the community. Neither have so far developed appropriate health indicators to demonstrate the usefulness of what they do. There is little indication that they are about to make the take-off from being enthusiasts pursuing a worth-while objective to being the effective catalysts of a modern locally based public health movement involving the general population. For that to happen it is necessary to have a clearly developed programme based on agreed principles, of which the following are probably among the most important:

1. Activity on health promotion and disease prevention should be carried out at the most decentralized level that is compatible with effective action.
2. There should be a team approach.
3. Participation by the community should be an over-riding principle.
4. Health promotion teams should have security of employment and independence of action.
5. A strategic plan for the promotion of health should be produced at regional level which is informed by the priorities and objectives decided at the periphery.
6. Health promotion teams should produce annual reports based on the development of appropriate indicators that can be used to assess progress and revise objectives.

1. Activity on health promotion and disease prevention should be carried out at the most decentralized level that is compatible with effective action

If account is taken of WHO as an international agent whose role is to oversee the realization of the target of 'Health For All By the Year 2000', there are five levels of organization involved (*Fig. 2*).¹³ The important thing is that the most appropriate activity should be carried out at the most appropriate level. The work of each team can be divided into functions, which include monitoring to inform the evaluation and revision of strategy and those which are catalytic in the sense of facilitating the activities of those elements that are functioning closer to the community. The implication of this is that the operational component is strongest at a district and primary care level where the public is in a small group or a one-to-one relationship with members of teams. At these levels teams should be seen as resources which are more or less directly accessible to the population served. The corollary of this is that regional health promotion teams, the national health promotion team and the WHO subcommittee should only become involved in operational activities if they cannot be more effectively carried out more peripherally; such operational activities as they are involved

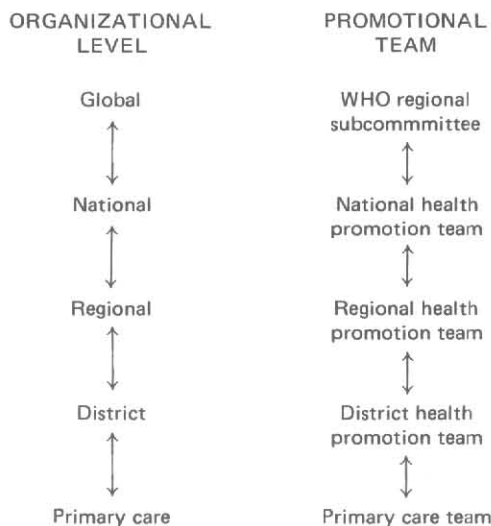


Fig. 2. The five levels of organization for prevention.

with are likely to be those involving government policy and the policy of organizations and institutions.

2. *There should be a team approach*

That a team approach is necessary follows on from the complexity of the modern public health task. The composition of the team will vary depending on the level. At all levels it will be multidisciplinary but will be kept at the smallest size which is compatible with representation of all the necessary interests, and this brings with it the implication that a representative from a team to a team at a higher integrative level will need to be able to represent a collective view rather than just the view of his or her own area of expertise.

At the higher levels of integration the emphasis is likely to be on information and evaluation with educational support to professionals whilst at lower levels of integration the emphasis is more likely to be on the effective deployment and communication of health information to the general public by field workers on the basis of appropriate information derived from local epidemiological study.

The most effective composition of health promotion teams is so far unknown and is something which requires evaluation. The teams which have been organized so far have been put together in very much of an ad hoc, empirical fashion and much greater thought needs to be given to this if they are to be generally successful rather than being dependent for success on the charismatic leadership of individuals. The composition of the Wessex Regional Team is similar to that which currently seems to be finding favour around the country (Table I).

Health promotion teams operating at different levels will have different orientations and emphases and training programmes need to be developed to ensure that they possess the necessary skills to carry out their tasks effectively.

3. *Participation by the community should be an over-riding principle*

Paternalism has no place in a modern public health movement. The public increasingly demands to be involved in decisions affecting individual, family and social health. From the

Table 1. Membership of the Wessex Positive Health Team

Regional health authority member (nominated by Wessex RHA)
Medical representative (nominated by the regional medical officer)
Nursing representative (nominated by the regional nursing officer)
Regional Specialist in Community Medicine (Information and Research)
Regional Press and Public Relations Officer
Regional Administrative Assistant, Development Division
Senior member of the Department of Community Medicine at Southampton University
Regional medical advisory committee member
Health Education Officer (nominated by Wessex HEO group)
Community health council secretary (nominated by Wessex CHC secretaries' group)

behavioural point of view the attainment of congruence between individual health beliefs and behaviour and public health goals is most likely to occur when the public has been involved in the identification of those goals. This can pose a problem for doctors who are unaccustomed to a partnership approach to working with their patients and the general public.

The implications relate to the style of clinical medical practice but also to the necessity for health professionals to accept and work closely with patient groups, community health councils, employers, trades unions, local authorities and other formal and informal community organizations and institutions. Teams need to see themselves as important resources which should be widely known about and used.

4. Health promotion teams should have security of employment and independence of action

When Duncan was appointed Medical Officer of Health for Liverpool in 1847 his salary was £300 per annum with the right to private practice. The appointment was criticized at the time in *Punch* in sarcastic terms:

If the Officer of Health recommended by Mr Punch shall have for a patient a rich butcher, with a slaughter house in a populous neighbourhood; an opulent fellmonger or tallow-chandler, with a yard or manufactory in the heart of town, he shall not hesitate from motives of interest to denounce their respective establishments as nuisances. He shall not fail to point out the insalubrity of any gas-works, similarly situated, the family of whose proprietor he may attend; and if any wealthy old lady who may be in the habit of consulting him shall infringe the Drainage Act, he shall not fail to declare the circumstances to the authorities . . .

The reservations expressed in *Punch* were confirmed in practice and one year later Duncan's post was made full-time. His protection from dismissal as a result of carrying out his duties rigorously was also established as an important principle. This principle is no less valid today for health promotion teams.

5. A strategic prevention plan for the promotion of health should be produced at regional level which is informed by the priorities and objectives decided at the periphery

The function of the regional level is to coordinate and support activity at the district and primary care level. Without a strategic plan such activity will continue to be haphazard and

undirected. The prerequisite for orderly progress is a regional strategic plan which takes account of preventive prospects and enables their attainment to be monitored. This can be done by requiring districts to produce their own preventive strategies for inclusion in the regional plan.

6. Health promotion teams should produce annual reports based on the development of appropriate indicators that can be used to assess progress and revise objectives

The World Health Organization strategy document on 'health for all by the year 2000' has produced health indicators that are recommended for use at global and national level. These cover a number of areas including indicators of survival, lifestyle, 'quality of life', socio-economic indicators and indicators of progress towards primary health care.¹³

Some of these indicators can be used at regional, district and primary care level but others need to be developed. It should be possible to have reliable community diagnoses available at the appropriate level, and this probably means building up profiles of small area statistics from ward level which can be used by primary health care teams or in aggregate at district or region.

It is probable that a regular system of sample surveys for risk factors using the 'dipstick' approach will be necessary based on practice list populations or the electoral roll.

The development of an epidemiological orientation among primary care staff and of appropriate primary care morbidity statistics deriving from routine work will be a priority and will require the provision of special educational programmes of short courses and continuing educational support from academic departments of community medicine.

The provision of annual reports from primary health care teams and biennial aggregate reports by district and regional health promotion teams will provide information to professionals and the general public in a form that will facilitate public involvement in identifying and achieving goals for prevention.

CONCLUSION

The challenge facing preventive medicine is quite clear. All the fine words, articles and books of the past 10 years and the World Health Organization's strategy of 'health for all by the year 2000' are in danger of becoming just so much hot air. Despite being a signatory to the WHO strategy, our own government has done nothing in practical terms to facilitate its realization.

At a time when community medicine seems to have all but lost its way, here is an opportunity to make a real contribution to the development of a new public health movement. Let us not pass it up.

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