
Controversy: 1

Health promotion – caring concern or slick salesmanship?

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Author's abstract

There is an increasing tendency for administrators and government to expect both the health services and the education service to 'show results' for the investment of public money in them. One response to this has been the growing commitment to 'health promotion', where measurable objectives may be set in terms of desired behaviour (stopping smoking, breast self-examination, child immunisation etc) and where evaluation can be made on the evidence of statistical improvement.

Health workers use the term 'promotion' in a variety of ways which seem to be as confusing to them as they are to their clients – the general public. Since successful promotion is likely to depend on the 'hard sell' (and since the methodology and aims of this may be incompatible with those of health education) this paper looks at some of the questions which the customer might wish to ask the salesman before deciding whether or not to buy.

Health has always been a prime candidate for fad and fashions – for the latest diet or miracle cure, for wonder drugs, and for promises of longevity, virility, attractiveness, or whatever. Whilst our interest in health reflects our concern and, perhaps, an eternal optimism, it also reflects our fears and insecurities, and leaves us prey to sharp practice, to naive beliefs, and to unfounded claims which even if they do us no harm – are likely to do us no good either.

Recognition that people in search of health may fall easy victims to the quack or charlatan, or to those whose vested interests are not always to the benefit of the consumer or client, has been reflected in the increasing professionalisation of health care over the last century. 'Experts' have arisen whose job is to define or diagnose problems (which may already exist or which are anticipated) and who can prescribe or recommend ways of dealing with such problems, or of preventing future occurrence. These 'experts' will also make evaluations about the success or failure of such interventions. This kind of approach (the 'medical model') to the preservation and enhancement of health is claimed to protect individuals and groups from the

harm which might arise, not only from those who set out to exploit others for their own gain, but also from the misguided attentions of well-meaning 'amateurs'. Most of us would, I believe, be sympathetic to such a view since we recognise that when we are in need of help and advice the idea of expertise has considerable appeal. But unlike the case of disease, where it may – in some cases – be possible to develop expertise, or in the field of education where subject specialisation enables the identification of expertise within narrow confines, claims to 'expertise in health' are much more difficult to justify. Not only is it difficult to see how the multi-factorial nature of health could be encompassed within one, all-embracing framework but there is also the problem that some individual 'health practices' may be harmful in relation to others and, in turn, to the whole person. Thus, for example, the recommendations of the dental profession that children should be encouraged to take crisps and nuts to school rather than sweets may, indeed, help to achieve the aim of their slogan 'Teeth for life'; it is unfortunate that on the other hand there is also some evidence that increased intake of saturated fats, increased intake of salt, and obesity, all increase the risk of life-threatening disease. Yet presumably any or all of these may result from the dentist's advice.

The most recent manifestation of professional concern for our health can be found in the new trend towards 'health promotion', where some health authorities have already appointed or advertised for Health Promotion Officers or have set up Health Promotion Teams, often under the leadership of the community physician. Just what 'health promotion' is, what qualifications are needed for team membership, and what the theoretical basis for health-promoting activities might be is hard to establish. Some teams, for example, seem to be formed on the basis of collecting together under one label all those employees whose job descriptions make any kind of reference to health, reflecting the definition of Nelson and Summers (1) that health promotion is

'... any combination of health education and related organisational, political, and economic interventions designed to facilitate behavioural and environmental adaptations that will improve health.'

Key words

Health; health education; health promotion.

Leaving aside, for the moment, a suspicion that this is an open invitation to administrative empire-building on a vast scale, such an all-embracing definition is either so bland and vague (health promotion as anything which is to do with encouraging health) as to be meaningless as a basis for practice or, more worrying perhaps, could be seen as a justification for any kind of manipulation or interference in the lives of individuals merely on the grounds that those with status or power believe that it will lead to 'better health'. The paternalistic, or authoritarian, nature of this statement, and the absence of any reference to the person (except by implication as the future host of improved health), raise questions about the ethics of interventions which may lead to loss of freedom and to discrimination against minority groups. Such questions are largely ignored at the present time even though, as Nelson and Summers admit, this definition has so far led only to emphasis on holding down medical costs and the need to show cost-effectiveness (2).

Not all health promotion is envisaged as being on such an all-embracing scale, but limitations of team size bring further problems since the logic of team composition is neither self-evident nor explicated. It is difficult to form a coherent picture from observation, since promotion teams range in size from single-handed operations to large groups with a mixture of professional backgrounds ranging from community medicine, psychology, and nutrition to nursing, research and so on. Not all professions are included in each team and the formation seems to be largely a matter of administrative convenience or the personal preferences of whoever has the power to set up such groups. In a similar way the purpose of such teams is equally blurred or difficult to grasp. 'Health promoters' appear to be unaware of the need to communicate clearly about their purposes and their slipshod use of language compounds the difficulties for anyone trying to come to grips with what they are proposing to do. Terms, for example, such as promotion, prevention, education, and behaviour-change are used as if they are interchangeable whilst attempts to offer constructive criticism, or to question the logical entailments of certain proposals, are often met by statements such as 'You have misunderstood my point' or 'That wasn't what we meant'. This may be true, but it seems reasonable – as a matter of professional ethics – to expect groups such as these to make clear just what they are trying to do and the grounds on which they feel their activities may be justified. In the absence of such clarity many health-promotion proposals at present seem to fall into one of three categories. The first is the all-embracing model which ignores paradigm boundaries and seems to claim that promotion of health is a *portmanteau* term into which everything and anything to do with health can be packed. If this is the case then the idea of a selected professional team makes no sense, since it ignores those non-professionals such as parents and peers who are highly influential on health attitudes and

behaviour, and it is unlikely to have the necessary status to exert political and market influence. The second category includes those selected teams separated from other 'health professionals' to perform their functions of promotion; it seems reasonable to expect that such groups should first specify their roles and intentions, and the basis of their expertise, and then obtain agreement about their value and obligations before demanding funds and support from established areas of health care or, indeed, from any other public source of finance which may be available.

The third category of health promotion is the one advocated by Cowley (3) and his team in South Australia. It is the only one which, so far, has attempted to delineate clear boundaries and to define its terms. It seems to have some features in common with the other two models (the need for services, which is normatively defined, and an indoctrinatory approach which seeks conformity rather than understanding, for example) and, in its strenuous attempts to answer demands for demonstrable success, it is likely to exert a strong influence on future developments in health promotion in this country; as such it is worthy of further examination.

The South Australian version of health promotion recognises that professional commitment is not enough and that commitment on the part of the client is also essential. Thus far, it is no different from health education. Where it does differ, though, is that Cowley and his colleagues advocate a 'hard sell' approach, claiming that this is a highly effective way of changing behaviour which can prevent illness and suffering, and save money and lives; more importantly, they say, it can do it quickly, avoiding the inevitable time-lag which is a feature of most 'educational' processes. Health promotion, they claim, is no different from any other form of 'selling'; it requires either a ready market or the means to stimulate one; it requires concentrated efforts by expert communicators in the media and in the health services; and it requires a 'market research' approach to evaluation to prove that it works. This kind of health promotion, in contrast to the broad spectrum approach, focuses on the same kinds of methods which are available to those who sell other kinds of 'goods'. It is true that what is being sold is different, and so are the personnel or 'salesmen'; nevertheless, there are many similar features whether people are being persuaded to buy cigarettes, low-fat spreads, the latest fashion in clothes, music, medicine, or health. Promotion is about convincing other people that they need, or ought to have, what the salesman or promoter wants them to have. If this is the case then one way of assessing the appropriateness of the health-promotion approach is to ask the same sorts of questions as we might ask of any salesman; indeed, it is not only a matter of common sense to do so, it is also a matter of ethical necessity for professionals who claim to be acting in the best interests of their clients.

It seems to me there are five questions which might form the basis for inquiry. They are:

1. What am I being offered or sold?
2. Is it necessary/do I want it?
3. Does it work/do what is claimed?
4. Might it do harm/could I be worse off?
5. What's in it for the salesman?

The first is so obvious that it is tempting to ignore it (as, in practice, often happens); but 'What am I being offered or sold?' is crucially important. If we look carefully at commercial advertising we often find that the goods on offer are claimed to be a means to an end, rather than an end in themselves. We are in the world of indirect selling where cigars and cigarettes bring us happiness ('... a cigar called Hamlet'), alcohol brings us friends and a youthful life style (Martini), cars give high social status and a good self-image, and a whole range of other goods appear to offer a world of ease and comfort, attainment, or pleasure. And so it is with marketing 'health', for here again is an ideal which cannot be directly marketed. What is on offer is sold to us as a means to a desired end; but what those who seek to 'promote health' must face up to is the need to provide evidence that there is a proven link between means and ends. We may scoff at the advertising for low-fat spreads which appears to offer the buyer everything from the sexual attraction of a slim body (or for middle-aged men, a caring wife) to the chance to avoid heart attacks and so cheat death. But to many there is a similar 'credibility gap' between health and the stress of giving up cigarettes, the aches and pains of jogging, or the chore and tension of feeling for breast lumps! 'What is being sold?' then, is an important question, for though the consumer of 'health' is not protected by the Trades Descriptions Act there is no reason to take this as an invitation to be less than truthful. Pious talk about the Broad Street Pump (4) (which is often heard in reply to requests for evidence) does not justify, in my view, a hard sell for unproven procedures, especially where – in contrast to Snow's approach – there is a marked reluctance by present-day promoters to accept responsibility for undesired or unintended outcomes which may result from their advocacy.

The other four questions follow from the first and are clearly linked to it. The answer to the question 'Is it necessary/do I want it?' is fairly straightforward, though there are deeper and interesting questions which we might want to ask about meaning, quantity, and quality. For the purpose of this paper, though, I am going to assume that the promoters are right – that health is desirable and that most of us want (and need) to be healthy as a basis for going about our daily lives in a way which suits us.

Question three, though, 'Does it work/do what is claimed?' is likely to give health promoters more difficulty for there are at least two major problems inherent in the idea of 'selling' health. The first is that there are relatively few cases where there is unequivocal evidence that certain courses of action will lead to health. There are, of course, some – but whether they, and the numbers of people who might

benefit, justify the wholesale reorganisation of health professionals, and the consequent administrative expense, is not yet clear. The second inherent problem of 'selling' is that there is a marked difference between selling goods and selling health; not only do goods tend to be 'one off' purchases which may be repeated if the customer is satisfied but the purchaser also has something tangible for the outlay. Health promotion, though, is a different matter for not only is there unlikely to be any immediate evidence of benefit from the 'purchase' or commitment but the effects may be negative, involving pain and effort or – since much desirable health behaviour involves stopping what we are doing at present – we may feel that we have nothing to show for our investment. Even if we compare long-term purchases and health-promoting activities there is still the difficulty of proof that the latter do bring the desired results. Mortgages or insurance policies, for example, are similar to 'investment' in our health in that they have long-term goals; the crucial difference, as we have already noted, is that health promotion has none of the safeguards built into it that we have come to expect from other kinds of investments; indeed, health salesmen have so little evidence for their claims and can offer so few guarantees that they would be unlikely to make a living as insurance brokers or the like. It is not clear why we should take more on trust simply because health and not money is at stake, or because those selling are employed by the State and thus, unlike those selling insurance, are protected even when they fail.

The idea of doubt about 'results' leads to the question 'Might it do harm/could I be worse off if I do what is suggested?' There are some who would argue that risk or harm to a minority can be justified by the benefit to the majority, but such a view is not shared by all since it is one which can lead to the worst kinds of discrimination against minority groups. Because, in its present manifestation, promotion is a relatively new area, there is considerable pressure to show results, and the 'best' promotion teams are going to be those which can produce statistical evidence to back up their claims, for it is this kind of 'fact' which government (through the Department of Health and Social Security) seems to want. The interest is not in whether people are healthier, feel better, or – as Katherine Mansfield (5) suggests – can become all that they are capable of becoming. The interest is in the statistics of behavioural change; just as success in the world of commerce is measured by improved sales figures so will health promotion be rated.

But many kinds of promotion may produce harm as well as beneficial results. An example from recent practice illustrates this: The South Australian Health Promotion Department's campaign to combat breast cancer has been based on widespread media campaigns (newspapers, magazines, television and a 'health shop') which are intended to raise women's consciousness of the problem and to teach the technique of breast self-examination (BSE). In an

interim report on the campaign, Cowley (3) claimed that success could – and would – be measured on two specific measurable criteria: firstly that women would visit their general practitioner for consultation, having found breast lumps by BSE, and that the anticipated increase in the numbers of such women could be counted as success; secondly, that such presentation (and referral for surgery) would be at an earlier stage than at present, with a reduction in average lump size of more than 50 per cent.

What examples such as these have in common with much health promotion is that they highlight the way in which promotion is not only unscientific but also mechanistic, behavioural, and – above all – indoctrinatory. Promotion ignores and disvalues the individual except as a contribution to the overall statistics, and the whole idea of counting success in crude totals such as the number presenting with smaller breast lumps, (or as percentages who have given up smoking,) illustrates this approach; it says nothing of the consequences of such behaviour. There is no convincing evidence, for example, that finding a breast lump at an earlier stage necessarily increases the chance of cure (6); it may do so – in some cases – but there will be many others who will have to live with the fear of death for a longer time as a result of such promotion. The subtleties and complexities of decision-making for women in risk groups are beyond the scope of health promotion, and yet self-examination is claimed to be a ‘high priority’. This may, unfortunately, be because the natural fears which result in a high take-up by the captive target group can be shown as a good ‘success rate’ – as has been claimed by the team in South Australia.

In a similar way, pressure to stop smoking is always a ‘banker’ in promotion and it is tempting simply to look at the overall figures of those who have given up. Smoking, though, like overeating, is rarely just a naughty bit of behaviour, and we need to look for reasons why people smoke since giving up often leads to the substitution of other behaviours; we should be wary of claiming success until we are sure that what those who have given up smoking are now doing is less harmful than cigarettes. It may be that we also need to think about whether such ‘victim-blaming’ could be avoided if we were to concentrate our efforts on the personal and social stresses which often lead to such behaviour. The promotion of health is often outside the scope of individual decisions and it may, perhaps, be the case that promotion teams ought to attempt the more difficult (but ultimately more effective, I suspect) task of influencing government, producers, and manufacturers rather than put their efforts into changing behaviour by inducing guilt in individuals. A lobby for the removal of sugar and salt from canned foods, or for the production of lean rather than fat meat, for example, might be worthwhile starting places and would represent a positive approach to health rather than the present, mainly negative, one.

The fifth kind of question which any sensible

consumer asks is ‘What’s in it for the salesman?’ and though it may seem harsh to do so, I believe we should ask this of the health promoter too. I have already hinted at some of my reservations – in particular the way in which I think promoters may have taken the easy way out by claiming credit for results which are not as good as they might appear to be, and by focusing their efforts on the victims (clients) and not on those whose vested interests cause the harm. To deal with governments and industry requires political clout and the health-promotion teams do not seem to have this, so my criticism may be unfair; but if they can only focus in a piecemeal fashion on the behaviour of individuals, and may – as we have seen – cause harm in the process of doing so, it is hard to understand their *raison d’etre*. If health promotion is about all those measures which can enhance and develop health then the present development of teams is either inadequate or inappropriate. Individual needs and variations are ignored and the teams take no responsibility for harm, yet they lack the clout to make decisions or to exert influence on the large scale; they make claims for scientific rigour in the evaluation of results whilst the practices which they advocate may lack adequate supporting evidence or be characterised by conflicting evidence which is ignored. Also, the membership of promotion teams is often idiosyncratic or an administrative convenience which lacks rational explanation. The idea, then, that ‘health promotion’ in its present guise is the way forward to better health seems to be a matter of some dubiety and to require far more discussion than is the case at present – where bodies such as the Health Education Council are committing themselves to the enterprise, where health authorities are already setting up teams or advertising for ‘Health Promotion Officers’ – and where the initial benefits seem likely to accrue to the ‘salesmen’ in terms of job, status, or salaries rather than to the ‘customers’. It is, I believe, incumbent upon such promoters to spell out their value to the community, the evidence on which their claims are based, and the way in which they perceive their professional responsibilities towards their clients (and to other professionals with whom their approach may be in conflict) before we can be expected to give our wholehearted support to this enterprise. Until this is done, ‘health promotion’ is either a meaningless slogan which does not merit serious attention – much less, funding – or it is a ‘hard-sell’ technique which means customers are entitled to consumer protection from sharp practice, exploitation or harm – features which are noticeably absent at present. It is a sad reflection on a ‘caring profession’ that the professionals or ‘salesmen’ appear to be deriving more benefit from the enterprise than are the clients, but there seems to be little evidence available to the contrary at the present time.

It has become popular for those who support ‘promotion of health’ to accuse those who are not yet convinced of its overriding value of not caring about better health. My answer to this accusation is that it is

just that care which gives rise to doubts of the kind which I have expressed. Health promotion, like advertising campaigns, cannot hope to do more than induce superficial change, which is susceptible to the next round of gimmicks or hard sell. Long-term commitment to sensible health behaviour – what R S Peters (7) has characterised as travelling with a different view – is needed if we are to improve health, and this is a function of education, not promotion. Indeed, the very activity of hard-sell promotion is in direct conflict with the rational decision-making and personal autonomy which are central to educational, long-term goals, and the two cannot co-exist. What we are gambling with is the long-term good of others; if there is such convincing evidence as the promoters claim it is likely to be better, long term, to offer people such evidence as a basis for their own decision-making rather than to manipulate them to conform to the experts' views. It is not only a more ethical way of going about things but, pragmatically, it is more likely to be effective since people tend to behave sensibly if they can see the point of so doing, and if they have made up their own minds about what it is they want to do.

In conclusion: health promotion in its present guise has serious conceptual, ethical, and methodological problems. Its supporters are, I believe, sincere but they are misguided in claiming that their activities will lead to health for, in encouraging reliance on experts and in adopting manipulative techniques to induce

behaviour change and conformity the whole basis of good health may be undermined – a matter of considerable concern to many health educators. If our view is mistaken then it is up to the 'promoters' to make it clear where and why we are wrong.

References and notes

- (1) Nelson E, Summers J. Health promotion – the second public health revolution: promise or threat? *Family and community health* 1983; vol 5, 4: 2.
 - (2) As in *Healthy people*, Surgeon General's report on health promotion and disease prevention. Washington DC: US Department of Health Education and Welfare; DHEW pub no 79-555071, 1979.
 - (3) Cowley J C P. Health promotion in South Australia. Paper given to Health Promotion Conference, King's Fund Centre, London, 1983 Oct 7.
 - (4) Dr Snow is credited with an inspired act of anticipatory disease control. He removed the handle of the Broad Street Pump in London during the cholera outbreak, amid considerable criticism, believing that the water was the cause of the infection. The subsequent drop in numbers contracting cholera appeared to justify his actions, and now this is often taken as an example to justify intervention in the absence of evidence.
 - (5) Mansfield K. Quoted in preface to *Fit for the future*, Court Report. London: Her Majesty's Stationery Office, 1976.
 - (6) Chamberlain J, for example. In: Alderson M, ed. *The prevention of cancer*. London: Edward Arnold, 1984.
 - (7) Peters R S. In: Archambaut R, ed. *Education as initiation. Philosophical analysis and education*. London: Routledge and Kegan Paul, 1965.
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