

The Evidence of Health Promotion Effectiveness

*Shaping Public Health
in a New Europe*

Assessing 20 years
Evidence of the
Health, Social,
Economic and
Political Impacts of
Health Promotion,
and
Recommendations
for Action.

*A Report for
the European
Commission
by the International
Union for Health
Promotion
and Education*

PART ONE
GOVERNANCE DOCUMENT



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PART TWO of this report can be read in conjunction with Part One, which provides a summary of the main evidence, and puts forward a case for ensuring that Health Promotion is properly resourced. This will enable Health Promotion to play its full part in the public health policy framework which is currently being shaped by the European Commission to meet the health, social, economic and political challenges of a developing European Union.

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The Main Players

In order to contribute to the debate on Europe's developing public health policy, the International Union for Health Promotion and Education (IUHPE) decided to undertake an ambitious and innovative project which would assess and collect the evidence of 20 years of health promotion effectiveness.

As an integral part of the project, which received financial assistance from the European Commission, the IUHPE created forums which allowed wide consultation beyond the health promotion community, entering into dialogue with representatives from political groupings, non-government organisations, the private sector and academia.

Two international meetings were held in Brussels and Paris with an invited audience – a 'Witness Group' – who engaged in dialogue with health promoters on the health, social, economic and political impacts of 20 years of health promotion activity.

Under the guidance of Director of Programmes, Anne Bunde-Birouste, who first conceived the project, the IUHPE invited a group of experts from around the world, and from a variety of disciplines, to join an Advisory Group to oversee the work. This included health promoters from Europe, Canada, the United States and Australia. The IUHPE also invited leading European health lobbyist, David Boddy, to participate as Project Editor, and in addition, as part of the bridge-building process between the political and health promotion communities, to draft Part One of this report.

The IUHPE President, Professor Spencer Hagar, acted as Chairman of the Project Advisory Group. Professor Maurice Mittelmark (Norway) and Professor Don Nutbeam (Australia) provided special technical assistance to Mr Boddy.

This project has also benefited greatly from the contribution and collaboration of the US Centers for Disease Control and Prevention, Atlanta, Georgia, USA, and from the Department of Health Promotion, Social Change and Mental Health Cluster, WHO Headquarters, Geneva.

The IUHPE

The International Union for Health Promotion and Education (IUHPE) is the only international NGO in the field of health promotion and brings together individuals and organisations from more than 90 countries worldwide, with seven different regional offices. The mission of the IUHPE is to promote global health and to contribute to the achievement of equity in health between and within the countries of the world. The IUHPE fulfills its mission by building and operating an independent, global, professional network of people and institutions to encourage the free exchange of ideas, knowledge, know-how, experience and the development of relevant collaborative projects, both at global and regional levels.

For more information, please contact:

IUHPE
2 rue Auguste Comte
92170 Vanves
France

tel: 33.1.46.45.00.59
fax: 33.1.46.45.00.45
e-mail: iuhpemcl@worldnet.fr
web: www.iuhpe.org



INTERNATIONAL UNION
FOR HEALTH PROMOTION
AND EDUCATION

Symbol Key

The symbols used throughout the text are designed to help the reader follow and understand faster and with greater ease, the main points being made in each section. They have been identified and positioned solely at the discretion of the Project Editor, and do not represent any comment on the text by any other party. The main symbols represent:



Action Point. Ideas identified with such a symbol could form a positive basis for action by either a political, health or social grouping.



Consider Carefully. Paragraphs or sections marked with this symbol are particularly thought-provoking, and require special or particularly careful consideration.



More Research. Parts of the text marked with this symbol show that further research is necessary to gain clarity or fulfil the understanding of health promotion effectiveness.



Open Debate. These are points for political, social, or economic debate. They either serve to stimulate new debate, or are worthy of contributing to existing debate.



Concerted Action. Sections marked with this symbol show the effectiveness of more than one strand of health promotion activity uniting for better results.



Health Added Value. Parts of the report showing this symbol indicate where health promotion moves have added new dimensions of social, economic or political value.

Also available

Improvement of the Effectiveness of Health Education and Promotion

A Series of Publications and a Database

This project was carried out by the European Regional Office of the IUHPE in close collaboration with the NIGZ (the Netherlands Institute for Health Promotion and Disease Prevention), and was financed by a grant from the European Commission.

Within the project, a database with structured information on evaluations of health promotion and education interventions was developed, and is available on diskette. A series of thematic publications consisting of information on relevant studies, resource articles, as well as the publication, *An Instrument for Analysing Effectiveness Studies on Health Promotion: Development, Use and Recommendations* are also available.

For more information, please contact:

NIGZ
PO Box 500
3440 AM Woerden, The Netherlands
Tel: 31 348 43 76 00; Fax: 31 348 43 76 66

The Evidence of Health Promotion Effectiveness

Shaping Public Health in a New Europe

A Report by **The International Union for Health Promotion & Education** for the European Commission DGV

What is this Report and Who is it for?

This two-part report is the product of 12 months research and study of the effectiveness of what has become known as ‘health promotion’.

Leading academics from around the world were asked to research the known evidence of health promotion and disease prevention strategies and programmes, conducted over the last 20 years. They were not asked to conduct new or original research, but they were asked to use their expert knowledge to comment on their findings.

As the research findings began to emerge, other expert witnesses from the political, economic, social and health sectors were invited to enter a debate with the health promotion community and comment on their discoveries. International meetings were held in Brussels and Paris. The aim was to find ways to bridge the divide of understanding between the political audiences of decision-takers and advisers, and the academic and scientific practitioners of health promotion. The common question in focus was: What is the evidence that health promotion works and is an effective strategy in public health?

Part One of this report seeks to crystallise the evidence and makes recommendations for action. It is designed as a guide to decision makers.

Part Two of the report presents in detail the Evidence. It is designed for public policy advisers who wish to study in greater depth either the general issues or certain specific topics. It also carries an international case history of health promotion in Canada, outlining how a structural framework for health promotion played a part in focussing and revitalising that country’s health services.

This report does not aim to ‘educate’ readers on the art of health promotion. Rather, it seeks to concentrate on what health promotion actually does, and how effective that is. Each chapter in the Evidence Book (Part Two) therefore examines the health, social, economic and political impacts of the strategies, and the authors draw conclusions.

The aim is to stimulate debate as Europe heads towards framing its new Public Health Framework.

A Short Guide to Health Promotion

The practice of professional health promotion gained its first international recognition and framework for development with the Ottawa Charter for Health Promotion in 1986.

It was appropriate that the Charter should emerge in Canada. At the start of the 1970s, the then Minister of Health and Welfare launched a controversial report claiming that medicine and the health care system play only a small role in determining health status, and suggesting health promotion as a key strategy for improving health and the quality of life. ▶ *See Lessons from Canada – Evidence Book, Ch 12*

The Ottawa Charter identified five key strategies. These have formed the spinal cord of health promotion practice and policy development. The strategies urged:

- ▶ Building healthy public policy
- ▶ Creating supportive environments
- ▶ Strengthening community action
- ▶ Developing personal skills; and
- ▶ Reorienting health services

The Charter also defined health promotion as:

‘the process of enabling people to exert control over the determinants of health and thereby improve their health.’

It is important to recognise health promotion as ‘a process’. This is not just an academic definition; in practice, it is the way it is. If someone quits smoking, for example, did they do it because they had seen an advertisement, talked to a doctor, suffered peer pressure from friends as a result of special initiatives, or had a family relative die of lung cancer? The fact is, it is very hard to tell. The point is, however, that the person actually stopped smoking. Health promotion is therefore directed at achieving an outcome. Specific outcomes differ, but they nearly always involve improvement in quality of life, and sometimes over a long period. Health promotion is not a quick fix.

Effective health promotion strengthens the skills and capabilities of individuals to take action, and the capacity of groups or communities to act collectively to exert control over the determinants of health. ▶ *See The Questions to be Answered – Evidence Book, Ch 1*

Effective health promotion leads to changes in the determinants of health, both those within the control of individuals (such as health behaviours and the use of health services), and those outside of their direct control such as social, economic and environmental conditions. Poverty, housing standards, clean water, war; all these affect the health status of people. Over the last 20 years, health promotion has been a strategy used to deal with the consequences of the inequalities that such determinants inevitably produce. ▶ *See Equity in Health, Evidence Book, Ch 14*

The platform provided by the Ottawa Charter has been built on progressively with international conferences in Adelaide, Australia (1988), Sundsvall, Sweden (1991) and Jakarta, Indonesia (1997). Throughout this time, several key ingredients aimed at lifting the health status of people, improving their quality of life, and providing cost-effective solutions to health problems, have been clarified. Evidence clearly indicates that:

Comprehensive approaches using all five Ottawa strategies are the most effective

Certain 'settings', such as schools, workplaces, cities and local communities, offer practical opportunities for effective health promotion

People, including those most affected by health issues, need to be at the heart of health promotion action programmes and decision making processes to ensure real effectiveness

Real access to education and information, in appropriate language and styles, is vital

Health promotion is a key 'investment' – an essential element of social and economic development

A declaration made at the Fourth International Conference on Health Promotion in Jakarta called for new players to form new partnerships in developing health promotion strategies, and to adopt an evidence-based approach to policy and practice. This report therefore forms the next milestone in the journey of health promotion.

Chapter One

Health Promotion – a part to play in New Europe’s Public Health Framework

“ So, my friends, I strongly urge you all, in no way to stint time, money or labour, so that you may embrace with all your might this most wholesome art, the preserver of human life.”

Marsilio Ficino, Statesman, Philosopher, Priest & ‘Health Promoter’, 1433-1499

Actually, health promotion has been with us forever.

Historically, it was the preserve of the philosophers who drew close connection between the body, the mind and the soul, and propounded remedies. The health, they said, of the soul, and the vitality of the mind had a direct effect on the state of the body. The evidence of effectiveness, they said, was by virtue of observation.

This report, after 20 years of professional health promotion activity and an evolving international acceptance and supporting infrastructure ▶ [See A Short Guide to Health Promotion, page 2](#), attempts to bring together the evidence of its effectiveness, and to formulate what this means in meeting Europe’s health challenges. The health promotion community clearly understands that policy makers need to know this before providing either additional resources, or diverting more of existing ones, towards health promotion policies and strategies.

The process of generating this report has allowed the political audience to let the health promoters know what they are looking for. Firstly, there is the need to know that health promotion is a sensible, safe and efficient use of public resources. Secondly, there is the need to know that it will produce better health for people and a better quality of life.

This report should act as a catalyst for a new debate; a debate in which the political audiences and the health promoters look towards each other as natural allies in finding ways together on how to cope – politically, socially, economically, and health-wise, with developments in ‘The New Europe’.



The ‘New Europe’

As this report is finalised, the horrifying spectacle of the greatest forced migration of European peoples since the Second World War is unfolding nightly before our eyes. Into our ears pour the horror stories of hundreds of thousands of refugees who, until the marauding butchers of enemy forces invaded their homes, had a measure of self-responsibility for the health and welfare of themselves and their families.

Now, they have become a political, social – and a health – problem. For the whole of Europe. The inequities of health have dramatically risen, and there will be an

impact both within the immediate European Union, as well as throughout the countries of its near neighbours, some of whom seek to become members of that Union as soon as they can.

Already, about 120 million people in the wider Europe, including countries of the Commonwealth of Independent States (CIS) live below a poverty line of US\$4 a day. In 10 countries across the wider Europe in the 1990s, average life-span varies by 15.3 years between Iceland (at 79.3 years) and Turkmenistan (64 years). (Source: WHO 'Health 21')

All of this will be exacerbated by the most recent Balkans developments. Yet, whilst uncertainties abound, there are also major issues policy planners already do know about, and are preparing for. These include:



A redefined political map which will embrace many Central and Eastern European states in an expanded European Union, creating one of the largest political, economic and trading blocks in the world, with perhaps in excess of 500 million people.

A Union that will contain more older people than any other region in the world, with fewer people available for employment but required to generate economic output to sustain, support and provide for greater numbers than at any time in modern history.

At the same time, this new and expanded Union will have to cope with not only new disease threats – but also with the return of diseases we all thought had been eliminated, such as TB. In the midst of all of this, our political and health systems will have to manage a problem which has always been with us, but which has only recently been acknowledged for what it is - the burden of mental illness. One in five teenagers today suffer some sort of mental illness. They will be mature adults within the operational time frame of the new public health framework. The problem is not going away.

Other issues such as rising unemployment, illicit drug use, stress and alcoholism, plus continuing high numbers of smokers, will pose extraordinary challenges to health decision makers over the next 25 years. Violence, especially against women, is on the increase everywhere. In industrialised countries, domestic assaults have been reported to cause more injury to women than traffic accidents, rape and muggings combined.

The questions this report seeks to address are:

- ▶ What relevance has health promotion in tackling these issues?
- ▶ What levels of resource are needed?
- ▶ What strategies work?
- ▶ Is the evidence strong enough to allow policy makers to embrace the health promotion processes fully, and with real confidence, in the development of a public health policy mix, and to provide the necessary resources to make it happen with measurable effectiveness?



Standing the Test

Measuring health promotion effectiveness is not like taking the temperature of a patient.

Measuring health promotion effectiveness is more like waiting for spring crops to appear after preparing the ground in autumn and winter. Time is always involved before the effects of an interweave of coherent and related health promotion strategies and processes begin to show measurable results.

Don Nutbeam, Professor of Public Health at Sydney University, and an international authority on health promotion effectiveness, urges the political and expert audiences reading this book to see beyond the ‘randomised clinical trial process’. ▶ *See: Ch 1, Evidence Book.* ‘In the short-term, a successful outcome from coronary bypass surgery is different from the outcome that would be expected following an educational programme to help a person improve knowledge and skills to adopt a healthy lifestyle. In the long term, both are directed towards reducing the impact of coronary heart disease,’ he says.

Some of what is presented in the Evidence Book might therefore not seem as ‘pure’ as some ‘scientists’ would like, nor as ‘scientific’ as some ‘purists’ would like. Inevitably, it spans a very broad range of disciplines and study methods, from international ecological analyses that depend on statistics, to community demonstration projects that depend on qualitative methods. Some of the answers political audiences would wish for simply cannot be provided because over the past 20 years, the questions simply have not been asked, or if they have, they have not been asked in the way that budget managers in governmental finance departments now demand. But the research is honest and faithful.

After 20 years of professional practices, it does provide a wide-ranging body of evidence in support of the argument that health promotion is effective, and should have its place confirmed as an integral aspect of the public health policy mix.

That being so, the rational political response should be to devote adequate financial and manpower resources to health promotion and disease prevention processes.



Tipping the Balance

At a time when health care budgets across Europe are being carefully examined, and politically acceptable means of reducing budget percentages on health care are being sought, there need to be sound arguments for devoting more resources to health promotion. Crudely, the protagonists (including some from other parts of the medical community) would lay down the challenge that 100 Euros spent on new drugs would produce more ‘political and health impact’ than a similar sum spent on dietary advice to elderly people; and a political compromise, forced by electoral pressure, could be all too easily arrived at in support of such a view.

This is why this report does not make extravagant demands for new resources. What it does demand, however, is a far better understanding, and a larger vision, of the impacts of the weave of inter related health promotion activities on people and their environments. With that understanding will come an appreciation of how in

health terms, health promotion can often tip the balance towards achieving better quality of life, the availability of healthier and more productive human resources to enhance the well-being of society, and play a crucial social and political part in removing inequalities in society.

Health is a fundamental human right. Health promotion is therefore not the answer to the budget-cutter's prayers. But the money spent on it goes a long way, and over a long time. It is low risk, high value expenditure.

Politicians who are convinced that health promotion is worthy of development should be asking of their colleagues in finance and all other governmental departments questions such as:

- ▶ What expenditures will be necessary to sustain the New Europe's rising elderly population; how much in direct health care costs will be needed; how much in indirect costs? If health promotion can help keep people healthier and more active contributors to society for longer, is it not worthy of support?
- ▶ What political and social impact will there be, and how much will it cost, to keep safe in the community millions of young people suffering mental illness? If health promotion can reduce the incidence of mental illness; if it can reduce stress and help return to the workforce quickly those psychologically affected by losing their jobs, is it not worthy of support?
- ▶ As the productive force in society can be kept healthy and at work by legislation banning smoking in public places, or preventing injury by the wearing of helmets, or keeping children fitter and healthier through better nutrition, why is more political attention not given to such developments? Should these and other issues not become a priority in and across all areas of government?



In summary, can governments afford NOT to spend more on health promotion?

Developing a Framework


If policy makers become convinced that health promotion has an enhanced role, and agree to divert additional resources in the direction of programmes and strategies with known effectiveness, where can the most impact be made? What are the first steps?

A structural framework for progress and development is already underway. The European Commission's current review of the public health framework is driven by the fact that eight of the existing public health programmes are heading towards a conclusion next year. In the light of the new health threats, budget pressures and enlargement process, and now in light also of the growing refugee crisis in Eastern Europe, is the current framework satisfactory, or does it need to change?



Three policy strands have evolved so far: improving information for development of public health; rapid reaction to health threats; and tackling health determinants through health promotion and disease prevention.

The platform upon which the Commission can build, and which can inspire European Union member state governments to act, is Article 152 of the Amsterdam Treaty. This Treaty widens the scope for action through health promotion as never before. The Article ensures a high level of human health protection in definition and implementation in all policy areas. In other words, there is a health-benefits test in new policy, across the board.

The international leader in health promotion experience is Canada.  Inspired leadership in the health ministry was effective because of a strong conceptual basis for action provided by the Ottawa Charter and also because of early and financially-meaningful Federal government commitment, bringing regional and local commitment in its wake. A further driver – some would argue the main one – was political concern about rising costs of health care, and the need for health care reform. The parallels in Europe today are clear. The lessons for the ‘New Europe’ tomorrow could be equally clear.

Evidence of health promotion effectiveness must now be examined in the light of these dynamics.

Chapter Two

Taking the Health Promotion Pulse

Introducing the Evidence

International experts from a variety of health promotion disciplines were invited to examine the literature and published research documentation of numerous interventions across the world. They were not asked to conduct new research. Their job was to analyse, critically, and within the boundaries of scientific tolerance, what had worked and what had not.

They were then asked to tread new ground. In order to build a bridge between the health promotion discipline and the political community, our panel of international professors, academics and acknowledged world-leaders in health promotion practice were then asked to formulate a series of Impact Assessments. In their view, as experts, what health, social, economic and political impacts did the interventions under consideration achieve? ▶ *These impacts are analysed in Chapter Three of this Part; each chapter in the Evidence Book carries subject-specific assessments.*

Traditionally, health promotion interventions have either been targeted within defined settings (such as schools, workplaces, cities) or with identified population groups (such as elderly people or youth). Inevitably, programmes and strategies cross boundaries. In order to best illuminate and demonstrate the work of various strategies, we decided to report on topics of political relevance as well as healthcare and social relevance. Some are settings-based; others are populations-based; still others straddle both. The report, especially the *Evidence Book* in Part Two, is not designed as a comprehensive best-practice manual, but it is designed to be a rounded analysis of health promotion effectiveness, demonstrating where and how it is relevant to decision makers.

We therefore asked our research team to look at the major political challenges in the New Europe: *ageing*, *mental health*, and the challenge of coping with disenfranchised groups such as *out-of-school youth*. We asked others to look at major health issues, such as *heart health* and the impact of *tobacco*, *alcohol* and *illicit drug use*. We researched areas where health promotion has gained high public profiles, such as *nutrition* and *safety issues*. We examined two key settings where health promotion activity has a particularly important social and economic impact – in the *workplace*, and *in schools*. We asked for a case history on *oral health*, an often neglected issue in many countries, but one where major health gains have been made. And we asked about health promotion in the *health care sector* itself: what role can doctors, nurses and other health sector practitioners play in promoting better health.


Finally, we looked at the heated issue of *Equity*. Put simply, the health of lower economic and social groups is significantly poorer than higher groups, right across Europe. With poverty comes disease. And with poor education, poor housing, poor family stability comes violence, substance abuse, mental illness, heart disease and increased morbidity and mortality. The evidence shows that inequity in social and

economic conditions is a key determinant in health and human welfare.



Politicians want to make a difference. Our evidence concludes, therefore, with a case history of *Canada*, leaders in international practice of health promotion, where frameworks have been structured at the federal, regional and local levels to deliver better health. ▶ See *Lessons from Canada – Evidence Book, Ch 12*. The lessons are clear and provide an important guide in structuring the development of health promotion everywhere.

Evidence Highlights


Political Challenges 1: The Ageing Issue

- 1 Disability in elderly people accounts for around 50% of health care costs in EU countries. The challenge to the Europe of the new millennium is to capture the energy and experience of this important sector of society, keep it healthy and active, and allow people to continue to contribute to the development and welfare of the communities in which they live. Much research supports the fact that older people want this. Many health promotion programmes specifically targeted at this group clearly show not only the positive health benefit for the people concerned, but the positive contributory effect on the society of such people continuing a healthy lifestyle for longer. Instead of regarding this exploding population group as a ‘burden’, policies and initiatives could be formulated to acknowledge, value and enhance their many formal and informal social and economic roles. 
- 2 The development of best-practice for the management of an ageing workforce is identified as a priority by the Economic & Social Committee of the EU, the European Parliament and the Commission. Data from a pan-European study of 60-69 year olds, co-ordinated by WHO-EURO, indicated significantly worsening health status over a ten year period for accidents, trauma and chronic disease affecting daily life, hearing, use of drugs, use of sleeping tablets and functional ability.
- 3 The real key to healthy ageing is to begin health promotion early, and to embrace the key messages into daily living throughout the span of life. However there is evidence that age 50 marks the beginning of a period in the life during which the benefits of physical activity programmes are most relevant. Evidence shows that regular physical exercise helps regulate blood glucose levels, improves sleep, improves cardiovascular functioning, helps maintain independence in old age, enhances motor control and performance, reduces the risk of falls and enhances cognitive function and mental health. The impact on society is seen by keeping the elderly population active and therefore productive for longer, reducing health and social care costs. Policies should ensure that elderly people can stay active, that those who want to continue to contribute to society can do so, and that a positive and active image of ageing is created and then maintained.
- 4 An ageing population which is not healthy will be a massive drain on resources. The evidence shows that maintaining healthy lifestyles in old age is directly associated with health gain. There is also clear evidence that there is considerable


scope for ameliorating the experience of poor health and disability in old age by appropriate health and social policies.

- 5 Ageing people need the opportunity for real choice to enable healthy living which in turn will reduce disability costs. For this, adequate pensions provisions must be made. There is also evidence that community health and social services provisions improve the quality of life of this group, alleviate handicap and reduce the need for institutional living. A minimum core set of services needs specifying and policies are needed to deliver them.
- 6 Healthy eating in this age group also provides major health gains. However, people on low incomes, the very old, chronically ill and elderly males are at particular risk from nutritional deficiencies. This is a priority for intervention. 
- 7 Breast-cancer screening has been demonstrated as cost-effective in women up to age 74. 
- 8 Targets for dietary habits, activity levels and disability levels of elderly people should be set and monitored through lifestyle surveys.


Political Challenges 2: Removing the Shadows of Mental Illness

- 1 Many of the most important causes of morbidity in Europe, and the world, are associated with poor mental health. These range from mild forms of depression through to complex psychiatric disorders. Evidence shows that between 15% and 20% of adults suffer some form of mental disorder. Between 17% and 22% of teenagers under 18 suffer from developmental, emotional or behavioural problems, and fewer than one in five of these young people are currently receiving appropriate treatment.
- 2 The consequences of poor mental health can be seen in alcohol and drug misuse, interpersonal violence, and self-harm, including suicide. The shadows across the face of society cast by mental illness and its consequences are now better understood and recognised. Managing this issue will require greatly improved detection and treatment of the more serious problems, but mental health promotion has proven that it can play a major role in reducing the personal, social and economic costs of poor mental health. It should be assisted to play that role more widely.
- 3 There is significant evidence to show that mental health promotion strategies have reduced depression, reduced suicide rates, and reduced behavioural problems. Interventions targeted towards help in the family have resulted in less domestic aggression, fewer learning problems with small children, and generally more positive environments in which they can grow and take up active and responsible citizenship. There is evidence of significant reductions in child abuse (up to 50%) and in reductions in cases on the child protection registers (41%). 
- 4 Other mental health promotion programmes have furthermore shown complementary social and health benefits, including decreases in teenage pregnancies, reductions in HIV and AIDS and other sexually transmitted diseases. There have been clinical impacts too. Pre-natal projects have resulted in up to

75% reductions in pre-term delivery, reductions in babies born with low birth weight (eliminating consequent health problems in later life), and fewer babies born with brain damage.



- 5 Suicide is a common outcome from mental illness. It is a catalogue of despair for families, associates and colleagues of the sufferer, and a tragic waste of human potential. Health promotion strategies have been found to be effective. The Swedish Educational Programme (Nordic countries have a very positive and progressive record of successful health promotion in many areas) decreased suicide rates from 19.7 cases per 100,000 population, to 7.1 cases after just three years. An important economic side-effect was that the programme reduced the number of in-patient days to treat sufferers by 70%, and other programmes have reduced the numbers of tranquillisers and anti-depressant drugs prescribed.
- 6 Policy makers will be aware of the high costs of treatment of mental illness. They are rising, and are expected to continue to rise sharply, as countries come to see that many of their policies of the past decade, including community care, have not been holistic enough for patients or safe enough for the rest of the community. The social dynamic involved in mental health should also not be under-estimated, and there is evidence to indicate the effectiveness of programmes targeted at specific community groups.
- 7 Schools-based programmes in promoting better mental health show clear evidence of achieving higher literacy levels and reductions in drop out rates; there are additional health benefits measured with success in smoking cessation, reductions in substance abuse, reductions in the social consequences of teenage pregnancy and unsafe sex. Work-based mental health programmes also have measurable success. Reviews have shown not only advances in 'soft' measures, such as better job satisfaction and reductions in stress levels, but also there is clear evidence that a number of programmes have helped unemployed people return to work quicker, and reduced the amount of sick leave in workforces. 
- 8 Effective mental health promotion programmes must be disseminated across Europe, and guidelines for their effective management must be established.

Political Challenges 3: Reaching the Disenfranchised

- 1 Out of school youth represent a tremendous challenge to policy makers. They are often vulnerable to disease and high risk behaviours and are notoriously hard to reach through conventional educational media. They are often turned off or tuned out to traditional health messages, especially if presented by 'authority' figures.
- 2 Smoking, alcohol and drug abuse, sexually transmitted diseases, suicide, eating disorders and violence are among the many health risks faced by a group which often regards itself as forgotten or disenfranchised by the rest of society.
- 3 There is evidence that peer education training programmes, targeted mass media campaigns and targeted distribution of information, products and services (often controversial items such as male and female condoms, clean needles and methadone) have all assisted in providing adolescents with improved choices and access to new health options. 




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- 4 Engaging this group in the development of health promotion programmes has been key to success. There is evidence of increased condom use, and decreases in drug use. There is less risky sexual behaviour. Socially, there is evidence of dialogue restarting between the generations, with the young people feeling they are valued. Some of the programmes in themselves actually provide a source of income, and cost savings to other health services can be identified. Perhaps above all, the health promotion work in this area has helped put this important social group back on the agenda.

Health Challenges 1: The Lifestyle Killer – Heart Disease


- 1 Cardiovascular disease (CVD) is the number one killer and the major cause of disability in Europe. Half the deaths in the industrialised world are the result of CVD. Contrary to widespread mythology, CVD is not something which attacks only elderly people. Much of the burden concerns the middle aged, women and people in lower socio-economic groups. It is a major contributor to inequality in health.
- 2 The problems facing decision makers in a Europe which is already witnessing a reduction (by demographic causes) of its available working population are first, the early elimination from the workforce of human talent and much needed resource and second, the cost of treatment when CVD disables, but does not kill. The costs to health services are enormous. 
- 3 The major causes of CVD are well known and have been well documented: smoking, poor dietary habits, lack of exercise, high cholesterol. The effects of these are very heavily influenced by the capacity of people to discriminate and make positive health choices. Health promotion strategies over the past 20 years have been shown, without doubt, to make a major difference in tackling those diseases and illnesses which are most significantly affected by the way people choose to live.
- 4 One of the most carefully documented interventions has taken place in North Karelia, Finland, where cardiovascular mortality has been reduced by 73% since 1972, and all-cause mortality has been reduced by 50% in the working age population over the same period.
- 5 As so often happens, lifestyle changes introduced to deal with cardiovascular disease threats have a positive benefit in other health areas too. The North Karelia experience recorded reductions in lung cancer mortality of 71%, and cancer (other causes) mortality by 44%. 
- 6 The example in Finland, while spectacular in its success, is not alone. Other studies show that programmes aimed at changing lifestyle habits bring very positive health benefits. In Belgium, a WHO collaborative worksite project for CVD prevention resulted in a 25% reduction in CVD mortality. Programmes aimed at lowering serum cholesterol through healthy diets in schools produced an average reduction in levels of 15%, with huge positive health implications.

Health Challenges 2: The ‘Smoking Gun’ –

Tobacco, Alcohol and Illicit Drugs

- 1 Among the greatest risk factors in CVD and other diseases, such as respiratory illness, lung cancer and some other cancers, is smoking. Tackling the issue can also be seen as a particular case study of the effectiveness of the comprehensive approach of multiple-strands of health promotion and disease prevention. When a smoker quits, is it because the price went up, he was banned from smoking at work, he read an article in a newspaper or his doctor told him the consequences of not stopping? In reality, it was probably all of these things. The best health promotion is where various strands delivering a single message come together.
- 2 The World Bank estimates that the economic burden from smoking, including health costs and loss of productive capacity by disability or death, is around \$200 billion annually. The WHO indicates that 3 million people die annually from smoking. Fifty percent of all people who smoke regularly will die from cigarettes, half in middle age, with an average loss of 20 years of life expectancy. Smokers are making their own coffins, and furthermore, are contributing to disease among their close families by polluting the atmosphere in their own homes and public places.
- 3 There is evidence that a 10% increase in the price of cigarettes (through taxation) leads on average to a 5% decrease in the quantity smoked across the whole population, and up to a 15% decrease in the quantity smoked by the young people. 
- 4 Legislative restrictions in worksite smoking in Finland led to 2.4% of smokers quitting, 2.6% stopping smoking while at work, and 14.3% reducing their cigarette consumption. 
- 5 Since the 1970s, smoking cessation programmes have been conducted in schools. Some programmes, particularly those involving peer groups, indicate 30-50% fewer smokers in programme groups compared with controls. However, there is also evidence to show that without determined follow-up with multiple strands of action, these rates do not hold.
- 6 Health professionals are effective in smoking cessation programmes. Over a 20 year period, there is evidence that, of those people offered smoking cessation advice by doctors, 13% were less likely to die from coronary heart disease, and 11% less likely to die from lung cancer, as a consequence of quitting smoking. With pregnant women, 11 trials showed increased rates of smoking cessation (up to 50%), lowering the risk of low birth weight and reducing adverse obstetric outcomes.
- 7 Smoking cessation programmes appear as part of virtually every health promotion or disease prevention initiative – in the workplace, in the out-of-school youth sector, with elderly people. In Spain last year a comparison of a range of interventions designed to reduce cardiovascular disease was undertaken. Smoking cessation was the most cost effective. The cost per life year gained from these programmes ranged from \$2600 to \$5700, whereas the costs per life year gained from treatment for mild hypertension was up to \$86,000. The costs of extensive drug treatment per life year gained was more than double that. 




Social Challenges 1: Feeding our Families – the Impact of Nutrition

- 1 The impact of proper dietary controls on the health of people – particularly heart health - has been proven to be immense. Such an issue is of course regarded with high political sensitivity: can we live in a democracy and be directed or even advised what to eat? A key role in health promotion is to increase through literature and other means the comprehension of health issues, and to provide every assistance for people to make positive health choices. Nutrition is one such example.
- 2 In recent years, diets in most European countries have become richer in animal protein and saturated fats, whereas the consumption of vegetable protein, complex carbohydrates and dietary fibre has decreased. There is clear evidence to link increased incidence of coronary heart disease, type2 diabetes and some types of cancer to these dietary changes. There is also a causal link between diet and obesity and impaired bone development.
- 3 An expert panel of the World Cancer Research Fund has concluded that eating the recommended five servings of fruits and vegetables each day could reduce cancer rates by more than 20%. They further report that adhering to dietary recommendations and physical activity, plus maintaining a healthy body weight, could reduce cancer risk by 30-40%. There is a consistent body of evidence which supports the beneficial effects of diets rich in plant-based foods, and relatively poor in alcohol and foods from animal origin. 
- 4 Time and again, reviews of effective health promotion show clearly the inequity existing in the provision of health services. The poor are always worst off. It is statistically proven that they face higher mortality rates and more disability than individuals with a higher socio-economic status.
- 5 On the issue of diet, for example, poorer families take more cheap energy from foods such as meat, fats, sugars, preserves and potatoes, but have relatively little intake of vegetables, fruit and whole-wheat bread. The link between this and the prevalence of CVD amongst the lower income groups is direct.
- 6 In the Netherlands, a 'Fat Watch' campaign, run in partnerships with supermarkets and other private sector allies, brought favourable changes to consumption of saturated fats (from 16.4% to 14.1% of energy intake over a five year period). Mainly due to such changes in fat intake, the prevalence of hypercholesterolaemia dropped by 6%. A 1% reduction in serum cholesterol achieved through dietary knowledge would bring a 2-3% reduction in coronary heart disease. The example shows, amongst other things, the importance of involving new partners in health promotion, a theme now actively supported by the WHO, and embraced in the Jakarta Declaration on health promotion.



Social Challenges 2: Keeping Safe

1. Injuries are an increasing health threat – and they attack at any age. At present, one in seven premature deaths is injury related ; this is predicted to rise to one in five by 2020. Health promotion strategies aimed at injury prevention are being

under-utilised.

- 2 There are many strands to successful health and safety promotion, but researchers report the best effects when legislative developments are coupled with well-targeted information campaigns.
- 3 In Victoria, Australia, campaigns to improve the use of cycle helmets increased wearing from 5% before to 83% after, corresponding to a decrease of head injuries by 70%. In the United States, campaigns promoting the use of child safety seats in vehicles reduced the likelihood of fatal injury by 69% for infants and 47% for toddlers. What are described as ‘comprehensive’ SAFE community programmes in Nordic countries produced decreases of up to 30% in the number of injuries. 
- 4 Legislation in this field can be a key strategy. In Washington State, USA, a law on tap water heat decreased the number of hospital admissions for burns from that source by 50%. A Poison Prevention Packaging Act, designed to reduce the incidence of aspirin poisoning, did so by 45-55%. Policy makers should note carefully the positive beneficial effect of strategically placed health promotion-related legislation, and the added impact it brings when related to well formulated education programmes. 
- 5 Article 152 of the Amsterdam Treaty probably provides more opportunity for action than at any time in the last 20 years. For example, in the field of transport policy, there is clear evidence that speed restriction policies and road-calming initiatives – all of which could viably be called health promotion – have produced the most cost-effective health promoting environmental change in traffic areas. Furthermore, legislation and community information campaigns on safety devices – smoke detectors, fireguards, stairgates, child restraint container closures, thermostat control of tap water – have been shown to be extremely effective and cost efficient. Evaluation of a three year, Swedish based Accident Prevention Programme across the community reduced accidents in the home by 27%, in the workplace by 28%, and traffic-related accidents by 28%. In Norway, a similar traffic-related programme reduced injury to cyclists by 37% and pedestrians by 54%, while accident rates in a reference community hundreds of kilometres away actually went up over the same period. 


Settings 1: Effective Health Promotion in the Workplace

- 1 The ‘Productive Capacity Gap’ – i.e. the gap between the available working population and the numbers of people it has to support – is predicted to grow significantly over the next decades. In the United Kingdom, the gap will grow by 40% between now and 2025. 
- 2 A key issue facing all European governments and political institutions is to ensure that Europe’s workforce remains healthy and productive, and that the ‘dependant’ population of elderly people remains fit, active and healthy for longer, available to contribute to society and not be considered as a burden. 
- 3 Over recent years, many European countries have embraced an increasing number of Workplace Health Promotion (WHP) programmes. There is evidence that such programmes, combined with occupational health and safety practices, improves

productivity, product and process quality, and keeps labour costs controlled, thereby improving competitiveness.

- 4 Ten major reviews between 1968 and 1995 produced a weight of evidence indicating the positive effect of WHP programmes on industrial health awareness and behaviour. This is significant in that recent EU surveys have shown that up to 42 million employees throughout Europe believe that their health and safety in the workplace is at risk. That risk stems from heavy physical work (25%), pressure of time (20%), small decision latitude (35%) and monotony (60%).
- 5 The costs of work related illnesses are high. The German Federal Institute for Occupational Safety & Health calculated costs of DM89 Billion solely due to people's inability to work. The work related proportion of widespread common illnesses is estimated at 33% for musculo-skeletal disorders, 20% for cardiovascular disease, and 45% for skin diseases. Evidence shows major cost savings for hypertension control, back injury prevention and pre-natal care programmes. Building on experience and evidence, occupational health and safety practices are now based on well-substantiated ergonomic knowledge of workplace design. Some of this has been included in national and European standards and directives. The results have been positive. In the area of musculo-skeletal problems, for example, most studies report between 20% and 50% reduction in disorders.

Settings 2: Effective Health Promotion in Schools.

- 1 There is a substantial body of evidence which shows that poor health inhibits learning. In addition, studies have found a strong relationship between health behaviour and educational outcomes (e.g. grades and classroom performance), educational behaviours (school attendance, disciplinary issues) and student attitudes. 
- 2 School health promotion interventions can be effective in transmitting knowledge, developing skills, and supporting positive health choices. But evidence indicates greatest effectiveness where programmes are comprehensive and 'holistic', linking the school with agencies and sectors dealing with health, and where it lasts several years. Adequate attention needs to be given to teacher training for health promotion.
- 3 The 'health promoting school' concept has emerged in the last decade in Europe and has spread in the world as a mechanism to combine a variety of elements to achieve maximum success in pursuing educational and health outcomes. It is clear that the school, in conjunction with the family, is one of the key sites where individual and social development occurs.
- 4 Schools have been shown to be cost effective sites for health promotion interventions. The effectiveness and sustainability of school health interventions is governed by how closely the health promotion interventions are linked to the primary business of schools in developing the educational skills and knowledge base of young people. Evidence shows that programmes should focus primarily on cognitive and social outcomes, rather than concentrate on achieving specific behavioural outcomes.

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- 5 The European Network of Health Promoting Schools is operational in 38 countries. Whilst its potential is great as a model for development of programmes, the evidence is clear that schools cannot be looked upon to solve health and social problems in isolation from other forms of public health action.


Settings 3: Effective Health Promotion in the Health Care Sector

- 1 What part in health promotion can the health care sector play? Is it an effective health promoting ambassador? Should governments divert resources towards the health care sector and hope that the professionals there can do the health promoters job?
- 2 Evidence indicates success by members of the health sector through interventions to promote smoking cessation and to deal with problems of alcohol abuse. Other evidence is inconclusive about the effectiveness of the health care team in delivering health promotion programmes and messages. What is plain, however, as recognised by the WHO and its Jakarta Declaration, is that the health care sector is an essential partner in creating the right conditions for health in society. It has an important leadership role in society.
- 3 This leadership role can either be exercised by providing examples of what can be done to achieve a healthy environment, or as an advocate for healthy public policies, or as a source of advice to individuals on healthy behaviours.
- 4 It is widely recognised that the health sector alone cannot deliver major changes in health behaviours and depends on co-ordinated action across a range of sectors.
- 5 This means that a health promotion policy that depends on reform of the health care sector to achieve its goals will not work. If health care professionals can be re-oriented to become advocates for health, rather than simply part of the repair service, they can become powerful allies for those seeking to promote health. But interventions to stop smoking are an example of the challenges faced. Despite its undoubted effectiveness, advice by doctors to quit is given rarely, and in some countries is undermined by the high frequency of smoking by doctors.




Oral Health: A Case Study in Effectiveness

- 1 Oral diseases are an often neglected, but nonetheless, important aspect of the public health problem. Prevalence is high, treatment costs can be high, and there is often a trauma involved for individuals. Dental disorders rank as the third most expensive to treat among all diseases, exceeded only by costs related to cardiovascular diseases and mental disorders.
- 2 Water fluoridation is the most cost-effective method of prevention. But it is a controversial issue and requires political commitment. Evidence shows that since the 1970s there have been dramatic declines, from mean levels of 5 and 10, to lower than 1 decayed, missing or filled permanent teeth in children.
- 3 The generally held reason for the decline is the impact of widespread use of fluoridated toothpastes. This is an example of how industry and public health can

-
- work together to promote health.
- 4 Studies show that the current traditional curatively-oriented strategies for improving oral health are relatively ineffective and very expensive. Oral health promotion should be aimed at achieving rational use of sugar products, fluoridation of the mouth, effective oral hygiene, reductions in smoking and drinking, prevention of trauma and appropriate use of dental care.
 - 5 What is very clear is that a number of chronic diseases, such as heart disease, cancer, strokes, accidents and oral diseases, have some important risk factors in common. Health promotion strategies are therefore relevant to more than one disease area or issue. Strategies oriented towards risk factors, as distinct from specific diseases, are likely to be more inclusive and therefore more cost-effective. 

Health Equity: A Fundamental Human Right

- 1 Equity in health is at the heart of nearly every health promotion strategy. The term *Equity*, as described by the WHO, focuses on the ideal of providing a fair opportunity for all people to enjoy health to their fullest potential. It does NOT mean equal health status for everyone; but as the well-known Black report on Inequalities in Health (1982) points out, a realistic goal should be the reduction of differences between people's health as much as possible through equal opportunity for health.
- 2 There is very substantial evidence that socio-economic conditions related to income, education and employment are at the root of much of ill health. In 1993 it was estimated that more than 57 million people in Europe lived in almost 23 million poor households. Even in the richest countries in Europe, people with the best resources live several years longer and have fewer illnesses and disabilities than poorer people. 
- 3 Evidence indicates that 'relative deprivation' rather than absolute poverty is the crucial element in understanding health inequalities in a Europe that is far from the crushing poverty of some other regions of the world. Relative deprivation can have many faces : poorer education, higher unemployment, lower capacity to deal with information, lack of material resources, among others. Evidence is strong that relative deprivation in these areas is closely linked to poorer health.
- 4 The fundamental understanding of this evidence is that health promotion to improve equity in health must be conducted within the context of economic, social and human development.
- 5 Many 'equity interventions' for health have their most important impact at community level. Evidence shows that people gain increased ability to define and solve local problems, and at every stage participation or involvement of the local community is a key factor in success.
- 6 *Healthy Cities*, a component of WHO's *Health for All* strategy, with hundreds of participating communities, provides a strong multi-agency framework and philosophical model for the support of community development and health approaches in Europe. Programmes have shown evidence of effectiveness including generating increased income through work opportunities, improved

community support with counselling services, better community involvement, closer links with professional services and improved inter-agency collaboration.

- 7 Data also shows that health and education are among the most powerful forces for economic health. In poorer countries basic investments in health and education can leverage positive economic outcomes. Outside of Europe, in countries such as Trinidad, Cuba, Chile, and Costa Rica, this form of investment has high priority, and poverty has been reduced to affect less than 10% of people. Yet in Europe there remains great disparity, both in the levels of health investment, and in economic vitality. This disparity could increase still further with the imminent refugee problem arising from the Balkans crisis.
- 8 Most European countries are signatories to WHO's *Health for All* programme, recently updated as *Health for All in the Twenty-first Century*. With equity for health at its heart, this sets global priorities for the first two decades of the new millennium, and 10 targets to create the highest attainable levels of health. This has led to the formation of frameworks for action at the national level, with many European countries having health policies that aim at reaching the *Health for All* targets.
- 9 There remains a long way to go before Europe enjoys a degree of equity in health that would signal success, despite the progress recently made. There are sound health, economic and political reasons for reductions in inequity in health.
- 10 All of these reasons, however, are underpinned by the fact that good health is a fundamental human right.



Chapter Three

Bridging the Gap

When the health promoters met with representatives of the political community over a total of four days in Brussels and Paris as part of the innovative development process leading to this report, several things became clear.

First, the language spoken by each side was different. A health promoter would be more likely to advocate a health solution first and worry about the cost later; the politician would understandably view it the other way round.

Next, as the dialogue unfolded, different sets of priorities became clearer on both sides, until finally, and most importantly, common ground began to emerge. There was recognition from the health promotion community that the need was to demonstrate to audiences unfamiliar with the health promotion ‘jargon’ or terminology the clear relevance in health, social, economic and political terms of what they actually do. Each section in the Evidence Book spells out how, in the opinion of its author, a particular health promotion discipline has been politically, socially and economically relevant.

The dialogue has begun. A bridge is being built to remove the gaps in understanding. From both sides.



This chapter summarises some of the key points made during the dialogue between the health promoters and the political audience. The next chapter offers some opening recommendations for political action.

Health Impacts

- 1 Europe is facing greater health challenges than at any time since the end of the Second World War. The emphasis needed to meet these challenges must be on health, not sickness. The need is for effective health services, not just effective repair services.
- 2 The evidence shows health promotion as an essential element in the provision of health services. Significant experience, supported by a sound and supportive governmental framework at all levels, enables health promotion to deliver measurable results.
- 3 In tackling the issue of the rising ageing population in Europe, it is clear that health promotion interventions can sustain a more active and significantly enhanced quality of life for millions of people. It is equally clear that health promotion is a life-cycle issue – work done with and for children, in homes and schools, can show a short-term impact, but if sustained through the working life and into old age, the health benefits can be enormous.
- 4 In meeting the epidemic of mental health problems, it is clear that interventions tackle depression, suicide, stress and anxiety. The evidence shows reductions in





child abuse, child neglect, learning difficulties and other behavioural problems. Programmes demonstrate possibilities for greater life satisfaction, increased sexual satisfaction and optimal functioning in the psychological domain. Some projects help people back to work more quickly after suffering the trauma of unemployment; others can show benefits with fewer teenage pregnancies and on the other hand, major reductions in pre-term deliveries.

- 5 Health promotion programmes can reach disenfranchised groups, helping to increase their perception of risk-taking behaviour, and in some cases decrease the use of illicit drugs. Work in schools can produce health gains in nutrition, safer-sex, reductions in tobacco usage, and the evidence points to other gains such as enhanced academic performance as a consequence of regular physical activity.
- 6 Other health impacts are detailed in the Evidence Book. What is clear, however, and was widely agreed upon at the joint meetings, is the need for sustainability. Health gains do not come quickly, whereas attempting to repair health damage nearly always has to.
- 7 The debate acknowledged that fundamentally, health promotion is clinically safe and ethically friendly.
- 8 It was also acknowledged that effective health promotion works on the determinants of health i.e. the causes, and not just the effects. It is an interweave of actions and reactions, but all focused on providing enhanced quality of life, and the sustaining of human well-being as productive and contributive members of society. People have a responsibility to choose better health options, but society has a responsibility to help them do so with the provision of proper, timely and well-targeted resources through well funded health promotion.
- 9 Evidence from around the world is mounting, and will continue to do so, that health promotion needs to play an increasing part in the public health policy mix. The health promoters were keen to point out that not too much should be claimed; the health promotion strategy was not the sole answer to major issues. Equally, however, after 20 years experience, it deserved a higher priority than it has at present with governments and decision makers. 
- 10 Both sides recognised that regular monitoring of best-practice around the world would be very helpful. It was widely encouraged. 



Social Impacts

- 1 Health promoters have always strongly linked social inequalities with health inequalities. Health is a fundamental human right and that concept is held onto with firm determination. The evidence is available to indicate that poverty, homelessness, joblessness, poor sanitation, and various social breakdowns, including the family unit, are significant contributory factors to poor health. These are all issues of political and social importance.
- 2 It was recognised that health promotion can play a part in tackling some of the social crises in our societies. It has the potential to contribute to the reduction of these inequalities, and amongst its many methods is the empowerment of people and community groups. Health promotion is very supportive of local democracy



and is a means of helping to develop strong and united communities.

- 3 Debate also indicated the need to be watchful that health promotion did not increase inequality of health opportunity, and there was some support for interventions to be subject to an equity-impact analysis. The evidence is clear that people from lower socio-economic groups face relatively higher mortality rates and more disability than those with a higher socio-economic status.
- 4 Health promotion programmes have helped claimants on benefits programmes to take up their dues, and to reschedule debts; others have helped vulnerable and socially isolated clusters or individuals to re-connect, improving self-esteem, motivation and life-skills; for the most part, the programmes have improved the quality of life.
- 5 The evidence is equally clear that poor housing, low income, lone parenthood, unemployment and homelessness are associated with high rates of smoking and low rates of quitting. Policies that regulate the availability of, and demand for, tobacco and alcohol will not succeed in the long term if the social factors that determine their use are not tackled. The broad framework of social and economic policy must therefore support effective substance-use policy. 
- 6 Partnerships across society are a dynamic growth point in health promotion. Health promotion is a contributory factor in helping tackle social issues; often, however, other partners will need to take the lead. In areas like nutrition, for example, private and public sector co-operation can bring about health and social gains. 
- 7 However, as work in the nutrition field has clearly shown, disadvantaged groups are often those suffering from poor literacy and poor cognitive and communication skills. There is a need, therefore, to support health promotion programmes with the right infrastructure and framework. The experience of the Canadian government, which has led the way through the 1970s, is worthy of examination in this respect.

Economic Impacts

- 1 Health promoters are suspicious when politicians look to them for cost-cutting solutions to over-spent health budgets; and the political audience is suspicious of the health promoters if it is suggested that major additional spending is needed to maximise the impact of interventions. The debate on this issue needed to reach consensus.
- 2 It became clear that health promotion is not a cheap fix to the problem of over-extended health budgets; the most effective programmes require proper funding, over sustained periods. Equally, however, the debate clearly indicated that the right level of resourcing could produce significant economic gains, for governments, societies and individuals, as well as health gains. 
- 3 While recognising that there was a lack of traditional cost-benefit analysis work available to support many of the health promotion arguments (an area that both politicians and health promoters 




recognise needs rectifying), it could nonetheless be argued that evidence was available to indicate clearly that investment in health does pay dividends.

- 4 The ageing issue has already been well addressed; but alongside that is the issue of the ‘productive capacity gap’. The demographics are clear. Over the next 30 years, Europe’s working population will have to support more dependants than at any time ever before. Therefore, to lose one in two smokers in middle age, cutting 20 years off their productive life cycle, is economically ridiculous. Equally, to have men and women in middle age crippled by cardiovascular diseases, causing not only the loss of productive output but creating a burden of expensive care for many years, is a sheer waste. And particularly so when there is clear evidence that effective health promotion can make a huge difference. 
- 5 The productive capacity in Europe is also threatened by accidents, and safety is a rising health issue. If the prediction that one in five premature deaths by the year 2020 will be caused by injury holds true, again that is a phenomenon which health promotion strategies can address directly.
- 6 There was wide agreement that the economic impact of health promotion was not just the obvious ‘cost-saving’ side; there is a significant positive economic benefit to be experienced by increasing health promotion investment.
- 7 Controversy inevitably surrounded the issue of ‘public-services versus personal responsibility’. Should smokers, for example, be able to claim by right continued medical care when the disease they suffer is self-inflicted? And on the other hand, if nutritional benefits can be clearly demonstrated as being positive for health, should governments take a firmer line in legislating the content of school meals, hospital diets, and the rest? This debate merely started and needs to continue. 
- 8 Where measures of agreement, however, did emerge was a growing understanding that even limited amounts of health promotion investment could show a positive gain – in economic, as well as health terms. Instead of analysing interventions on the traditional cost-effectiveness or cost-benefit analysis, some interest was shown in developing a cost-utility methodology ▶ *See : Effective Health Promotion in the Workplace, Evidence Book, Ch 9.*
- 9 There were calls for more attention to be paid to eliminating those risk factors to health which also have a severe cost to society, such as smoking. Often, governments can make big health and economic gains through advancing health promotion by the legislative process, for example, banning smoking in public places or ending tobacco advertising and promotion.
- 10 Throughout the new Europe there was great disparity between developed and developing economies. To gain the maximum economic outcomes from health promotion, there was a clear need for a supportive infrastructure which would allow best-practice to flow across borders.

Political Impacts

- 1 Examining the political impacts of health promotion practices was a novel experience for many health promoters. Yet lack of familiarity in framing political

arguments could be overcome with open dialogue on all sides.

- 2 Providing the right level of resources for health promotion is ‘politically safe’. The major ethical dilemmas facing governments over issues such as cloning and genetic engineering, are not part of the core health promotion argument.
- 3 Health promotion, properly resourced and sustained, is also inherently accepted by a wide variety of population groups, who simply regard it as ‘common sense’. It provides governments with an effective and practical approach to dealing with important social issues. 
- 4 The Canadian experience demonstrates how the health promotion concepts can translate into effective political action plans. Health promotion can demonstrate that governments are ‘doing’ something.
- 5 Health promotion is capable of affecting the largest and one of the most influential population groupings – elderly people. They are an important political constituency. 
- 6 Health promotion can also provide practical responses and play a part in dealing with other major political problems. Interventions can help the unemployed find self-esteem and regain the energy to look for work; programmes can reduce the psychological impacts of stress, and reduce anxiety and depression; strategies can ensure greater academic excellence from schooling and greater productivity in the workplace.
- 7 The dialogue between the political representatives and the health promoters agreed that as Europe faces a new millennium, decision takers in the European Union and in member state governments should be urged to re-examine the health promotion case, and devote appropriate and sustainable resources towards those initiatives which are backed by evidence that they work. 

Chapter Four

Making the Journey




Recommendations for Political Action

The process of analytical study of health promotion effectiveness, and public dialogue between representatives of the political and health promotion communities, has allowed for a creative and dynamic ‘brains trust’ response to a variety of important public health issues.

None of the ideas presented below has been fully developed or costed; nor do they necessarily represent the views of all the participants in the process. They are not designed as a ‘manifesto’ from IUHPE. They have emerged in the process of preparing this report, and they provide a catalyst for those decision makers who would wish to lift up the health promotion profile on the new public health agenda.

Some of these ideas are initiatives where European competence already exists. Others are where health value can be added by adoption of policies or practices across the Community. Still others would require concerted action by all member states of the Union, and all prospective member states. Most of the issue-specific recommendations are covered in greater detail in the Evidence Book.

General Recommendations

- 1 As with the Canadian government experience, the Commission is urged to consider the appropriate framework and infrastructure for development of successful health promotion programmes in identified areas. In particular, the Commission is urged to look at the levels of funding and practical support for its own health promotion directorate, and its profile within DGV. (IUHPE has already worked hard on the infrastructure issue, with a global seminar and development of a set of recommendations and findings.) 
- 2 There is now an impressive body of evidence on best-practice in health promotion. This needs to be made available, and to be regularly updated, in a systematic and authoritative way to all member state governments. The Commission is urged to examine which of the existing European-wide bodies would be best placed to undertake this role, or whether a specific and independent health promotion monitoring authority should be created. 
- 3 The Commission is urged to consider developing and supporting a ‘European league table’ as a tool for measuring and managing community wide progress on adopting effective health promotion practices. Again, there is already some preliminary work in place, particularly the WHO Verona Benchmark Initiative for investment in health. Health promotion ‘Audits’ 

could provide significant political and health advantages.

- 4 This twin-track approach of capturing and encouraging best-practice, and the ‘stick’ of league table performance measures, would be a low-cost but effective means of improving the health status of Europeans.
- 5 The Commission should seek to use its considerable influence with other international organisations, as well as with member and applicant state governments, to take a leading advocacy role in developing health promotion. Article 152 of the Amsterdam Treaty, which provides a ‘health test’ across all policy areas, is a platform from which to build. The Commission might set an example by creating systems which allow public monitoring of its own health promotion performance.



Issue Specific Recommendations

- 1 There is considerably further to go with action against the use of *tobacco*, and other forms of substance abuse. Further action is needed to promote a total ban on tobacco advertising and sponsorship of public events, services and products, especially those marketing initiatives aimed at young people. There is also clear evidence that increasing prices on tobacco products does reduce demand and use; a 10% rise in price will bring up to a 15% reduction in the quantity of tobacco smoked by young people.



Member and applicant state governments are urged to adopt further aggressive hikes in excise duties on tobacco products, especially cigarettes.

Member state governments, and the Commission, are also urged to eliminate the inconsistencies in policies which often show as sympathy for health promotion on the one hand, but as active support for the tobacco growing or manufacturing industry on the other.

- 2 A key to healthy ageing is the adequate provision of *pensions* to ensure healthy living environments, lifestyle choices and access to health and social care. This is a much wider issue than health promotion, but the health dimension needs to be fully embraced in the debate.



- 3 Governments are encouraged to work with the *food* industry towards improving the diet of elderly people, for example from better labelling and packaging, reduction of salt content (especially of convenience foods), provision of small food portions, development and promotion of low fat products.



As the evidence shows that health promotion in *nutrition* leads to health gains at a much lower cost than medical treatment of either high risk groups or patients, this is recommended as an arena for political attention. Governments are urged to develop intersectoral alliances between their own departments (especially agriculture, health, finance and social affairs), local government, food producers, distributors and retailers.

- 4 *Transport* policies impact on health in a variety of ways – especially on elderly and poor people – by affecting opportunities for exercise, access to social facilities, shops and health care. Lack of affordable public



transport is a distinct disadvantage, and has a health impact on the elderly, the poor, and those in rural areas. Close examination of the health dimension of transport policies, either under Article 152, or independently by member state governments, could have a positive impact on overcoming health inequalities.

5 Governments are also urged to give greater attention to *safety*. Many of the predicted deaths, and loss of productive capacity as a consequence, are preventable. Again, inter-sectoral collaboration is needed between and within governments.



6 In the *workplace*, the European Union needs to be encouraged to proceed with implementation of key health promotion recommendations in its Green Paper, *Partnership for a New Organisation of Work*. Special emphasis should be given to ensuring health promoting working conditions, especially in those industry sectors which depend on motivated and highly qualified employees.



7 *Schools* are also cost-effective sites for health promotion action, and frequently attract political support. But the effectiveness of these interventions is closely linked with the development of educational skills and the general knowledge base of young people. Schools should not be looked on by politicians to solve health and social problems in isolation from other forms of public health action. Support, however, should be given to the joint WHO-EU-Council of Europe Health Promoting Schools Programme.



8 Political awareness of the *Out-of-School* youth problem is also called for. To get this group on political agendas as an audience, and not a problem, is a key target. Pragmatic recognition of the needs of this largely disenfranchised group is needed. This would include opening debate on training, housing, welfare, the provision of sexual health products and services, safe injecting equipment or abusive-substance alternatives, such as methadone.



9 With one in five adults already suffering some form of *mental disorder*, and with one in five of those young people with mental illness not getting proper treatment, the whole issue of well-being in this area needs to come out of the political shadows. Health promotion in this area evidently works.

Effective model programmes need to be disseminated across Europe and analysis undertaken as to the likely outcomes following their large scale implementation. Guidelines for effect management and quality indicators also need to be established, and the Commission could take a lead in this work.



Perhaps above all, a properly resourced policy platform, providing a co-ordinated response to this enormous health and social problem needs to be created.



10 Governments in Europe, and those joining the Union, need to act on their commitment to Article 25 of the Universal Declaration of Human Rights, that health is a *fundamental human right*. With that commitment comes responsibility to work with determination to tackle the determinants of health, and to enable health equity to prevail. This means adopting a high profile political response to tackling poverty, homelessness,



sanitation, and the clutch of social issues which create poor health.

Governments need to acknowledge that investments in health are a positive contributor to social and economic development.

- ▶ *Readers wishing to pursue these arguments are referred to *The Evidence Book*, which forms Part 2 of this report.*

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