Preamble

Why We Need a Healthy Settings Approach

City-super (fictitious name) is working as a special assistant to the City Mayor. The Mayor received several reports concerning the level of physical fitness and sub-optimal functional health status of the residents of the city. The reports did not make explicit which particular aspect(s) of health was of great concern. The Mayor called City-super asking him or her (hereafter refer as "him") to contact the City Health Authority and City Public Health Bureau to improve the situation.

City-super had a meeting with senior representatives of the City Health Authority. They told City-super that they had reviewed the city's health statistics based on hospital activities. There was no major increase in hospital admissions or visits to outpatient clinics. They did not identify any changing disease patterns, but they said they would closely monitor the situation. To promote greater health in the city's population, they suggested seeking advice from the City Public Health Bureau.

Thus, City-super met with the City Public Health Bureau. The representatives mentioned that they did not detect any major changes in mortality or morbidity patterns for the city's residents. They suggested talking to the Sport and Recreation Bureau for improving the general fitness of the population. They also suggested contacting the Social Work Bureau because there may be psycho-social issues causing a sub-optimal health status.

Following their advice, City-super visited the Sport and Recreation Bureau. They agreed to provide more facilities for sports and exercise. They also started a programme for people diagnosed as "unfit" to help them improve their fitness. City-super asked how these individuals would be diagnosed. They told him that some schools would perform fitness tests for students and adults, and individuals could also be referred to the programme by their family physician. However, the number of referrals was low as not all schools or family physicians performed routine fitness assessments.

City-super then discussed with the Education Bureau whether every school should conduct an annual assessment of physical fitness for students. Their response was that individual schools would decide on the scale and time frame of fitness assessments through school-based management. City-super then met with a local group of family physicians to ask whether they would be willing to conduct periodic assessments of their patients' fitness. The physicians indicated that they would conduct the assessments based on need and refer any individuals for further training if necessary.

City-super finally visited the Social Work Bureau to request improving the psycho-social well-being of the city's population. The Bureau agreed to step up measures for cases referred to social workers. However, they could not commit additional manpower to work with individuals without known psycho-social problems.

Over the course of these various meetings, City-super had been in contact with colleagues from many different departments and disciplines, but he was not given any constructive advice to rectify the situation. Considering this, City-super reflected, asking himself: "Do we have a system to address health promotion within our city?" The answer seemed to be "Sorry, no."

The situation outlined above is a common one. In many countries, there is a well-structured health care system to address diseases and illnesses but there is no system addressing health, particularly the promotion of positive health. The United Nations has set Sustainable Development Goals (SDGs) to be achieved by 2030, called the "UN 2030 Agenda" (United Nations [UN], 2015). These goals are structured to enable our planet to not only be more peaceful and pleasant for those living on it, but they also seek to bring equality and equity to mankind irrespective of age, gender, ethnicity, or socio-economic background. SDG 3 — "Ensure healthy lives and promote well-being for all at all ages", for example, is referring to more than just the prevention of premature death but also includes the empowerment of

individuals and communities to protect themselves from harm and enhance their capacity to achieve optimal health and well-being. Regarding the right to health, there is a global aspiration for all citizens to enjoy the highest attainable standard of health. However, this standard varies among different countries and locations, and it might not be justifiable or equitable to impose a fixed standard. Even so, a universal standard would still provide a benchmark for health. The Ottawa Charter for Health (WHO, 1986) asserts that "health is created and lived by people within the setting of their everyday life; where they learn, work, play, and love".

After three decades, the Ottawa Charter is still seen as a "gold standard" for health promotion practitioners worldwide wishing to improve health and enhance health equity. However, the opportunities to transfer these principles into the radical changes and practical solutions needed globally to improve health are still missing. Thompson et al. (2018), for instance, examined how the Ottawa Charter had influenced health care policies in the UK and found that the emphasis is still very much focused on personal responsibility and behavioural change, rather than tackling fundamental societal issues. While the Ottawa Charter itself may not fully address these issues, some of the concepts it inspired, including the Healthy Settings Approach, are making greater headway as they are implemented in more locations. It is only natural that the settings where people live, play, learn, and work are a part of the framework for building healthy public policy and re-orienting health services to promote and protect health. Using an approach that encompasses all of the environments an individual encounters will allow health to be viewed as more than just treatment. It will instead promote the strengthening of community actions for better health, building up of personal health skills to enhance health literacy, and the development of greater health advocacy.

The Healthy Settings Approach has a long history of being organised around settings such as schools, communities, and workplaces. It is an umbrella term for concepts such as Health-promoting Schools, Health-promoting Workplaces, Health-promoting Health Care Organisations, and Healthy Cities, and provides the social structures to reach the defined population and deliver health promotion activities in the context of people's daily lives. The Healthy Settings Approach has the ability to translate change into real terms that fit the context of each particular setting. This approach is an ecological model of health promotion in which health is determined by a complex interaction of environmental, organisational, and personal factors. It can be used to tackle the determinants of health at the downstream, midstream, and

upstream levels, and reduce health inequities. The Healthy Settings Approach also facilitates the right to health for all as it argues for investment in social systems in which people spend their daily lives and addresses the multifactorial determinants of an individual's health at all levels of society.

Winslow (1920) defined public health as

> the science and the art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing service for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health. (p. 30)

Similarly, Mckeown and Lowe (1974) concluded that social advances in general living conditions, such as improved sanitation and nutrition, have been responsible for the decrease in mortality rate achieved during the last century. The contribution of medicine to this reduce mortality level has been minor compared with the contribution of improved environmental conditions. Promoting health is not just the business of health professionals within the healthcare industry, but is "everybody's business" (National Health Services [NHS] Providers, 2017). Viewed through the lens of the Healthy Settings Approach, public health is concerned with a health problem, based on the assumption that the social, physical, and political environments play major roles in the amelioration of the problem (Hanlon and Pickett, 1984), but it is distinguished from other approaches by its focus on comprehensively understanding the ways in which lifestyles and living conditions determine health status.

It is important to recognise the need to mobilise resources and make sound investments in policies, programmes, and services which create, maintain, and protect health by supporting healthy lifestyles and creating supportive environments for health. Tulchinsky and Varavikova (2014) described this concept of "New Public Health" as

> a cumulative philosophy of saving lives and improving health by a wide variety of professions and methods based on scientific achievements in the context of societal responsibility for the health and well-being of the population. The New

> Public Health is a composite of social policy, law, and ethics, with integration of social, behavioral, economic, management, and biological sciences. It is an intersectoral and interdisciplinary application of social policy, health promotion, preventive, and curative health services, all of which are vital to sustain and improve health for individuals and populations. (p. xxiii)

The Healthy Settings Approach can, therefore, be used to build the capacity of individuals, families, and communities to create strong human and social capital. There is a widespread myth that economic growth will improve health conditions. In fact, one should aim to improve population health conditions to enhance the economy. It will take years to build up the economy, but it only takes a short time to see the impact of poor population health and the burden it creates on society and community resources. The notion of human and social capital begins to offer explanations as to why certain communities are unable to achieve better health compared to other communities with similar demographics (Yamaguchi, 2014). Thus, the synergistic effects of different settings and how they can be used to improve population health and reduce health inequity require exploration.

Chapter 1

The Settings Approach for Health Promotion: How Does It Work?

Albert Lee

City-super, the special assistant to the City Mayor, suggested to the Mayor that the Healthy Settings Approach should be adopted to solve the community's health concerns. The Mayor responded, "Excellent idea! Please help us implement this approach." City-super then wondered, "How can we apply the Healthy Settings Approach? How does it work?" Although City-super had obtained post-graduate qualifications in public health as well as public policy, and had been appointed as the special assistant to the Mayor so he could research better public policies for the city (focusing on health and well-being of the residents), he was not familiar with the Healthy Settings Approach or how it would enhance health promotion.

Evolution of Health Promotion

We have been largely successful in improving the health of the population by minimising risk factors through education and regulation as well as through better disease management and preventive measures, such as immunisation, periodic screening, and better access to health services. This leads to the question: What added value would result from implementing the Healthy Settings Approach? To

appreciate the changing needs of a population and the benefits of implementing the Healthy Settings Approach, it is important to first understand the evolution of health promotion.

Pre-modernisation

During the pre-modernisation period (19th century), the main health threat was life-threatening infectious diseases with acute onset. The goal of health promotion at that time was to protect people by minimising health hazards and promoting better hygiene. The measurement of success was based on the reduction of mortality and incidence of diseases. A biomedical approach was used to find out the aetiological agent(s) and remove them, leading to the rapid decline of the disease. While this benefits the community, it did not address the complexity of health promotion. It was during this period that Snow (1849) identified polluted water as the source of the cholera outbreak in the mid-19th century. This was the first published germ theory of disease.

Post-World War II

Although infectious diseases still constituted a major health burden in the late 1900s and early 2000s, chronic diseases accounted for a much greater portion of the global health burden (Horton and Sargent, 2018). The first major step towards addressing these issues was the Ottawa Charter for Health established in 1986 (WHO, 1986). Table 1.1 outlines the evolution of health promotion since the Ottawa Charter and includes various Declarations of Health Promotion and recommendations by leading scholars up to the early 21st century.

The health-risk behaviours contributing to the leading causes of mortality and morbidity later in life, such as cardiovascular disease, cerebrovascular disease, and malignant neoplasm, are often established during childhood and extend into adulthood. The Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (NCDs) was adopted by the United Nations General Assembly in September 2011 (UN, 2011). It set out a new international agenda on the prevention and control of key NCDs. The World Health Organisation (WHO) pointed out that, with the exception of sub-Saharan Africa, NCD-related mortality "exceeds that of communicable, maternal, perinatal, and nutritional conditions combined", accounting for 36 million

Table 1.1: Global Movement of Health Promotion

Sources	Key contents
Adelaide Recommendations on Healthy Public Policy: *Extracts from the Second International Conference on Health Promotion in Adelaide, Australia* (WHO, 1988)	• Healthy public policy is characterised by an explicit concern for health and equity in all areas of policy and by accountability for health impact. • The main aim of health-focused public policy is to create a supportive environment to enable people to lead healthy lives. Such a policy makes health choices possible or easier for citizens. • In the pursuit of healthy public policy, government sectors concerned with agriculture, trade, education, industry, and communications need to consider health as an essential factor when formulating policy. • These sectors should be accountable for the health consequences of their policy decisions. They should pay as much attention to health as to economic considerations.
The 3rd International Conference of Health Promotion was held in Sundsvall, Sweden, in 1991 and the focus was on creating supportive environments (WHO, 1991)	Key strategies at the community level are: • Strengthening advocacy through community action, particularly through groups organised by women. • Enabling communities and individuals to take control over their health and environment through education and empowerment. • Building alliances for health and supportive environments in order to strengthen the cooperation between health and environmental campaigns and strategies. • Mediating between conflicting interests in society in order to ensure equitable access to supportive environments for health.
Ten Vital Signs of Quality Health Promotion (Catford, 1993)	• Understanding and responding to people's needs fairly • Building on sound theoretical principles and understanding • Demonstrating a sense of direction and coherence • Collecting, analysing, and using information • Re-orienting key decision makers • Connecting with all sectors and settings • Using complementary approaches at both individual and environmental levels • Encouraging participation and ownership • Providing technical and managerial training and support • Undertaking specific actions and programmes
Jakarta Declaration on Health Promotion into the 21st Century (WHO, 1997)	• Promote social responsibility for health • Increase investments for health development • Consolidate and expand partnerships for health • Increase community capacity and empower the individual • Secure an infrastructure for health promotion
Mexico Ministerial Statement for the Promotion of Health: From Ideas to Action (WHO, 2000)	• To position the promotion of health as a fundamental priority in local, regional, national, and international policies and programmes. • To take the leading role in ensuring active participation of all sectors and civil society, in the implementation of health-promoting actions to strengthen and expand partnerships for health. • To support the preparation of country-wide plans of action for promoting health, if necessary drawing on the expertise in this area of WHO and its partners. • These plans will vary according to the national context, but will follow a basic framework agreed upon during the Fifth Global Conference on include among others: – The identification of health priorities and the establishment of healthy public policies and programmes to address these. – The support of research which advances knowledge on selected priorities. – The mobilisation of financial and operational resources to build human and institutional capacity for the development, implementation, monitoring and evaluation of country-wide plans of action.

Table 1.1: Continued

Sources	Key contents
The Health Society: Importance of the New Policy Proposal by the EU Commission on Health and Consumer Affairs (Kickbusch, 2005)	• To protect citizens from risks and threats which are beyond the control of individuals and cannot be effectively tackled alone (e.g., unsafe commercial practice, unsafe products) • To enhance the ability of citizens to make better decisions about health • To mainstream health and consumer policy objectives, putting health on agenda
Bangkok Charter for Health (WHO, 2005)	• Advocacy • Invest in sustainable policies, actions, and infrastructure to address the determinants of health • Capacity building for policy development, leadership, health promotion practice, knowledge transfer and research, and health literacy • Regulate and legislate • Partner and build alliances with public, private, non-governmental, and international organisations and civil society to create sustainable actions
Nairobi conference closes with adoption of Call to Action (October 2009) (WHO, 2009a)	A consultation is under way with global health programmes, developing a practical package of evidence on health-promoting interventions that addresses the top health risks and the conditions with the highest disease burden. This product will be examined in the light of experience from various countries and emerge as consolidated, practical guidance for countries. *Call to action* • A political statement that calls for the inclusion of health promotion outcomes within the design of development programmes will be drafted through an expert- and Web-based consultation in the months leading up to the conference and will be adopted on the last day of the conference. • Advocacy for extending the international development goals to include non-communicable conditions will also proceed in parallel. The possibility of a launch of a Partnership Council on Non-communicable Diseases is being considered.
Shanghai Declaration on Promoting Health in the 2030 Agenda for Sustainable Development (9th Global Conference on Health Promotion) (WHO, 2016)	• We recognize that health and well-being are essential to achieving sustainable development. • We will promote health through action on all the SDGs • We will make bold political choices for health • Cities and communities are critical settings for health • Health literacy empowers and drives equity

deaths (63% of the global total), 80% of which occurred in low- and middle-income countries (WHO, 2011). The main areas of health concerns for healthcare systems and policy makers in the modern 21st century are:

- an ageing population;
- increasing health care expenditures;
- disrupted flow of health information, health products, and health services;
- increasing debate on rights and responsibilities; and
- changing views of the importance of health as major goal in life and a key component of a citizen's rights.