

Module 2

Milestones

Introduction

In this module, you will get the opportunity to examine the historical milestones contributing to the emergence of health promotion and the development of **health promotion** practice as we know it today.

You will be able to review content that is organized in six sections.

Introduction

Learning Outcomes

Reflective Exercise: Considering the History of Health Promotion

Content Discussion

- Emergence of Health Promotion
- Timeline: The Beginnings
- Timeline: The Past Thirty Years

Reflective Exercise: Milestones Past and Future

Readings and Resources

Learning Outcomes

By the end of this module, you will:

- identify the key historical milestones contributing to the development of health promotion;
- understand how developments and events, both within and outside the field of health promotion, influenced thinking about the root causes of health and illness; and
- be able to relate how key developments and events shaped the field of health promotion practice.

Reflective Exercise

Considering the History of Health Promotion

Before you start working through this module, consider the following questions and contribute to your Reflective Journal.

Points to Ponder

1. Can you think of some of the key events in the past century related that enabled the development of health promotion in Canada?
2. What do you think might be considered some of the key events in world history to the development of health promotion?

Content Discussion

Emergence of Health Promotion

The **emergence of health promotion** as a concept distinct from traditional public health practice or disease prevention took place in the **20th century**. However, many of the strategies used to promote health and prevent disease have **deeper roots**.

For example, the ancient Egyptians, whose writings provide some of the earliest records of public health practice, developed systems for sewage disposal, distributed surplus grain to feed the poor, and printed tracts warning against the harmful effects of consuming too much alcohol.

This example from 4000 B.C illustrates the **longevity** of two health promotion strategies that have remained in use to the present day:

- education encouraging healthy behaviours at the individual level, and
- the development of healthy public policies at the community level.

Timeline

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What follows are some key milestones by date affecting the development of health promotion in Canada over the past century.

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Timeline: The Beginnings

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Think about this point. The earliest published reference to health promotion was by C.E.A. Winslow who describes public health practice as:

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“the art and science of preventing disease, prolonging life and promoting health and well-being through organized community effort for the sanitization of the environment, the control of communicable infections...the education of the individual in personal health and the development of a social machinery to ensure a standard of living adequate for the maintenance or improvement of health” (cited in Green, 1990, p. 4).

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The concept of health promotion was further refined by Harry Sigerist, a British Medical Historian, who noted that:

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“ health is promoted by providing a decent standard of living, good labour conditions, education, physical culture, and means of rest and recreation” (Sigerist, 1946, pp. 127-128).

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Sigerist called for the coordinated efforts of politicians, labour, industry, education and the health care sector to ensure that these prerequisites for good health were within reach of everyone. Many of Sigerist’s ideas, such as his **holistic concept of health** and his call for action addressing the **determinants of health**, re-emerged thirty years later with the publication of **Ottawa Charter**.

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The World Health Organization (WHO) defined health as

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“a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity.”

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This holistic, positive definition of health provided the basis for the **features and values** that have come to characterize health promotion practice, such as a focus on:

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- strengths and assets,
- **participatory, empowering approaches** and
- attention to the broader **determinants of health.**

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1946	1946 to 1974
1950	The 30 years following the end of the Second World War saw a marked improvement in the health status of Canada and other western, industrialized countries. Mandatory public health measures , including mass immunization, sewage disposal, water purification and the mandatory pasteurization of milk, had substantially decreased the incidence of communicable (i.e., contagious) diseases.
1960	At the same time, years of advocacy efforts by labour unions, community activists and progressive political movements led to the development of the “social safety net” and other economic reforms that resulted in substantial progress towards the elimination of poverty, poor housing and unhealthy living conditions.
1970	As a result of these measures, chronic diseases (e.g., cancer, heart disease and stroke) replaced communicable diseases as the leading causes of mortality in Canada and the western world.
1974	This resulted in a shift in public health practice that placed increased emphasis on addressing the risk factors contributing to these diseases (e.g., tobacco, high fat diets, alcohol and physical inactivity) through the promotion of healthy lifestyles .
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The *Medical Care Act* (later modified and re-introduced as the **Canada Health Act**) ensuring **universal access** to health care for all Canadian citizens is passed into law by the Trudeau government. During the decades following the passage of the Act, increased concern about the costs of financing universal health care leads the federal and provincial governments to place increased emphasis on health promotion and disease prevention as a means of controlling rising health care expenditures.

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ParticipACTION, the first **Canada-wide media campaign** promoting healthy lifestyles, is launched with the (false) premise that the average 60 year-old Swede is more physically fit and active than the average 30 year-old Canadian.

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1920 **Timeline: The Past Thirty Years**

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The growing emphasis on reducing health risks through the promotion of healthy lifestyles received a further boost with the publication of ***A New Perspective on the Health of Canadians***, more commonly known as the Lalonde Report (named after then-federal Minister of Health, Marc Lalonde, who commissioned the report).

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The **Lalonde Report**, which is recognized as a milestone document that resulted in the international recognition of Canada as a leader in the conceptual development of health promotion, introduced the **health field model**, which viewed health as a product of lifestyle, biology, environment and health care organization. <http://www.hc-sc.gc.ca/hppb/phdd/pdf/perspective.pdf>

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In spite of the holistic nature of the health field model, the importance of lifestyle and personal responsibility for all aspects of health are emphasized throughout the Lalonde Report. For example, unhealthy practices are described as “self imposed risks” (p. 18); another section of the report notes that “individual blame must be accepted by many for the deleterious effect on health of their respective lifestyles” (p. 26).

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The Canadian government responds to the Lalonde Report by establishing a **Health Promotion Directorate** within the federal Department of National Health and Welfare. The Directorate, the **first bureaucratic structure devoted to health promotion in the world**, was organized around the health field concept of lifestyle, with a focus on areas such as smoking and nutrition.

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The first Canadian postsecondary degree program in health promotion is established at the University of Toronto.

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http://www.phs.utoronto.ca/mhsc_health_promotion.asp

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1979 to 1984

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Emerging research points to the importance of social, economic and environmental determinants in affecting the health status of individuals and communities. For example, the Black Report on health inequalities in the United Kingdom revealed significant inequities in the health status of low-income groups, while the Alameda County study in California revealed the importance of social support and social networks as determinants of health (Berkman and Syme, 1979).

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As a result of these studies and related developments, the narrowly focused “lifestyle” approach to health promotion recommended by the Lalonde Report began to fall into disrepute. Many health promotion programs were criticized for “blaming the victim” by ignoring the social and economic barriers to making healthy choices (e.g., Labonte and Penfold, 1981).

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1920 **1984**

1930 The 'Beyond Health Care' Conference hosted in Toronto leads to the launch of the worldwide "Healthy Cities" movement. The **Healthy Cities Projects**, one of which was located in Toronto, utilized a **participatory approach** to health promotion by engaging community residents in the identification of health priorities in their community and the development of appropriate activities to address these priorities.

1940 The approach used by the Healthy Cities Projects was widely adopted by health promoters. Over time, the Healthy Cities Projects becomes the "Healthy Communities" initiative as it spreads to towns, villages and rural areas throughout the world.

1950 **1986**

1960 The first international conference of health promotion convenes in Ottawa. The consensus document produced at the conference, *The **Ottawa Charter** for Health Promotion*, becomes the **predominant framework** for health promotion practice.

1970 At the same time that the *Ottawa Charter* was released, the Canadian government introduced ***Achieving Health for All***, a framework for the implementation of a national health promotion strategy. Unfortunately, the implementation of this framework was never fully realized due to budget cuts in the late 1980s and a subsequent change in government in 1993.

1980 **Note to Learners: For a more detailed discussion of the *Ottawa Charter*, please refer to Module 1.**

1984 **Note to Learners: For a more detailed discussion of the *Ottawa Charter*, please refer to Module 1.**

1986 **Note to Learners: For a more detailed discussion of the *Ottawa Charter*, please refer to Module 1.**

1990 **Note to Learners: For a more detailed discussion of the *Ottawa Charter*, please refer to Module 1.**

2000 **Note to Learners: For a more detailed discussion of the *Ottawa Charter*, please refer to Module 1.**

2005 **Note to Learners: For a more detailed discussion of the *Ottawa Charter*, please refer to Module 1.**

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1986 to 1991

The years immediately following the release of the *Ottawa Charter* witnessed the expansion of **health promotion**, both **as a profession and a field of practice**. For the first time, health and social service organizations, such as public health units and community health centres, began staffing positions as “**health promoters**”. Provincial governments re-organized their bureaucratic structures to include health promotion and funded a series of health promotion projects at the provincial and community level.

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1991 to 1996

Health promotion begins to face a number of challenges, including setbacks in the progress against tobacco use as a result of tax reductions and threats to the well-being of communities resulting from a severe economic recession and the erosion of the social safety net. The resulting fiscal restraint placed increased demands on health promotion to demonstrate its accountability and prove the ‘effectiveness’ of its initiatives.

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At the same time, the federal government’s shift from health promotion to a population health approach forced health promoters to integrate their concepts and values into **new frameworks for thinking about health**.

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Health promotion's commitment to social justice, equity and sustainability was reaffirmed at the Fourth International Conference on Health Promotion with the adoption of **The Jakarta Declaration on Leading Health Promotion into the 21st Century**, which identified poverty as "the greatest threat to health" and noted the dangers to health posed by globalization and environmental degradation.

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http://www.who.int/hpr/NPH/docs/jakarta_declaration_en.pdf

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2000 to the present

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Health promotion continues to evolve, embracing new technologies such as the Internet as tools for education and community mobilization. It also grapples with challenges such as continuing fiscal restraint and a shift in public health priorities due to the re-emergence of communicable disease threats such as the West Nile Virus and Severe Acute Respiratory Syndrome (SARS). What do you think the next century holds in store for health promotion?

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Reflective Exercise

Milestones Past and Future

Think about your learning, consider these questions and compare your thoughts now with those you described in your Journal when you completed the Reflective Exercise at the beginning of this Module.

Points to Ponder

1. In your opinion, what are the three most significant milestones affecting the development of health promotion?
2. What do you see as the key developments affecting health promotion over the next five years?
3. One recent, unanticipated development affecting the broader public health sector is an increased emphasis on communicable disease prevention due to the emergence of West Nile, SARS and other conditions. How do you think this development will impact on the development of health promotion?

Readings and Resources

You can find out more about key milestones in the field of health promotion at these **online resources**.

Hyndman, B. "The evolution of health promotion, 1920-1986". Excerpt from **Health Promotion in Action: A Review of the Effectiveness of Health Promotion Strategies**. Toronto: Centre for Health Promotion/ParticipACTION, 1998, pp. 4-12. (Available for order at <http://www.utoronto.ca/chp/ParticipACTION.htm#evaluation>)

Lalonde, M. **A New Perspective on the Health of Canadians**. Ottawa: Health and Welfare Canada, 1974. <http://www.hc-sc.gc.ca/hppb/phdd/pdf/perspective.pdf>

World Health Organization. **The Jakarta Declaration on Leading Health Promotion into the 21st Century**. Geneva: World Health Organization, 1997. http://www.who.int/hpr/NPH/docs/jakarta_declaration_en.pdf

For those of you who may want more information on health promotion milestones, **these additional printed materials** may be of interest. If they are not available at your local library, you could consider requesting them through Inter Library Loan.

Berkman, L.F., and Syme, S.L. "Social networks, host resistance and mortality: a nine-year follow-up study fo Alameida county residents." **American Journal of Epidemiology** **109**, 186-204, 1979.

Black, D., Morris, J.N., Smith, C., and Townsend, P. **The Black Report**. London: DHSS, 1980.

Green, L.W. **Community Health** (4th Edition). Boston: Times-Mirror/Moseby College Publishing, 1990.

Labonte, R., and Penfold, S. "Canadian perspectives in health promotion: a critique." **Health Education** **19** (3-4), 4-9.

Pederson, A., O'Neill, M., and Rootman, I. (Eds.) **Health Promotion in Canada: Provincial, National and International Perspectives**. Toronto: W.B. Saunders, 1994.

Sigerist, H.E. **The University at the Crossroads**. New York: Henry Schuman, 1946.