Health promoting settings: future directions

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Looking back: reflections

In 1986, the Ottawa Charter (WHO, 1986) declared that *«Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love.»* The charter is widely acknowledged to have been the catalyst to the health promoting settings movement – resulting in the settings approach becoming the starting point for WHO's health promotion programmes, with a commitment to *«...shifting the focus from the deficit model of disease to the health potentials inherent in the social and institutional settings of everyday life»* (Kickbusch 1996: 5).

Two decades later, it is clear that the settings approach has captured the imagination of organisations, communities and policy-makers across the world. Since the Ottawa Charter, a plethora of international and national programmes and networks have emerged, covering settings as diverse as regions, districts, cities, islands, schools, hospitals, workplaces, prisons, universities and marketplaces. Accompanying this, the concept of health promoting settings has become firmly integrated within international health promotion policy. For example, the Jakarta Declaration strongly endorsed the approach within the context of Investment for Health (WHO, 1997); WHO included the term 'settings for health' within its Health Promotion Glossary, defining it as *«the place or social context in which people engage in daily activities in which environmental, organisational and personal factors interact to affect health and wellbeing»* (WHO, 1998a: 19); the new European Health for All Policy Framework, Health 21 included a target focused on settings (WHO, 1998b: 100); and most recently, the Bangkok Charter (WHO, 2005) highlights the role of settings in developing strategies for health promotion and the need for an integrated policy approach and commitment to working across settings.

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However, despite this popularity and championing, the approach has, arguably, not gained as much influence as it might have – in terms of either guiding wider international policy or driving national-level public health strategy. In seeking to understand this, it is useful to reflect on the views of Ilona Kickbusch, an early advocate. She has suggested that because the logic of the settings approach is a non-medical one, it is more easily understood by community members and political decision makers than by 'health' professionals (Kickbusch, 1996) and has commented that what settings initiatives achieve *"does not fit easily into an epidemiological framework of 'evidence' but needs to be analysed in terms of social and political processes"* (Kickbusch, 2003: 386).

Looking to the future: challenges

In looking to the future and seeking to increase the influence of the settings approach, we therefore face a number of inter-linked challenges.

Clarifying the theoretical base for health promoting settings work

Firstly, a range of terminology has been used and a diversity of understandings and practice has been brought together under the health promoting settings 'banner'. Whilst terms such as 'health promoting settings' and 'healthy settings' have increasingly been used interchangeably, with a dual focus on context and methods, it is important to acknowledge the semantic differences between them and the possible influences on understanding and practice – the former more clearly suggesting a focus on people and a commitment to ensuring that the setting takes account of its external health impacts. This echoes early work by Baric (1993), who suggested that standards should include three key dimensions – a healthy working and living environment, integration of health promotion into the daily activities of the setting, and reaching out into the community.

At a conceptual level, Wenzel (1997) has highlighted the tendency to conflate 'health promotion *in* settings' with 'health promoting settings', suggesting that the settings approach has been used to perpetuate traditional individually-focused intervention programmes. Whitelaw *et al* (2001) have discussed the variance in understanding and practice, emphasising the difficulties of translating philosophy into action and presenting a typology of settings practice. And Poland *et al* (2000) have focused on the differences within and across categories of settings – for example, workplaces differ in size, structure and culture; and a 'total institution' such as a hospital or school is very different to a less formal setting such as a home or neighbourhood. These differences become even more apparent when settings are viewed globally, and the influences of different cultural, economic and political factors are taken into account.

All these issues point to the importance of balancing an acceptance of heterogeneity and difference with a complementary focus on building a shared conceptual understanding of the settings approach. Whilst there can indeed be a *"tyranny...in the assertion or creation of consensus"* (Green *et al*, 2000: 26), the articulation of theory can be constructive in guiding future practice. To this end, Dooris (2005) has drawn on the literature to suggest that the approach is characterised by three key characteristics: an ecological model of health, a systems perspective and a whole system organisation development and change focus.

Staying with the bigger picture

The second challenge, closely related to the conceptualisation of settings, is to stay with the bigger picture. Although people's lives straddle different settings

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(either concurrently or consecutively), there is a continuing danger that the settings approach may encourage insularity and fragmentation, and unwittingly divert attention from the overarching social, economic and environmental influences on health. It is important, therefore, to make connections both outwards and upwards.

Settings operate at different levels and, like 'russian dolls', may be located within the context of another. Galea *et al* (2000) discuss this, suggesting that a distinction should be made between different levels of 'elemental' and 'contextual' settings. For example, a hospital or school will be within a particular neighbourhood, within a larger town or city, within a district, region or island. Echoing Bronfenbrenner's work on social ecology (Bronfenbrenner, 1994), we need to view individual settings as part of a bigger whole – and work to enhance the synergy between them and to maximise their contribution to the well-being of communities and cities. We need to lift our focus and consider what makes places liveable and vibrant, then take this diagnosis and apply it to the settings with which we work. Maybe we have to risk letting go of the explicit language of health, but in doing so release the energy to facilitate the innovative and creative change that can lead to more sustainable system-level well-being.

As highlighted in the Bangkok Charter (WHO, 2005), it is also necessary to use advocacy and policy development to encourage action to address the determinants of health in the context of our globalised world. This will mean ensuring an integrated approach within settings, whereby the connections between health and other policy arenas are acknowledged and understood; developing wider corporate social responsibility as an integral dimension of the settings approach, thus highlighting external as well as internal institutional impacts (Dooris, 2004); and joining up settings in partnerships to speak with a single voice that can maximise their collective ability to influence regional, national and international policy.

Developing the evidence-base

The third challenge concerns evidence. Whilst the settings approach is widely perceived to have a range of benefits, and evidence and evaluation reviews have included a focus on settings (International Union for Health Promotion and Education, 2000; Rootman *et al*, 2001), it remains true that:

The settings approach has been legitimated more through an act of faith than through rigorous research and evaluation studies...much more attention needs to be given to building the evidence and learning from it.
(St Leger, 1997: 100)

There are a number of specific issues that make it difficult to build a convincing evidence base (Dooris, 2005). Firstly, the ways in which evaluation is funded and the evidence base for public health and health promotion is constructed reflect a continuing focus on specific diseases and single risk factor interventions. Secondly, the diversity of understandings and practice referred to above creates obvious problems in generating a substantive body of research that allows comparability and transferability. Thirdly, it is complex to evaluate the settings approach as defined in terms of an ecological approach and systems thinking – which, as Senge (1990) has argued, is a framework for seeing interrelationships and patterns of change rather than static 'snapshots'. This requires a non-linear approach that recognises the interrelationships, interactions and synergies within and between settings. Researchers also need to recognise the synergistic effects of combining different methods to answer different research and evaluation questions (Baum, 1995, Steckler *et al,* 1992) and to combine specific 'health' measures with measures that focus on the core business of the setting (Lee *et al*, 2005).

The result has been a tendency to evaluate discrete projects in settings rather than initiatives as a whole, mitigating against the generation of credible evidence of effectiveness for the settings approach in terms of 'added value' and synergy. A possible way forward is to draw on the experience of 'theory-based evaluation', but to do this will require us to clarify the theoretical base, engage with policy makers to ensure that the evidence is being generated for a purpose (de Leeuw and Skovgaard, 2005) and secure adequate long term funding.

Conclusion

Ziglio *et al* (2000) have argued that, despite an apparent widespread acceptance of a socio-ecological model of health, health promotion has continued to focus on single issues, achieving little impact on the determinants of health or policy development. They go on to suggest that these impacts will not occur *"until the starting point for action is the creation of health...[and] it is accepted that social systems are complex and interwoven, and their interconnections are crucial to the creation of health."*

The settings approach can make a valuable contribution to planning and delivering health and well-being in ways that takes account of this complexity, within the places that people live their lives. To do so, it needs to address the challenges outlined above, clarifying theory, staying with the bigger picture and generating evidence of effectiveness.

IUHPE is committed to this process and to a vision of 'joined-up' health promoting settings. It will be looking to gather evidence of effectiveness and to encourage dialogue and debate at its forthcoming conferences – including the Nordic Health Promotion Research Conference in June 2006, the World Conferences in Vancouver and Hong Kong in 2007 and 2010. We invite you to contribute and get involved!

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