Health Promotion, Community Development and All That

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Proceedings
The activities of health promotion have matured in recent years to embrace epidemiology, community development, health economics and the new public health. Creating healthy environments and supporting community action are now regarded as essential components of the process of improving health status. Examples from the community development in health project in Western New South Wales will be used to highlight the successes and problems of delivering health promotions in rural areas.

Money for Prevention

In 1982 the W.A. government spent $100,000 on non-wages health promotion. By 1988 it was spending $3m. In 1987 a 5% increase in the state tobacco licence fee raised $23m for the Victorian Health Promotion Foundation. The NSW Health Promotion budget has grown from $8.4m to $18.7m in the 4 years to 1990/91. The Commonwealth government committed $41m over the 3 years 1989 to 1992 to the National Program for Better Health.

The allocation of these amounts of money follows a decade of intense debate about the means and ends of improving health status and promoting health. Further, the idea of prevention has become more appealing with the rising cost of providing a curative health service in an ageing population. Cost analysis that includes indirect costs such as loss of productivity and welfare support have provided the following national estimates for preventable conditions.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Cost (billion)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor vehicle accidents</td>
<td>$3.5</td>
</tr>
<tr>
<td>Poor nutrition</td>
<td>$6.0</td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td>$2.0</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>$1.5</td>
</tr>
</tbody>
</table>

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So health promotion funding is relatively impressive in an historical context but constitutes only 1% of most health budgets.
Principles and Charters

The rise of health promotion and popularity of community development has been analysed as a tribute to the social movements that were spawned in the 1960's or as the product of enlightened policymakers. W.H.O. papers and conferences have certainly been influential. The 1978 Alma Ata Declaration on Primary Health Care listed the 4 key principles of primary care as equity, prevention, community participation and intersectoral activity. By 1986 these principles had been expanded and are now enshrined as the Ottawa Charter. Ottawa, Canada, was the location for the first International Conference on Health Promotion. There are 4 major strategies in the Charter.

- Strengthen community action
- Develop personal skills
- Create supportive environments
- Reorient health services

These strategies should take place in the context of healthy public policies. The Commonwealth and most State governments have endorsed the intent of the Alma Ata and Ottawa documents. The 3 volume Better Health Commission report 'Looking forward to Better Health' was published in 1986. In 1987 a Health for All Committee was established to set health goals and targets for the year 2000. Their report was published under the title 'Health for All Australians' in 1988. The Better Health Program got under way in 1989. The prime concern is equity and improving health status of people with the poorest health. The 5 target areas are:

- Hypertension
- Nutrition
- Injury
- Preventable Cancers
- Health for Older People

The priorities in NSW are a variation of the national goals; heart disease replaces hypertension, immunisation and sexually transmitted diseases are included and the population target groups also include Aboriginal people, socioeconomically disadvantaged groups and people from non-English speaking backgrounds.

Individuals and Their Environment

The process of achieving these goals is considered to be just as important as the goals themselves. Further, the method of delivering health promotion is crucial to the object of improving health status. There are 2 contending models of health promotion. One focuses on individual responsibility to make behavioural changes that lead to a healthy lifestyle. The other model emphasises changing the environment and improving health of the total population or a specified target group within that population. This model uses community based strategies as well as the mass media, sponsorship and legislation. For example, individuals commence and quit tobacco smoking within a social environment. That environment until recently has encouraged and endorsed the practice and the product, through saturation advertising, sponsorship of sporting and cultural events, influence of significant people (movie and 'pop' stars) accessibility and pricing. Over the last decade health promotion activities have shifted from 'quit' groups for individuals to campaigning for a smoke free environment.
Equity is important because of the unequal distribution of illness and utilisation of health services. The middle class have responded to the promotion of healthy lifestyle because health is highly rated on their personal agendas. The poor and alienated are limited by time, money and the struggle of ‘making ends meet’. “Low socioeconomic status make the healthy ‘choice’ a hard choice.” 10 In summary, health education based on transferring knowledge is not sufficient to induce long term reduction of risk behaviour or improve health status.

Health promotion is Everybody’s Business

New public health and community development are now the passwords for the environmental model of health promotion. Health promotion is everybody’s business. The Ottawa Charter defines health promotion as ... “the process of enabling people to increase control over and to improve their health.”

Community development is used to describe an alliance between a community and advocates such as health promoters, community nurses and welfare organisations. In the Orana and Far West Region of NSW we have used the following definition:

“Community development in health is an ongoing process that encourages communities to be more involved in the decisions that affect the planning, delivery and evaluation of the provision of health services. The process should unite various sections of the community and provide an opportunity for the community to become more assertive and self-sufficient.”

Priorities are determined by examining both local opinion and research data. In simplistic terms the overlap in Figure 1 determines the area of mutual concern and the issues that can be potentially improved with popular support.11

Ron Labonte, a Canadian proponent of community development, describes most activities as being geared towards improving equity in consumption. Beyond that is community economic development where the quality of life of a community is improved by developing socially useful enterprises that generate employment, create local wealth and foster self-reliance12.
Using the experiences from the Fitzroy Community Health Centre, Victoria, Jackson et al describe a community development continuum, Fig 2. All activities on the continuum are important, although the goal is to link "individuals and groups with common interests in order to achieve a more equitable distribution of social and economic power". This power in society stems from control over information, relationships and decision-making resources. The Community Development in Health Project was launched in 1988 and is based in Northcote, Victoria. The project team has since published a Resource Collection which includes discussion papers, a directory and bibliography, a set of case studies and posters.

Rural Health Strategy

The National Rural Health Strategy draft document has a stated aim of "... achieving optimal health for all people in rural and remote Australia... through promotion of good health". Local consumers are encouraged to play a full and informed role and the special health needs of Aboriginal, older and disabled people as well as women, adolescents and children.

Apart from Aboriginal people, relatively little is documented about rural health. Aboriginal health status is very poor by any standard. In Western NSW life expectancy is 15 to 20 years less than the State average. Cardiovascular disease accounts for 40% of the excess risk with accidents and violence, diabetes and respiratory diseases also being important. Risk factor screenings revealed smoking rates of 70% and significantly higher proportions of Aboriginal people who were hypertensive and/or obese.

A household survey in the same town conducted by the community development officer revealed an unemployment rate of 70% amongst Aboriginal men which was 10 times the non-aboriginal rate. Interestingly, unemployment was the second ranked problem for the town. The first, and mentioned by 42% of householders, was alcohol abuse. In 1986-88 the all Australian Aboriginal infant mortality rate was about 3 times that of other Australians. Hospitalisation rates are considerably higher for Aboriginal people especially for respiratory diseases. A number of diseases with a higher prevalence amongst Aboriginal people are amenable to community development initiatives. Diseases such as undernutrition, otitis media, trachoma, diarrhoeal diseases and hepatitis B are directly influenced by living conditions and overcrowding.

The Australian Bureau of Statistics' Health Surveys do not allow a comparison between rural and urban residents. However a couple of studies do indicate that people from rural areas...
do have poorer health than their city counterparts. Fitzwarryne and Fitzwanyne surveyed
residents from 3 rural areas. They found a 10% higher incidence of recent illness 15% higher
prevalence of chronic conditions, "very poor lifestyle risks", fewer primary health service
consultations and above average use of hospitals compared to national data. Table 1
compares the risk factor proportions in Warren and the national heart foundation's national
data. Significantly higher proportion of the Warren sample were overweight or obese,
hypertensive or a current smoker. In addition alcohol consumption was far higher than the
national average. 31% of men drunk 6 or more standard drinks per session compared with
a national figure of 12.3%21. Poorer health status could be experienced by the increase in
sedentary work practices, the lack of and inappropriateness of city based health promotion
media campaigns, the culture of self reliance and the distance from health services.

Table 1
PROPORTION OF SAMPLE WITH HIGH RISK FACTOR

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Male</th>
<th></th>
<th></th>
<th>Female</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>War</td>
<td>CI</td>
<td>NHF</td>
<td>STAT</td>
<td>War</td>
<td>CI</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td></td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Cholesterol &gt; 6.5</td>
<td>24.5</td>
<td>18.6 - 30.0</td>
<td>19.00</td>
<td>NS</td>
<td>24.1</td>
<td>18.6 - 21</td>
</tr>
<tr>
<td>Hypertension **</td>
<td>28.9</td>
<td>22.7 - 35.1</td>
<td>19.0</td>
<td>P &lt; .001</td>
<td>18.3</td>
<td>13.4 - 14</td>
</tr>
<tr>
<td>BMI &gt; 25 F &gt; 26 M</td>
<td>52.4</td>
<td>58.8 - 35.1</td>
<td>42.6</td>
<td>p &lt; .01</td>
<td>43.0</td>
<td>36.7 - 35.1</td>
</tr>
<tr>
<td>Current smoker</td>
<td>39.7</td>
<td>33.0 - 46.4</td>
<td>34.6</td>
<td>NS</td>
<td>34.5</td>
<td>28.4 - 34.6</td>
</tr>
</tbody>
</table>

# Percentages are shown within a range of values, know as the Confidence Interval (C.I). This suggests that there
is a 95% "confidence" that the "true "value" lies within this range.

** The NHF (1983) defines hypertension as a Systolic Blood Pressure greater than 160 mmHg, or a Diastolic Blood
Pressure greater than 95 mmHg or being on current treatment for hypertension.

Table 2
SYSTOLIC BLOOD PRESSURE (SBP)

<table>
<thead>
<tr>
<th>SPB (mmHg)</th>
<th>Male</th>
<th></th>
<th></th>
<th>Female</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Warren</td>
<td>NHF</td>
<td></td>
<td>Warren</td>
<td>NHF</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td>%</td>
<td>%</td>
<td>NO</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Below 140</td>
<td>115</td>
<td>56.4</td>
<td>73.4</td>
<td>174</td>
<td>74.7</td>
<td>81.4</td>
</tr>
<tr>
<td>140 to 159</td>
<td>69</td>
<td>33.8</td>
<td>18.7</td>
<td>48</td>
<td>20.6</td>
<td>13.0</td>
</tr>
<tr>
<td>160 to 169</td>
<td>11</td>
<td>5.4</td>
<td>4.1</td>
<td>5</td>
<td>2.1</td>
<td>3.0</td>
</tr>
<tr>
<td>Above 170</td>
<td>8</td>
<td>3.9</td>
<td>3.8</td>
<td>6</td>
<td>2.6</td>
<td>2.6</td>
</tr>
<tr>
<td>Total</td>
<td>204</td>
<td>100.0</td>
<td>100.0</td>
<td>233</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Community needs assessments are a useful tool to determine issues and priorities as felt by the community. In Warren, NSW, recreational facilities, alcohol abuse and unemployment were seem as the major problems. The Wilcannia community development officer has been involved in town cleanups, monitoring and advocating on housing, employment and public health issues.

The Orana and Far West Region of NSW is developing a 3 tiered management of health promotion. Regional staff are the link between national or state initiatives and the local activist/advocate. The latter brings home the message to their own town, stimulates interest and works with the community. 8 of our 25 towns are involved in this process. The success of the process depends on the initiative, enthusiasm and commitment of the local person. For example the Warren community development officer, as part of a campaign to reduce the prevalence of tobacco smoking, organised quit groups (poorly attended), mapped outside advertising (80% of which was in breach of the NSW Voluntary Code), erected an anti-smoking billboard, distributed leaflets, wrote articles for the local newspaper, encouraged clubs and workplaces to become smoke-free and sponsored local sports teams with a smoke-free message.

Conclusion

This conference is a timely opportunity to commit the methods of health promotion and community development to rural areas. Success is likely because of the traditional loyalty and community support of country people. The same defiance and self-reliance that is so proudly displayed against natural disasters can be channelled against the unnecessary burden of ill-health. More work is needed to understand the ‘hearts and minds’ of rural residents, and combine this with epidemiological research. The health services will need to continually review their own efforts to promoting health amongst their own staff and the community. Finally, health and health promotion is everybody’s business. Schools, churches, service clubs, the CWA, shopkeepers amongst others, will need to be encouraged to adopt the healthy choice. Then we’ll all be winners.

References

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