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Prologue: Alexis de Tocqueville, the French social philosopher, provided what is perhaps the most penetrating analysis ever written of the relationship between character and society in America in his classic work, Democracy in America. In the 1830s, based on observation and conversation with many Americans, Tocqueville singled out family life, religious tradition, and participation in local politics as helping to create the kind of individual who could sustain a connection to a wider political community and thus support the maintenance of free institutions. But he also warned that some aspects of the American character, particularly the steadfast belief in “individualism,” might eventually isolate Americans one from another and, in the process, undermine the conditions of freedom. In this opening essay, Lester Breslow, a distinguished professor of public health at the University of California, Los Angeles, and dean emeritus of its School of Public Health, suggests that neither an exclusive focus on the individual nor the community in which he or she dwells is an adequate strategy to pursue health promotion and disease prevention in a complex, industrialized society. In his overview, he also touches on a variety of subjects that are covered in greater depth by other authors in this volume. Breslow, who holds a medical degree from the University of Minnesota, has long since broadened his horizons beyond curative medicine to focus on the pursuit of health. He has served as president of the American Public Health Association, the Association of Schools of Public Health, and the international Epidemiological Association. He also is a member of the Institute of Medicine (National Academy of Sciences) and is founding chairman of its Board of Health Promotion and Disease Prevention. For twelve years (1978–1990), Breslow served as editor of the Annual Review of Public Health and, at different times, has been an editorial consultant to several other health journals.
Although one can trace the idea of health promotion back to ancient times, the term itself has become prominent only in recent years. Current thinking on health promotion stems mainly from two roots: (1) the remarkable improvements in health during this century and the ensuing opportunity to focus on health in a positive as well as a negative (disease control) sense, and (2) increasing recognition that medicine constitutes only one factor in the advance of health and that a complete strategy for health must embrace much more.

The Recent Evolution Of Health

If, in the United States at the beginning of this century, a bold and optimistic futurist had undertaken to set health goals for the year 2000, he or she might have projected the following: (1) avoid epidemic disease and serious injury; (2) escape tuberculosis; and (3) live to age sixty-five and know your grandchildren. No consideration would have been given to coronary heart disease; its major manifestation, myocardial infarction, was first described in 1912. Neither lung cancer nor other cigarette-induced diseases would have been mentioned, because no publication had yet recognized them. Average life expectancy was less than fifty years in the United States as well as in other countries that were making rapid industrial progress. The idea that, in this century, the average length of life might exceed seventy-five years would have seemed rash.

Entering the 1990s, we have a vastly different perspective. In industrially advanced nations, life already usually extends well past age seventy. Formerly epidemic and endemic infectious diseases have been largely controlled in these nations, and smallpox has been eradicated worldwide. Malaria, schistosomiasis, diarrhea, and other infectious diseases, of course, still block health in many developing nations. On the other hand, what some call the “epidemiologic transition” means that we now must struggle throughout the world against the epidemic diseases generated by twentieth-century patterns of living: coronary heart disease, lung cancer, and other noncommunicable diseases.

Beyond disease control. Despite continuing concern with the “modern” diseases, we can begin turning our attention to the other side of the coin, namely, health. People in industrially advanced nations not only live into their seventies and eighties, but they live their years largely free of illness. To be sure, we still must confront disease and ways to minimize it; however, we have achieved a situation in which health, rather than disease control only, is on the agenda. For example, we hear debates as to whether the “natural” length of human life is approximately eighty-five years or whether as a species we can exceed that mark. Also, scholars are
considering whether increased longevity is necessarily accompanied by a
greater burden of ill health in the upper reaches of life.\(^4\) In any event,
reaching at least age eighty-five can be a goal for most people.

The extent of this health transition on a world scale may be illustrated
by recent health changes in China. With one-fifth of the world’s popula-
tion, still largely rural, this developing nation is already following the
health path of the more industrialized and urbanized world. In just two
decades, from the mid-1950s to the mid-1970s, China has had a complete
reversal in the pattern of diseases causing mortality.\(^5\) By the 1970s,
chronic, noncommunicable diseases in both urban and rural areas caused
more than twice as many deaths as communicable diseases, thus approxi-
mating the situation that prevailed in the Western world in 1950.

An important consequence of controlling communicable diseases,
which tend to strike people during the early years of life, is increased life
expectancy. During recent years, less developed nations have been mak-
ing greater advances in increasing life expectancy than have more devel-
oped nations.\(^6\) They are “catching up.” While chronic diseases seem to be
an increasingly prominent health problem worldwide, it should be noted
that they are being overcome in some places even as they advance in
others (Exhibit 1). For example, mortality from cardiovascular disease
has been declining sharply in the United States from its peak in the 1960s.

\section*{Exhibit 1}
\textbf{Age-Standardized Mortality From Cardiovascular Diseases Per 100,000, Selected Countries And Years}

\begin{tabular}{|c|c|c|c|c|}
\hline
\textbf{Country} & \textbf{Males}\(^a\) & \textbf{1975} & \textbf{1980} & \textbf{Females}\(^a\) & \textbf{1975} & \textbf{1980} \\
\hline
Hungary & 670 & 840 & 360 & 399 \\
Poland & 606 & 734 & 273 & 304 \\
United States & 703 & 596 & 284 & 244 \\
\hline
\textbf{Coronary heart disease}\(^b\) & \textbf{1969} & \textbf{1977} & \textbf{Percent difference} & \\
United States & 865 & 670 & –23\% \\
Australia & 844 & 683 & –19 \\
Canada & 703 & 624 & –11 \\
\hline
Japan & 127 & 103 & –19 \\
Poland & 187 & 308 & 65 \\
Bulgaria & 299 & 424 & 42 \\
\hline
Romania & 171 & 237 & 39 \\
Hungary & 442 & 499 & 13 \\
\hline
\end{tabular}


\(^a\)Ages 40–69.

\(^b\)Males ages 35–74.
At the same time, cardiovascular disease has increased among eastern Europeans, corresponding to their first heavy exposure to excessive dietary fat, cigarettes, and other factors believed to be responsible for heart disease and stroke. The same sequence, even the same social class sequence within countries, is being repeated in other developing nations, such as Papua New Guinea.

As the century comes to an end, curtailment of mortality from major chronic diseases is extending longevity well past age sixty. In fact, the greatest gains in U.S. life expectancy are now occurring in the later years. Thus, consideration should now focus on maintaining and enhancing health throughout life. The World Health Organization’s (WHO’s) definition of health as “complete physical, mental, and social well-being, not merely the absence of disease or infirmity” becomes an attainable goal rather than a quixotic statement, as so many have regarded it.

**Health As A Social Science**

As long as human health problems have consisted principally of dealing with disease, people have turned largely to specialized personnel, from primitive healers to modern Western physicians, for help in overcoming affliction. Advances in medical science, especially in this century, have brought cures of many kinds as well as increasing ability to prevent disease. The prevailing complaint/response system of medical service, however, has been arousing substantial criticism, particularly in the United States. For more than a decade, noting this overwhelming focus on diagnosis and treatment and the rise in medical costs, business and union leaders have called for more emphasis on prevention.

Extensive use of technology for little if any gain, especially in the terminal stages of life, is stimulating ethical questions. The economically minded worry about the still-rising cost of medical services, now about 12 percent of the gross national product (GNP).

Gross inequity in distribution of benefits from the medical service system also attracts recurring criticism. Henry Sigerist put the case well almost fifty years ago:

The task of medicine is to promote health, prevent disease, to treat the sick when prevention has broken down and to rehabilitate the people after they have been cured. These are highly social functions and we must look at medicine as basically a social science. Medicine is merely one link in a chain of social welfare institutions that every civilized society must develop. If we have a maladjustment today, it is to a large extent due to the fact that we have neglected the sociology of medicine. For a long time we concentrated our efforts on scientific research and assumed that the application of its results would take care of itself. It did not, and the technology of medicine has outrun its sociology.
Significance of lifestyle. Despite the contributions of Western medicine, many have questioned its significance to health. Thomas McKeown demonstrated that mortality from tuberculosis and several other communicable diseases declined about 90 percent or more prior to any biomedically effective intervention. He observed, “The improvement of health during the past three centuries was due essentially to the provision of food, protection from hazards, and limitation of numbers.” Further, he noted, “If health is determined essentially by nutrition, personal behavior and the quality of the environment, then it is clearly desirable to reconsider the role and responsibilities of medicine in relation to such influences.”

Today’s debate of medical versus other social factors in health includes the discovery that major diseases in industrialized society, as in previous eras, emerge largely from the conditions of life and the ways people cope with those conditions. In twentieth-century America, for example, the ready availability of excess calories, particularly in the form of fat; of alcohol and tobacco; and of physical ease are common conditions of life. Individual choices in such matters constitute what is sometimes called lifestyle—the way in which people respond to their situations. Lifestyle is strongly associated with health and mortality.

Individual versus community focus. One important question for those concerned with improving health is whether to emphasize identifying and treating individuals at high risk or to tackle the problem at the community level. Almost any effort to advance health may focus on the individual or on the community. One may seek to detect persons with blood cholesterol levels above 250 and follow up to reduce their levels to 200, or one may attempt to lower average levels in a community from 220 to 210. Both would be substantially effective. There is nothing inherently good or bad about either approach; it is merely a question of which lens to use and how to achieve the corresponding purpose.

Medical practitioners tend to focus on individual patients and specific aspects of their health. That approach enables physicians, ideally in partnership with the patient, to assess the patient’s health and to follow a path toward maintaining or improving health.

In contrast, the public health mode seeks improvement in the conditions of life for all people in the community. That course is based on favorable experience in assuring safe water supplies and otherwise creating a sanitary environment in which to reduce communicable diseases. Public health practitioners continue to concentrate on the conditions of life that lead to disease. For example, they seek to change the circumstances that favor tobacco use, rather than trying to persuade individuals not to use tobacco. Public health action thus attempts to establish
community conditions that facilitate healthful choices for all people. Recently, the Institute of Medicine (IOM) reaffirmed the mission of public health as “fulfilling society’s interest in assuring conditions in which people can be healthy.”

### Health Promotion: Some Concepts And Issues

Current ideas of health promotion are thus evolving in a milieu that reflects recent life extension and health improvement and recognizes that factors other than medical service largely determine health. For example, Milton Terris emphasized that promoting health means social assurance of a decent standard of living, including adequate nutrition, working conditions, and education. On the other hand, John Knowles pleaded for the responsibility of the individual, stating that “over 99 percent of us are born healthy and are made sick as a result of personal misbehavior and environmental conditions. The solution to the problem of ill health in modern American society involves individual responsibility, in the first instance, and social responsibility through public legislation and private voluntary efforts, in the second instance.”

Probably the most widely cited definition of health promotion comes from the Ottawa Charter for Health Promotion:

> Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capabilities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well-being.

This concept integrates ideas of community and personal effort in health promotion by focusing on the process of enabling individuals, through social action, to “take control” of their own health. Another formulation that combines purpose and modality is that health promotion consists of “the advancement of well-being and the avoidance of health risks by achieving the optimal levels of the behavioral, societal, environmental and biomedical determinants of health.” As consensus on the meaning of health promotion evolves, the concept clearly will emphasize social action to strengthen members of society and will go beyond disease prevention by (1) regarding health as more than the absence of disease and (2) aiming to change conditions and institutions.

**Defining the issues.** A fundamental issue is the definition of health itself. What is to be promoted? Beyond disease control, how shall health
be delineated? What are the fundamental aims and objectives of health promotion? To what extent is it a task for each individual, for physicians (in roles beyond traditional medical service), or for the community as a whole? Also, what ethical and political considerations surround health promotion? Do these considerations differ from those of other types of health work? Finally, how may the endeavor best be evaluated? The following sections expand on each of these issues.

**Definition Of Health**

Whether health consists of something more than freedom from disease is an important issue for health promotion. The question goes to the heart of what shall be promoted. If our focus is exclusively on avoiding disease and injury, then the term disease prevention is appropriate, and the term health promotion may be restricted to social efforts to minimize disease and impairment, such as assuring good housing, adequate income, and safe working conditions. If, on the other hand, health is conceived as a state of “physical, mental, and social well-being” as proposed by WHO, then it is necessary to define health as more than “the absence of disease and infirmity.”

While WHO’s statement is still not universally accepted as a working definition, the evolution of health increasingly evokes the notion that it includes well-being. Health can be regarded as a state toward the positive end of a spectrum as well as escape from the negative end, manifested by disease and ultimately death. It is certainly not something to be obtained by “consumers” from “providers.” That formulation, so common nowadays, grossly distorts the role of medicine in assisting people to regain, preserve, or improve health as an asset for achieving a full, enjoyable life.

A recent publication by the International Epidemiological Association and WHO describes two aspects of health: health balance and health potential. Health balance is essentially the Hippocratic notion of dynamic equilibrium between the human organism and its environment. In the constant interaction between the two, the organism does not collapse or deteriorate but maintains a basically stable relationship with the world outside. A vigorous person even strives to change the environment, making it more amenable to life for oneself and others. In this positive view, health is not merely defensive.

Health potential consists of reserves—the capacity of an individual to cope with environmental influences and thus keep in balance. This concept is related to but goes further than the idea of resistance to microbiologic agents that can harm the organism. Health reserves also
include the capacity to withstand the adverse effects of noise, factors causing atherosclerosis, ionizing radiation, loss of a loved one, and the myriad other hazardous circumstances of living.

Beyond the immunological, other well-known categories of health reserves are (1) physiological, such as adequate secretion of insulin; (2) anatomical, such as intact cervical epithelium; and (3) genetically excellent chromosomes. Psychological reserves, though in less well delineated categories, also help to maintain balance with one’s environment. Ideally, of course, optimal levels of these reserves are desirable, not just those that border upon or indicate pathology. For example, keeping blood cholesterol below some “norm” such as the clinically alarming 240 milligrams does not necessarily constitute an appropriate health goal. A level of 200 or lower may be better; in fact, the level may vary in individuals of different ages or life circumstances.

It is possible now in health endeavors to focus on achieving maximal health in the sense of staying in equilibrium with one’s physical and psychosocial environment, and not limit health efforts to avoiding or minimizing pathology. We must seek both maximum longevity and maximum health throughout life. Good health is, of course, not the aim of life, but it does constitute a major resource for life. It means more than freedom from physical and mental disturbances, such as those listed in disease nomenclature; it includes with equal importance the energy and reserves of health that permit one to lead a buoyant life, full of zest, competent to meet challenges. Indeed, one could enjoy considerable health of this kind even while having some handicapping conditions.

Aims And Objectives Of Health Promotion

Accepting that health means both the current state of a human organism’s equilibrium with the environment and the potential to maintain that balance, health promotion aims “to maintain and expand function generally and to build reserves against forces adverse to health.” The relationship between health promotion and disease prevention may best be portrayed as a continuum ranging from extreme infirmity to bounding health. Every person’s degree of health may be found somewhere on the continuum. Promotion of health means facilitating at least the maintenance of a person’s current position on the continuum relative to age and, ideally, advancing toward its positive end. Disease prevention, on the other hand, means avoiding specific diseases that carry one toward the negative end.

In some important respects, health promotion and disease prevention are two sides of the same coin. Many of the same actions—for example,
obtaining adequate exercise and appropriate nutrition—that are aimed at accomplishing one also achieve the other. To the extent that such measures are directed against a particular disease, such as cessation of smoking to minimize the risk of lung cancer, they may be regarded as disease prevention. To the extent that the same measures are aimed at advancing health generally, for example, preserving optimum respiratory and cardiovascular systems, they may be regarded as health promotion.

Chronic disease usually involves derangement of one or more of the biomedical parameters listed in Exhibit 2. Action to avoid or correct specific derangements that lead to irreversible pathology constitutes chronic disease prevention. Action to strengthen these parameters constitutes health promotion. The actions are the same. The multifactorial nature of chronic disease causation serves to juxtapose modern disease prevention and health promotion.

Besides actions directed toward such specific parameters, other measures that are well known to favor health include assuring adequate education, food, housing, working conditions, and economic security. Sometimes these factors affect health in ways that are clearly understood, as for example in the case of poor nutrition of hungry children; at other times, the channels of influence may be less obvious, although just as significant. To limit the term health promotion to health-supportive measures such as these avoids grappling with the issue of what constitutes health—an issue that seems ripe for consideration.

### Exhibit 2
**Examples Of Health Indicators To Be Sought By Health Promotion**

<table>
<thead>
<tr>
<th>Anatomical</th>
<th>Optimum weight/height ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Normal epithelial tissue</td>
</tr>
<tr>
<td>Physiological</td>
<td>Blood pressure approximately 120/80</td>
</tr>
<tr>
<td></td>
<td>No electrocardiographic abnormalities</td>
</tr>
<tr>
<td>Chemical</td>
<td>Blood cholesterol level 200–210 milligrams</td>
</tr>
<tr>
<td></td>
<td>Glucose tolerance</td>
</tr>
<tr>
<td>Bacterial</td>
<td>Freedom from bacteriuria</td>
</tr>
<tr>
<td></td>
<td>Absence of tuberculosis infection</td>
</tr>
<tr>
<td>Immunological</td>
<td>Immunity to current strains of influenza</td>
</tr>
<tr>
<td></td>
<td>Immunity to poliomyelitis</td>
</tr>
<tr>
<td>Genetic</td>
<td>Absence of trisomy 21 in fetus</td>
</tr>
<tr>
<td></td>
<td>No Tay-Sachs affected fetuses</td>
</tr>
<tr>
<td>Behavioral</td>
<td>No cigarette smoking</td>
</tr>
<tr>
<td></td>
<td>Moderate if any use of alcohol</td>
</tr>
</tbody>
</table>
A subtle but important difference has occurred between the time when exposure to hazardous agents such as contaminated water posed the main health problem and the present time, when access to hazardous agents such as alcohol and tobacco constitutes the main problem. Nowadays, personal choice enters substantially into the process. It has become the final segment of the exposure pathway. The choices made by individuals, however, do not occur in a vacuum. They reflect not only availability of whatever is involved but also, to a considerable extent, the social milieu in which the choices are made. Health promotion thus embraces both improving the health aspects of the physical and social environment in which people live and improving personal health practices. Lawrence Green, in reviewing this matter, has noted the convergence of “two trends—one seeking to distribute responsibility for lifestyle more equitably and the other seeking to distribute responsibility for planning health programs more equitably.”

Conceptually, individual action as a factor in determining disease and health (one’s place on the health continuum) is clear enough. Responsibility for such action is, however, by no means so clear. Since the action is ultimately taken by each person, and since individuals in advanced industrial societies confront so many choices that can affect their health, many observers have pointed out that personal choices concerning food, exercise, use of alcohol, tobacco, and the like largely determine individual health. This emphasis on ultimate personal choice, without reference to other factors in the decision-making process, often implies that the individual is totally responsible for his or her health. Some have objected that such imputation results in “blaming the victim” and takes no account of another decisive element: the social context in which decisions about drugs and the like are made. For example, cocaine is used for the most part when it is socially available and when one’s peers are using it; asserting that the person who uses cocaine has “free choice” actually obscures the reality. The decision takes place in a system in which the individual is the final, but only one, element in the process.

Thus, understanding the interrelationships between individual health-related actions and their social context becomes critical in attempting to deal with individual actions. Strong moral feelings often confound rationality in approaching such relationships.

Biological factors are also involved. Biological capacity is a fundamental limiting factor in actions affecting health, as it is to all human action. Infants do not make decisions about health, except to withdraw from pain. Two-year-olds given beer or snuff (as sometimes happens) do
not have much “choice” in the matter. Invalids may exercise their personalities, but their physical incapacity often restricts their freedom of choice. People addicted to opiates, nicotine, and other drugs also experience biological influences on health-related decisions, particularly the pain of withdrawal.

Influence of the social milieu on health-related individual actions to promote health, however, usually far exceeds biological factors. This can be seen in the dramatic changes that occur from one generation to the next, or even within a single generation. Prohibition greatly reduced cirrhosis due to alcohol toxicity among American males during the early part of the twentieth century, but that approach to the alcohol problem proved socially untenable, and cirrhosis mortality rose again.

Thus, essential to understanding individual action to promote health is a systems view of the phenomenon. That view takes into account biological, that is, suborganismic, factors on the one hand, and social factors that extend beyond the individual on the other. Although some would focus on individual behavior, the social context is the dominating influence, within biological limits.

In 1952, a presidential commission described the relationship between individual and social responsibility for health in these words:

The individual effort of an informed person will do more for his health and that of his family than all the things which can be done for them. In the past, measures for health maintenance demanded individual responsibility only to a limited degree. The development of pure water supplies, pasteurization of milk, and other sanitary accomplishments were achieved through social action in which the individual may have participated as a citizen, but was required to take no further individual responsibility.

Future accomplishments, however, depend to an even greater degree upon the individual’s assumption of responsibility for his own health. It is the individual who must consult his physician for early care, avoid obesity and alcoholism, and drive his automobile safely. These things cannot be done for him. They require both information and motivation. . . . Recognition of the significance of individual responsibility for health does not discharge the obligation of a society which is interested in the health of its citizenry. Such recognition, in fact, increases social responsibility for health. . . . Society must assure its citizens access to professional services, education concerning personal health practices, and a reasonably safe physical environment. Only then can individual responsibility for health exercised through personal action reach its full potential.22

Health professionals also carry special responsibility for health promotion. Their role is to delineate the prospects for preserving life and extending health for most persons at least into the ninth decade of life; to ascertain the barriers to achieving that potential; and to advocate the social and personal actions that are indicated. Although medical services
are now largely directed toward overcoming poor health by treating
disease, to the extent that medical services are aimed at health promo-
tion, they are certainly part of the total effort.

Ethical And Political Concerns

Philosophically, the community approach is consistent with the princi-
ple of the collective good, that we are “our brother’s keeper.” Dan
Beauchamp recently outlined what he calls the “second language of
community” in America.23 The first language of community health was
to protect the individual against hazards; a recent example is safety-belt
legislation. The second language goes beyond preventing harm to par-
ticular people, which is still political individualism. It includes “encourag-
ing citizens to share in reasonable and practicable group schemes to
promote a wider welfare, of which their own welfare is only a part.”
Instead of “The life you save may be your own,” which represents our
tradition of individualism, the public health slogan might become “The
lives we save together might include your own.” Its meaning appears in
various aspects of modern public health, for example, Mothers Against
Drunk Driving (MADD).

A second, more pragmatic strength of the community approach to
health lies in its avoiding dependence on efforts to influence thousands or
millions of individuals in their personal behavior. Two examples of this
approach include fluoridation and tobacco advertising. Rather than
persuading individuals to take fluoride with their toothpaste or to resist
tobacco advertising, the public health approach is to optimize the flu-
oride content in community water supplies and to stop tobacco advertis-
ing on television and radio. A community environmental policy that
protects essentially all people is obviously more efficient and effective
than seeking protective behavior by each person, But many such “protec-
tive” measures related to health behavior are regarded by some as
paternalistic and intrusive, if not a violation of rights.

Finally, a great strength of the community approach is its relative
permanence. Customarily, it deals with a situation “once and for all.”
Public decisions concerning health can, of course, be changed, but when
healthful life conditions are established, it is no longer necessary to deal
with an endless chain of individuals whose health may be impaired by the
same bad conditions.

The community approach to health, however, often encounters two
serious difficulties. First, health promotion typically involves multiple
sectors in a society. For example, advocating a policy to curtail cigarette
consumption usually brings the health official up against officials of
agriculture, industry, and finance. The health issue must be of paramount social importance to prevail over interests of other sectors in a society. Second, the community approach to health must confront the ideology of individual freedom. Cherished by democratic societies throughout the world, freedom in certain of its forms may be threatened by collective action for health. Licensing individuals to operate motor vehicles is widely practiced; restricting such license upon conviction for driving while intoxicated is also increasingly accepted. A further step, the systematic sample checking of drivers for intoxication, however, is being legally challenged by civil liberties groups as an infringement on individual freedom.

Measurement And Evaluation

As yet, measurement of health on the positive end of the continuum remains quite primitive, and thus, unsatisfactory. It is important, therefore, to carry WHO’s definition forward conceptually and operationally to quantify health, for both the individual and the community. In the meantime, some current although admittedly limited notions and tools can be used to measure progress in health promotion.

National health objectives. Exemplifying the community approach, the U.S. Public Health Service (PHS) in 1980 enunciated 226 health objectives in fifteen areas for 1990. In each area, PHS summarized the nature and extent of the problem, measures for dealing with it, and specific objectives for 1990. The example of one objective—that at least 60 percent of the estimated population having high blood pressure (140/95) should have attained successful, long-term blood pressure control (below 140/90 for two or more years)—shows the specific nature of these goals. For selected aspects of health such as these, it has thus been possible to set objectives in clear, quantifiable terms covering actual health status, reduced risk factors, increased public/professional awareness, improved services, and improved surveillance.

A midcourse review tabulated progress toward the various objectives and projected the extent to which they were likely to be attained by 1990. Continuing the process of establishing ten-year health objectives, PHS has issued, for public review and comment, a draft document looking toward the year 2000 and intends to release the final document in September 1990. (See articles by James Mason and by Ronald Andersen and Ross Mullner in this issue of Health Affairs.)

Individual goals. While setting health objectives at national or community levels is now feasible and apparently useful from a public health standpoint, what can be said about a comparable approach to individ-
uals? Perhaps the first target for individuals in advanced industrial nations should be awareness of their health situation. Many people already seem eager for appraisal of their own “health risk.” Several dozen schemes are now used in the United States for appraising and quantifying individual health risk. Generally, they include such elements as age and gender; certain bodily characteristics, such as blood pressure; and certain behavioral characteristics, such as whether one uses alcohol excessively. Knowledge about one’s health situation, derived from a health risk appraisal, together with related attitudes and beliefs, comprises the ground on which to project health goals. Data concerning weight, nutrition, and exercise typify items involved in formulating what one sees as desirable and achievable in health.

A second important step toward personal health consists of obtaining access to medical and other health services as needed, particularly including periodic health maintenance examinations. One difficulty here is that physicians generally have been trained and practice in a complaint/response system. The physician’s role in that system is to receive and evaluate the patient’s complaint, diagnose the condition, and offer treatment—an excellent way to deal with manifest disease, but not sufficient to help individuals toward health. Within medical service, however, practices in two fields indicate increasing orientation to health as the basic medical service goal. In obstetrics and pediatrics, the focus is preserving and improving, if possible, health during pregnancy, infancy, and childhood. Regimes in those times of life include periodic visits for specific health maintenance procedures, not just responses to disease.

**Specific recommendations.** This kind of health monitoring can now be extended throughout life. For each age period, it is possible to define sets of goals and professional services directed toward health maintenance upon which health monitoring and action can be based. For example, for middle-adult life; ages forty to fifty-nine, health goals might be established as: (1) to prolong the period of maximum physical energy and optimum mental and social activity, including menopausal adjustment; and (2) to detect as early as possible any of the major chronic diseases, including hypertension, heart disease, diabetes, and cancer, as well as vision, hearing, and dental impairments. Professional services might include: (1) four professional visits with the healthy person, once every five years, with complete physical examination and medical history; tests for specific chronic conditions; appropriate immunizations; and counseling on changing nutritional needs and physical activities; occupational, sex, marital, and parental problems; and use of cigarettes, alcohol, and drugs; (2) for those over age fifty, annual tests for hypertension, obesity, and certain cancers; and (3) annual dental prophylaxis.
Access to lifetime health monitoring by a physician should therefore be added to health awareness as a basis for establishing and pursuing individual health maintenance objectives.

A Future For Health Promotion

By the year 2000, chronic disease control should be well under way, at least in the United States. Cardiovascular disease has been declining steadily for more than two decades, and cancer mortality is now declining, having declined first among younger people and now reaching persons age fifty-four. A heavy disability burden will, of course, unfortunately continue for some years among older persons already affected by the precursors of chronic disease. The diseases themselves, however, will impair people’s lives less frequently, just as communicable diseases have relinquished their grip on health.

Further “epidemiologic transition” will increasingly clear the way for attention to health promotion, beyond disease prevention. Pressures for achieving optimal health will rise, along with understanding of how to move in that direction as individuals and as communities. Guidelines for better nutrition, cessation of tobacco use, control of alcohol use, improved patterns of physical activity, and the like are taking hold among increasingly larger segments of the population—with a view toward health, not just disease prevention. As longevity increases due to these and other factors, people will seek to preserve health as a resource for living in the later years rather than merely to avoid disease.

As health promotion becomes more prominent on the health agenda, care must be taken to reach people most in need. Prominent in this category are those in our nation who have been historically neglected in health matters: the poor, racial/ethnic minority groups, and the elderly. Health promotion activities in schools, small as well as large worksites, the medical care system, and neighborhood gathering places are the way to extend benefits to all persons. Indicators of the conditions that foster health in the whole population should replace GNP as the indicator of national well-being. Health indicators would more closely approximate progress toward securing the well-being of people than do the current gross economic indices. The well-being of people—physical, mental, and social—is the ultimate goal of society.

NOTES


18. Long-Range Planning Committee, School of Public Health, University of California, Los Angeles, 1984.


27. Breslow and Somers, “A Lifetime Health Monitoring Program.”