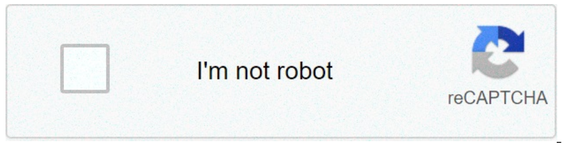

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Tannahill model of health promotion pdf

Share this: Facebook Twitter Reddit LinkedIn WhatsApp Drawing on appropriate literature, provide a critical analysis of the application of health promotion philosophies, principles and approaches underpinning public health practice in relation to a relevant topic (e.g. any public health policy in the UK) The chosen public health topic is smoking. The student has selected this subject because it is a current issue of particular relevance because of the prohibition to premises becoming smoke- free if they are open to the public, due to be enforced in England in July 2007 (Health Act 2006). Smoking is also an important topic because it has been identified as the single most significant public health problem in the UK (Royal College of Physicians 2000); approximately 114,000 smokers in the UK die as a result of smoking (Action on Smoking and Health 2005). The treatment of smoking- related conditions costs the National Health Service (NHS) up to £1.7 billion per year with an estimated cost of £1.7 million to British industry every year as the result of lost working hours caused by smoking- related illness (Gommans 2005). According to Tannahill (1985) health promotion is a broad concept which encompasses health education and health prevention. Health education refers to working with groups and individuals to promote healthy behaviours, whereas health prevention refers to strategies which prevent ill- health such as immunisation. Public health is defined as: 'The science and art of preventing disease, prolonging life and promoting health through organised efforts of society' (Acheson 1988) This definition implies a collective approach; however public health has been criticised as being medically dominated (McPherson 2001). Philosophies of health promotion provide a framework for exploring our rationale and justification for wanting to change health- related behaviour. Seedhouse (2002) refers to health promotion as a 'moral endeavour'; in other words health professionals are required to make judgments about if, how and when to intervene in relation to the health behaviours of patients, clients and service users, taking into account individual needs and priorities. In some cases health behaviours affect not only the individual but others, also; this applies to the effects of secondary smoking, for example. Taking into account the secondary effects of health behaviours may impact upon the 'moral endeavour' of health professionals and health policy makers. Moral judgements underpin the work of health professionals; the student recalls an incident when a lady aged 100 who had smoked all of her adult life and who clearly did not have long to live, asked to be helped to smoke a cigarette. This simple act gave her pleasure and it seemed irrational and unkind not to respond to her request. Moral judgements are not always straightforward. Get Help With Your Nursing Essay If you need assistance with writing your nursing essay, our professional nursing essay writing service is here to help! Find out more Philosophical principles applicable to health promotion include logic; the development of reasoned argument (Naidoo and Wills 2000a). Our arguments for changing health-related behaviour are evidence- based involving for example, the type of statistics about smoking highlighted in para 1 of this page. There is a large body of evidence which supports the argument that smoking is damaging to health and yet, as discussed further on (para.2, p.4), it can be seen that individuals do not always respond to logical reasoned argument in relation to modifying health- behaviours. Epistemology, another philosophical principle, is concerned with the debate about truth, in this case exploring what health really means. There are different models of health including the medical and social models. The medical model is concerned with the categorisation of illness and disease and with specific medical interventions given by the 'expert' (the health professional) to the patient, who has traditionally been a passive recipient of this expert advice and intervention. A social model of health involves a broader interpretation of health which is influenced by a range of determinants, such as age, gender, socioeconomic factors, education and environment. Within this model, strategies to improve health status adopt a wider perspective than the medical model, seeking to address the aforementioned determinants. In relation to health promotion, the medical model might not take into consideration, factors which affect the individual's behaviour such as their socioeconomic status. There is evidence that smoking behaviour is more prevalent among more disadvantaged socioeconomic groups (Gulliford et al 2003). It is important therefore to take into consideration this and other, factors when developing health promotion strategies and not to reduce the issue to one of the giving and receiving of information with an assumption that behaviour will be modified as a result. Health promotion philosophies are also concerned with ethics. The theory of ethics is divided into two main categories: deontological and consequential. Deontology is concerned with our duty to behave according to a set of moral principles. On page 1, paragraph 5, the issues/ dilemmas involved for health professionals in making moral judgements, were referred to. Consequential ethics are based on the premise that a judgment about whether an action is right or wrong is dependent on its end result, in other words whether the ends justify the means. This has some interesting implications for health promotion. Further on (p.4) some health promotion strategies are discussed including a debate about the use of legislation, i.e. enforcement, to bring about health- related behavioural change. As stated earlier (para.1, p.1) this issue is of particular relevance to smoking. The argument for enforcement is that the end result of reducing smoking behaviours and resultant improvement in health status as well as savings made to the cost of healthcare, justifies the prohibition legislation. Broad approaches to health promotion reflect the models of health referred to (para. 2 on this page) and are categorised by Naidoo and Wills (2000b) as medical/ preventative; behavioural change; educational; empowerment and social change. Within the medical approach there are three levels of prevention: primary, secondary and tertiary. To apply these specifically to smoking; the primary level aims to prevent smoking behaviour before it begins, the secondary level is concerned with preventing the recurrence of a smoking- related illness or disease by encouraging the patient to give up smoking and the tertiary level is about promoting quality of life within a chronic condition such as diabetes, in which case the message would be that the individual's quality of life would be optimised if they do not smoke. The behavioural approach focuses on lifestyle issues (Laverack 2004) Emphasis is placed upon the individual's responsibility for health which does not take into account factors outwith the individual's control and as such, this approach has been criticised for being 'victim- blaming' (Tones and Tilford 2001), shifting responsibility away from the government for example, in relation to individual health status. The educational approach is less about placing responsibility on individuals in relation to their health- related behaviours and more about giving information and facilitating people to make informed choices about their lifestyle choices. This approach relates to the rational- empirical strategy described further on (para. 2, p.4) as it is based on the assumption that giving people information will lead to attitudinal and behavioural change. As will be seen, this does not always happen. This approach is also dependent on a level of concordance from the individual, for example a commitment to attend regular sessions as part of an educational programme. The empowerment approach reflects the normative- re-educative strategy described further on (para. 4, p. 4) and entails giving people the means to have increased control over the determinants that affect their health status. This involves community participation, a collective approach which is embedded within the philosophy of public health. According to Laverack (2004) there can be different interpretations of what constitutes a 'community'. We tend to think in terms of a geographical community; a locality. It might be more effective in health promotion terms to think of a community as a group with shared characteristics, such as young people. The reality of community participation is that it tends to be more evident among communities who are educated and higher up the socioeconomic scale. People who are disadvantaged are less lilkely to be motivated to participate in health- related programmes- they may feel marginalised and are preoccupied with the issues that their situation presents, such as concerns about housing and income; health promotion is not viewed as a priority, and smoking might be used as a means of helping them to cope with adversity (Hanson Hoffman 1998). This leads onto the notion of the social change approach. This is quite a complex concept that involves health promotion initiating and driving social change in order to improve conditions that are conducive to health (Erben et al 2000). Social change would involve making the sorts of improvements that would place health issues more firmly on everybody's agenda. There are many factors that contribute to social change such as legislation and shifts in ideas about codes of behaviour. For example, attitudes about sexual behaviour have changed over the years, contributing to health issues such as increased incidence of sexually transmitted disease and a rise in teenage pregnancies (Measor et al 2000). There is some indication that social attitudes to smoking have changed (Moonie 2005) which is arguably, a positive development; some smokers report that they feel like social pariahs! The social change approach is underpinned by an acknowledgement of the complexity of what influences health- related behaviours and can be linked to the social model of health, discussed in para. 2, p.2. Specific health promotion methods are quite diverse including: giving information in a didactic manner, for example via talks to large groups; lobbying local health and Government authorities; making use of the mass media (for example there is currently a television information advertisement about the early signs of myocardial infarction); working with groups; teaching social or life skills that are related to health status; publicity events, e.g. health fairs; facilitating community groups; enforcing health regulation; one to one advice and education; networking and liaising with other workers; instructing on specific techniques, such as self-administration of insulin; facilitating self help groups and enabling health promotion by the provision of support services such as childcare and interpreting facilities (Naidoo and Wills 2000c). Most of these methods can be adapted for use with smoking cessation. The change strategies framework by Bennis (1976) can be applied to health behavioural change and is of particular relevance to anti- smoking legislation. It includes three strategies for bringing about change which are based on different assumptions about human behaviour, and which, when applied to health promotion, involve three distinctly different approaches. The first strategy (rational- empirical), is based on the supposition that 'knowledge is power'. Within this strategy it is assumed that an individual will modify their health- related behaviour in response to receiving reliable and valid information. For example, if the government or a health professional issues advice about the dangers of smoking, the individual should reduce or cease their smoking habit. It is well- known that this often does not happen; even some health professionals smoke, despite their level of knowledge about the dangers (McKenna 2001). The reasons for this are usually related to dependence. It is also possible that human beings adopt Freudian mental defence mechanisms, which are maladaptive coping strategies used (in this instance) to circumvent evidence of the negative consequences of a health- related behaviour, such as smoking. These include denial, intellectualisation (which involves citing contradictory evidence), or rationalisation, among others (Lupton 1995). Resorting to these defences can undermine the power of knowledge and evidence, however valid and reliable it is. The second strategy (power- coercive) involves the use of legislation and policy change in order to enforce health- related change. A good example of this is the anti- smoking legislation referred to in paragraph 1, page 1. There is some evidence to demonstrate that no- smoking policies do have the effect of reducing smoking behaviour (Brigham et al 1994). There has been criticism of the legislation as it is seen by some as an infringement of the individual's right to choose. However this view is countered by the argument that the health of non- smokers can be adversely affected by cigarette smoke, and these people have the right to be protected (HM Treasury 2004). It appears that many non- smokers feel that they should be safeguarded from the effects of passive smoking (Pilkington et al 2006). The first two strategies adopt a 'top- down' approach whereas the third strategy (normative- re-educative) is based on the assumption that an individual is more likely to change their health- related behaviour if they have had involvement in bringing about the change; if they feel empowered. This approach underpins some of the health promotion strategies referred to in para. 1 of this page; for example facilitating community groups. However as discussed earlier (para. 2, p.3), it seems likely that community participation and empowerment might be of limited value within certain groups, such as people who are disadvantaged or marginalised. In conclusion, it appears that a multi- faceted approach needs to be adopted in order to address health- behaviours which are harmful to health, in this instance smoking. The starting point is that there is incontrovertible evidence that smoking is harmful to health, and can lead to premature death, as cited in para.1, p.1. The question of whether we have the right to choose to smoke can be challenged because of the evidence- base that demonstrates that smoking can affect the health of others (para. 3, p. 4). However it is important to recognise that people who smoke need adequate support and resources in order to be able to stop. There is existing evidence that legislative and policy change can reduce smoking behaviours (para. 3, p.4) and it will be interesting to see the outcomes of the current legislation (para. 1, p. 1). 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