

# 'Settings' based health promotion: a review

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## SUMMARY

Over the past 10 years, 'settings' based health promotion has become a central feature of efforts to promote health that recognize the significance of context. Emerging in part from a perception of an over-reliance on individualistic methods, the approach was built on a profound belief in its value and deployed a range of novel theoretical resources, mainly from organizational sociology and psychology. This initial enthusiasm has been maintained within policy directives, in the published literature and, from our own experience, amongst health promotion practitioners. At the same time, with the maturing of the approach, has come a healthy element of critical review. Drawing upon the

literature and based upon our experiences within the Health Education Board for Scotland, this paper seeks to bring together a range of perspectives, casting a critical yet constructive eye on current settings theory and practice. The paper first reviews the nature of settings based work, highlighting the varied bases and expectations that underpin it. Similarly, the many factors that influence the ability of health promoters to deliver such activities are considered. In relation to the construction and delivery of such activity, the paper suggests that there needs to be an explicit and detailed assessment of the nature of the setting, the skills of the health promoter and the associated expectations.

*Key words:* health promotion; practitioners; settings

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## INTRODUCTION

The notion of health promotion operating in a context beyond the individual is one that has found increasing popularity over the years. This emphasis on context has been reflected in the proliferation of related terms: for example, 'settings for health' (Baric, 1991), 'organizational development for health' (Grossman and Scala, 1993; Simnett, 1996), 'health promoting environments' (Nutbeam, 1997), 'public health management' (Hunter, 1998), 'healthy public policy' (Ziglio, 1991), 'investment for health' (Ziglio, 2000), 'community development for health' (Labonte, 1998) and, within the Health Education Board for Scotland (HEBS), 'health promoting arenas' (HEBS, 1994).

One of the best developed and most popular expressions of this form of practice has been the emergence of 'settings' based activity during the 1990's (Baric, 1991, 1993). As Poland *et al.* [(Poland *et al.*, 2000), p. 11] recognize, sustained support for this notion has come from international (WHO, 1986; WHO, 1991; WHO, 1997; WHO, 1998) and national sources (HEBS, 1994; Secretary of State for Scotland, 1999), and has resulted in a range of settings based movements (e.g. cities, schools, workplaces), and a volume of associated descriptive and evaluative academic literature [e.g. (Chu *et al.*, 2000) and references cited subsequently throughout the article].

The conceptual development, practical use, formal evaluation and reporting of settings based activity appears to have been largely of a constructive and positive nature. On the other hand, as the area has evolved and matured, quite naturally a range of critical questions have been asked about, for example, the conceptual consistency of the approach [Springett, J. and Dugdill, L. (1997) *Health Promotion Programmes and Policies in the Workplace: A New Challenge for Evaluation*, unpublished paper] and the ultimate effectiveness of the interventions (Wenzel, 1997; Thomas *et al.*, 1998).

At this point in time, two specific and related challenges can perhaps be revealed. First, there exists a need to continue to broaden and develop the conceptual and theoretical base that informs this work. In this sense, the contributions contained within Poland *et al.* (Poland *et al.*, 2000) are invaluable. Secondly, based on the perception that many are finding it difficult to (i) translate discrete health promotion projects into wider more penetrating settings achievements [what Dooris has termed the problem of 'projectism' (Dooris, 2000)] and (ii) sustain activity within a setting over a significant period of time [(Poland *et al.*, 2000), pp. 26 and 347], there is a need to have a clearer vision of what is actually being attempted under a settings banner and how, on the ground, this starting point can be linked in a sustainable fashion to more profound end points.

This paper addresses these issues by drawing upon the general settings literature base, complemented by some of our experiences within HEBS; in particular work on a Health Promoting Health Service (HPHS) project. This on-going work is based on the development and delivery of a supportive framework resource that provides guidance to a range of health care settings in developing, for example, healthy policies and environments, partnerships, organizational communication and coordination, staff health programmes and patient/client health promotion programmes (see Appendix 1). The insights offered come from a 1-year pilot research project (1998/1999) where the implementation of the framework was appraised in five case studies, including a primary care centre, a maternity hospital and a hospital ward (HEBS, 1999).

The core theme of the paper centres on the need to base settings activity on a clear and explicit set of expectations, and supports the advice given recently by the Medical Research Council to those who deliver and evaluate 'complex programmes':

'We have urged investigators to expect to incorporate a theoretical phase to the development of their evaluation of a complex intervention ... in this way investigators force themselves to consider underlying assumptions being made ... regarding the postulated mechanisms and processes in the intervention' [(Medical Research Council, 2000), p. 6].

It reviews the various themes that inform the settings area and, using a range of significant variables, it develops a typology of settings activity that can be used to position activity within the typology and suggest progression. Similarly, the potential for health promoters to deliver such activity practically is considered and again a set of options is offered. The paper concludes by considering three central issues for settings based work that arise from this analysis: what is to be implemented (expected outcomes), how this will be done and how long it will take.

#### **THE ROOTS AND KEY FEATURES OF SETTINGS ACTIVITY: CONSENSUS AND VARIANCE**

At face value, the literature would appear to suggest that a degree of consensus exists around what a 'settings based approach' is. A range of World Health Organization initiatives [e.g. the Ottawa Charter (1986) and the Sundsvall Statement (1991)] have identified the social and cultural environment as central features, and accepting the need for an 'adjusting of the conceptual framework' (Baric, 1993), settings work has sought to draw upon theoretical bases that had traditionally been under-represented within health promotion: moving beyond what Bunton and Macdonald (Bunton and Macdonald, 1992) term the 'primary' feeder disciplines like education and psychology to 'secondary' areas such as sociology and social policy. This has been extended yet further into emergent disciplinary areas such as organizational sociology, ecology, geography and anthropology (Stokols, 1996; St Leger, 1997; Wenzel, 1997; Poland *et al.*, 2000). This re-orientation points to a theoretical shift in emphasis from the individual, health problems and topic based 'risk factors' to the nature of 'the system' and 'the organization', as relatively complex phenomena (Bateson, 1972; Tannahill, 1990; Baric, 1993). In practical terms, a number of key features are accepted as central to such activity: for example, as well as acting to develop personal competencies, there is a desire to act in

various ways on policies, re-shape environments, build partnerships, bring about sustainable change through participation, and develop empowerment and ownership of change throughout the setting (Baric, 1991; Grossman and Scala, 1993). Likewise, there is also a perception of a need for health promoters to develop new skills, adopt new roles and work with new partners; for example, Grossman and Scala identify a shift in potential health promotion roles from the traditional medical 'expert' to the 'change facilitator' (Grossman and Scala, 1993). This is seen to involve 'organizational development, building intersectoral co-operation, negotiating and creating infrastructures' requiring 'social skills, group leadership, organizational competencies and project management' [(Grossman and Scala, 1993), p. 34].

The development of a general consensus around the essential nature and perceived worth of settings has arguably been of benefit to health promotion. As Baric (Baric, 1993) suggests, there is a perception that it has expanded its theoretical and practical scope, and in a more pragmatic sense, there is an explicit belief expressed within the evaluative literature that settings based activity has delivered a range of successful 'outcomes' (Breucker and Schröer, 1999), including: (i) an increased awareness of health issues (Fawkes, 1997); (ii) the development of health promoting policies and creation of dedicated health promotion budgets (Jeffery *et al.*, 1994); (iii) improvements in 'structural' (Chu *et al.*, 1997) and 'psychosocial' environments (Hugentobler *et al.*, 1992); (iv) more frequent and better partnerships (Booth and Samdal, 1997); (v) the development of discrete health promotion/education projects (Erfurt *et al.*, 1991); (vi) changes in various individual attributes, behaviours and functioning (Lynagh *et al.*, 1997); and (vii) economic benefits (Oldenburg *et al.*, 1995).

This notion of consensus should, however, also be complemented by an important recognition of significant differences in many aspects of this base: for example, at a descriptive level, the sheer scale of the work (ranging from, for example, broad national approaches to highly localized work), the subsequent location of such work ('settings' ranging from, for example, nation states, cities, communities, schools, colleges, universities, health services/hospitals, workplaces and prisons) and, as is suggested by the diversity of the outcomes claimed in the name of settings activity, the respective emphasis of each of the components of activity (ranging from broad policy

and environmentally oriented work through to activity of a more individualistic and participative nature).

Thus, based on the premise that there is variation within the settings field, we suggest here that the drive to develop and apply settings based models has, at this point in time, created a range of problems. First, at a conceptual level and as a means of forming an area of consensus, there is a potential for what can be called a 'homogenization' of practice, where sharply contrasting activities are inelegantly brought under a single settings banner, concealing discrepancies between respective elements as well as the potential inter-relationship between them {for example, within the settings literature Poland *et al.* [(Poland *et al.*, 2000), p. 26] recognize the 'tyranny implied in the assertion or creation of consensus', and Whitelaw *et al.* (Whitelaw *et al.*, 1997) have developed a related general critique of 'global' health promotion models}. Secondly, this superficial consensus and the resultant notion that, when it comes to matching the settings approach to circumstances, 'one size fits all' [(Poland *et al.*, 2000), p. 346] creates a number of unfavourable consequences, where practical reality does not live up to the theoretical ideal. Most visibly, it can result in a conscious feeling of failure where practitioners feel that their 'modest' work falls short of the contextually oriented ideals of the rhetoric associated with settings activity. Poland *et al.*, for example, ask 'must everything that takes an educational approach or attempts to help individuals be regarded as trivial and misguided?' [(Poland *et al.*, 2000), p. 20]. This gap can perhaps be considered more problematic when practitioners are less conscious of their location, undertaking health promotion activity with little significant engagement with organizational features but within the convenience of a settings label. Wenzel for example, contends that settings approaches have largely been used as a vehicle for the continuation of traditional, individualistic health education activity (Wenzel, 1997). This would suggest that the expediency implied by this loose and flexible consensus around the identity of settings based work has contributed to the potential failure to comprehensively re-orientate practice by drawing upon innovative theoretical bases (Baric, 1993; Grossman and Scala, 1993). For example, Mittelmark notes 'the properties of settings themselves are too rarely objects of regard with reference to their health promoting and health damaging properties'

[(Mittelmark, 1997), p. 2]. Finally and most importantly, this may result in practitioners losing an overall perception of what they are trying to achieve via settings based work and/or for activity to 'stall', either in relation to achieving significant change in the deeper processes of the setting or in the general sustainability of the work.

It would be improper to suggest that there is an 'ideal' form of practice. Certain health promotion objectives do not require the breadth of a settings based approach and, as we will expand upon later, skills deficits and settings restraints may limit what is ideally preferable. However, to date, with the notable exceptions of St Leger (St Leger, 1998) and Poland *et al.* (Poland *et al.*, 2000) there exists little work that explicitly considers the relative contribution and worth of different types of practice to the broad notion of 'settings' based activity, and it is this awareness that we seek to promote. Therefore, in a similar fashion to the work that has underpinned progress in mapping general health promotion practice [e.g. (Tannahill, 1985; French and Adams, 1986; Beattie, 1991)], we believe that, as a contribution to the recognized need to both develop a more pragmatic and tactical orientation to the sustainable development of settings work and to connect appropriate health promotion activity to the specific settings features [a sentiment prominent in Poland *et al.* (Poland *et al.*, 2000), pp. 18 and 342], a more open and systematic consideration of the potentially varied nature of this work would now be helpful. We pursue this in two related ways. First, we offer a conceptual map containing a varied range of positions on what a settings based approach can be considered to involve. Secondly, as a means of understanding one of the most important explanations of this variation, we locate the 'ideal' model within a more practical analysis of the circumstances that health promoters actually face within settings and the associated skills they possess.

## THE BASIS OF SETTINGS ACTIVITY

Before embarking on the descriptive task, this section offers a brief review of some conceptual resources that will be used to help define the types of activity we identify. At the core of this are the well established perspectives that stress either the agency of the individual [e.g. the sustained espousal of individualistic, voluntaristic and psycho-social sentiments by the likes of

Le Fanu (Le Fanu, 1999), Marsland (Marsland, 1992) and Putman (Putman, 1995)], the deterministic social and environmental pressures [for example, the vociferous defence of a structural explanation of human behaviour by Kaplan (Kaplan, 1995) and Navarro (Navarro, 1987)] and, perhaps most fruitfully, the relationship between them [e.g. the 'structuration theory' by Giddens (Giddens, 1984) that rejects the polarization of these positions, favouring an interaction between 'agency' and 'structure']. On a more practical level, arising from this is what Mannheim (Mannheim, 1952) refers to as our 'world view'; in this case, the way in which the nature of the 'problem' that settings based work tackles is constructed and the 'solutions' offered correspondingly [see (Raphael, 2000), p. 361]. Expressed concisely, this foresees a number of possible options: (i) that both the problem and solution lie exclusively within the individual; (ii) in a similar vein, that they both lie within the system; (iii) that the problem lies in the individual but the solution arises from the system; or finally (iv) that the problem lies within the system but that the best solution comes from the individual.

These general perspectives have been reflected in two more specific areas of interest that are of relevance to a settings approach. First, the relative importance of health as a product of individualistic and 'psycho-social' oriented approaches against wider structural emphases has been debated vigorously within the health literature [e.g. Kelly and Charlton, 1995; Muntaner *et al.*, 2000; (Poland *et al.*, 2000), p. 345]. Secondly, a similar resonance can be found within efforts to describe the nature of 'systems' or 'organizations' (Bateson, 1972; Dawson, 1992). Again, these are conceptualized, respectively, as entities that exist above and beyond the individuals within them [what Hassard and Parker (Hassard and Parker, 1993) term a 'modernist' view of organizations as having a predictable and material nature that can be shaped and manipulated in a scientific and rational way] or more simply, the product of a multitude of individual contributions [what Hassard and Parker (Hassard and Parker, 1993) term a 'postmodern' view of organizations that stresses their intangible and unpredictable nature, as well as the difficulty of simply influencing organizations from 'above']. In turn, this wide basis is reflected in the existence of a range of more practical elements, as reflected in, for example, the varied policy, environmental and personal skills development elements of the Ottawa Charter

(WHO, 1986). Finally, these practical elements suggest the need to draw upon a varied range of disciplinary bases (Bunton and MacDonald, 1992; Poland *et al.*, 2000); for example, psychology, education, anthropology, public health, geography, ecology, political, policy science, etc.

## VARIED FORMS OF SETTINGS ACTIVITY

Using the criteria above, five broad types of practice are offered.

First, and most conservatively, the setting takes on a subordinate role within which traditional educational activities, with their assumptions of individual agency, are delivered (Whitehead and Tones, 1991). We see this as a 'passive' model. Working within a world view that sees the core problems and most appropriate solutions as resting exclusively within the voluntary scope of the individual, the setting is seen as a neutral and passive vehicle that simply offers access to populations and favourable circumstances to undertake a range of individually focussed health promotion activities (e.g. using mass media, health counselling and developing personal skills for health). Perhaps the best example of this comes from within the school sector, where a 1988 UNICEF report reflected 'the formal education system is the developing world's broadest and deepest channel for putting information at the disposal of its citizens' (UNICEF, 1988). The tone of this type of activity is captured in Mullen *et al.*'s belief that settings 'provide channels and mechanisms of influence for reaching defined populations (that) create efficiencies in time and resources for health education programming' [(Mullen *et al.*, 1995), p. 330]. Such work would tend to draw upon educational and psychological (traditional individualistic, cognitive) disciplinary bases.

Secondly, a variation on this theme can be seen where efforts are made to enhance this type of activity (usually topic focused) by drawing on the varied elements within the organization as secondary or contributory resources in fulfilling the aims. We see this as an 'active' model. The defined primary problem is still seen as resting within the individual (i.e. the core need to change specific health related behaviours like smoking and diet); however, the nature of solution is broadened to encompass features of the system in which the individual exists. The assumption is, therefore, that the individual is restricted in their potential to change and that this can be alleviated via action

across the setting. The setting is thus seen as an independent and controllable entity, invested with the potential to contribute to the shaping of individual behaviour. Various elements of the Ottawa Charter (policy development, environment, community action, skills and service orientation) are thus deployed in tackling topic specific problems. This form of practice was heavily represented in our Health Promoting Health Service (HPHS) implementation research, with work focussing around a particular health topic, to which the respective sections of the framework were applied. For example, a health centre manager suggested 'one of the specifics that we've chosen for the health centre is nutrition ... and we have looked at this topic using the different sections of the framework'. Similarly, topics of nurse hand washing, smoking cessation, physical activity and oral health were identified as focal points. In this context, the elements of the setting framework were being used in a 'functional' fashion to expand topic based health promotion work that was already underway, by assessing the nature of the existing approaches to the issue. The notion of using the elements of framework to 'look laterally' to 'fill in gaps' was thus frequently expressed. Therefore, in practical terms, this approach potentially involves the undertaking of activities that could range from those that are educational, to the development of policies, to the changes in environment, although this will be focused on a tightly defined topic area. For example, the hand washing work was extended from a simple educational exercise involving leaflets and posters to one that encompassed the development of hand washing policies, i.e. the provision of improved washing facilities (environment) and the provision of staff training.

Thirdly, there exists a model that still undertakes relatively focused topic centred health promotion activity, but does so with distinctly different expectations, namely an explicit anticipation of moving beyond the self-contained goals of topic specific individual behaviour change to having an impact on broader settings features. This can be called a 'vehicle' model. In contrast to settings resources being a secondary or contributory function to the primary and self-contained goal of individual change around a specific health topic (as described above), in this case the expectations are reversed, i.e. specific health promotion projects are used as a secondary vehicle towards the primary aim of wider development within the setting. The problem

is thus seen to lie predominantly within the features of the system. However, for either pragmatic reasons (see below for further discussion) or a deeper belief that sees changes and more specifically 'learning' in over-arching systems as best achieved via specific, tangible and grassroots health related developments, action occurs within defined projects. Holman sees this as a form of translation, from 'vertical' topic based settings programmes to having a wider 'horizontal' impact (Holman, 1997). Examples of this type of work are reported by Lynagh *et al.*, who start with relatively focussed areas of 'smoking, alcohol and solar protection' interventions as focal points of their consideration of the wider potential of the health promoting school (Lynagh *et al.*, 1997). Similarly, the development of lead 'Health Promoting Hospitals' in the UK at Stobhill, Glasgow and Sharoe Green, Preston, has been achieved via 'demonstration' or 'beacon' projects that focus on specific issues such as alcohol and staff health. Again, this approach requires activity and disciplinary expertise in a range of areas; however, given that the ultimate aim would be, in Holman's terms, to have 'horizontal' impact (Holman, 1997), the emphasis would be on policy and organizational activity and associated disciplinary bases.

Similarly, and again drawing on the vision of the 'organic' nature of systems, a fourth model can be recognized that places relatively greater emphasis on the development of individuals and small groups throughout the organization, although in this case, in contrast to the health promotion specific emphasis of the above model, the focal point of the action here tends to be of a more generic nature. We have called this an 'organic' model. Based on an assumption that over-arching systems are merely the product of a multitude of processes or individual actions, the problem is predominantly seen to lie within the wider system, and the solution lies in the multitude of day-to-day processes and practices that constitute the whole. As such, drawing on the notion of health being the product of psychosocial factors and favouring the communitarian ethic of grassroots participation (Muntaner *et al.*, 2000), generic functions like organizational communication, mechanisms of representation and participation within the setting, and training and development of settings staff are considered as general representations of 'health promoting' activity. Significantly, the products of such activity do not rest solely on tangible health gains in, for example, behavioural or environmental

change, but reflect a desire for a more incorporeal sense of an improved ethos or culture within the setting (Prowse, 2000). This approach suggests activity that focuses on the ability to 'strengthen' collective participation and action, and that is perhaps synonymous with the broad tradition of community development and, in particular, the 'bottom up/collective' form of this activity that Beattie terms 'community action' (Beattie, 1987). Our HPHS research identified activity of this nature within the cases studied. There were examples of health promoting activity that focussed on: developing better communication between different staff groups in a health centre; improving staff and client representation in hospital and ward decision making; and creating a more systematic training and development plan for health centre staff as well as formal programmes to identify and act upon a range of specific staff concerns, including general issues like family friendly working time patterns and healthy work environments. As suggested above, the products of this action went beyond the tangible and reflected a desire to change an established ethos within health services. Most ambitiously, the framework was seen by some to express an alternative set of practice values, reflected by the following extract from a respondent who was a senior manager in one of the cases: 'I think this HEBS thing is good, because it raises the possibility of doing things differently ... of creating a new feeling in the health service ... lots of people now know that certain practices and cultures in hospitals should be improved ... for staff and patients ... we accepted the most dreadful practice and conditions ... you knew that was wrong ... I want some new ideas ... a new culture for hospitals that focuses on health'.

We call the last and perhaps most ambitious form of practice, a 'comprehensive' model. This form of practice uses the notion of the setting as an entity above the individuals in it, and seeks to bring about direct and relatively significant changes in setting structure and culture within an assumption that individuals are relatively powerless to precipitate change to any significant level. This work thus tends to accept the deterministic view that potential for deep and enduring change can only come from relatively powerful levers within the system and, as such, the emphasis tends to be more on broad settings policies and strategies, with the focus on the direct actions of senior staff. For example, Leeder provides a strong endorsement of the need for 'policy driven' health

promotion practice in various settings (Leeder, 1997), and Ziglio, under the notion of achieving an 'investment for health', sees this form of action as 'identifying relevant policy attributes; considering factors that may enhance or inhibit policy change; assessing change options ...; and planning the political process of achieving the necessary legislative, regulatory, financial, organizational or educational changes' [(Ziglio, 2000), p. 27]. These five themes are summarized in Table 1.

Before moving on, an important point should be made. We have perhaps portrayed some forms of activity in a stereotypical fashion. We recognize that, in reality, there may be significant variability within each model. Within the active model, for example, there is scope to utilize varying degrees of system resources and, clearly, any policy development has the potential to follow many routes, including: (i) being more or less centrally driven or locally defined; (ii) being of a 'macro' or 'micro' nature; (iii) being simply imposed or negotiated upon; (iv) pertaining to a specific health topic like smoking, hand washing or transport; or (v) pertaining to generic issues like equal opportunities, communication, and training and development (Barker, 1996). Perhaps, preferably, there could also be considerable overlap and interaction between them [(Poland *et al.*, 2000), p. 345]. For example, the organic and comprehensive models are often seen to be complementary, with Ilona Kickbusch stressing that 'top level commitment is absolutely essential for success', but at the same time warning that 'if the health development process is not participatory, it is doomed to failure' [(Kickbusch, 1997), p. 432]. As well as overlap, there may also be a potentially constructive sequential effect between models, where progress in one area facilitates progress in another; for example, success in a health specific project within the vehicle model could lead to further work in organic and policy developments, and organic developments within a setting could lead to the development and implementation of more fundamental policy. In this sense, we offer these five types of activity as loose representations rather than definitive and discrete entities.

## SETTINGS ACTIVITY IN THE FIELD

As well as these conceptual considerations, pragmatic concerns are also a key influence on shaping the nature and development of settings based

work. For many, aspiring to bringing about significant change within a setting may in reality be tempered by a range of potential restrictions and this may be a significant factor accounting for variations in practice. For example, amongst others there may be: difficulties in translating the philosophy of the approach to practical and tangible activities within the setting (Lynagh *et al.*, 1997); 'competing' forces within the setting that may act against a 'health' agenda; and internal pressures to produce deliverable outputs that are identifiable as 'health promotion' (Crosswaite *et al.*, 1996; Galbally, 1997; Denman, 1998); problems associated with the status of health promoters as credible agents of change (Grossman and Scala, 1993); and limitations in providing sufficient support for change, e.g. financial and time resources, training and consultancy/expertise (Grossman and Scala, 1993; Dugdill and Springett, 1994).

Consequently, a form of practice has emerged that is largely modest and pragmatic in its orientation (St Leger, 1998). It places health promotion activity as one relatively small element of a wider organizational development movement and tends to restrict activity to familiar programme based health promotion as delivered by practitioners with skills in this area. Such pragmatism may come from a range of sources but, most importantly, it arises from a realistic vision of the role of the health promoter and the nature of the setting. Health is not seen as a setting priority, health-promoting change is seen to be difficult in hostile circumstances and health promoters perceive those within the setting as having a limited view of what they can offer.

At the same time, accounts from others who find themselves in more conducive circumstances (Moore, 1999) point to the possibility of more ambitious expectations. An aspiring form of practice therefore exists that is more enterprising in its outlook. Here, settings are seen as significantly more open and conducive in their nature, and their potential for change is greater. Most importantly, they are perceived to be driven by meeting their development needs independently of who fulfils them. As such, assuming that health promoters have the requisite skills, utility comes independent of traditional role boundaries. Harrison describes this ground as involving a shift in the management skills required to solve social problems within complex social systems (Harrison, 1998). This involves a move away from traditional 'positional' authority based on a given organizational role

**Table 1:** Five types of settings based health promotion

Type	Core perspective/ analysis of problem-solution	Relationship between the health promotion and the setting	Practical focus of activity	Indicative contributory disciplines	Indicators
A 'passive' model	The problem and solution rest within the behaviour and actions of individuals	Setting is passive; only provides access to participants and medium for intervention; health promotion occurs in setting independent of setting features	Mass media and communication, individual education	Educational/ traditional psychological focus	Traditional individual indicators (e.g. knowledge, attitude, behaviour)
An 'active' model	The problem lies within the behaviour of individuals, some of the solution lies in the setting	Setting provides 'active' and comprehensive resources to fulfil health promotion goals; health promotion utilizes setting resources	Mass media and communication, individual education plus complementary work on policy development and structural change around the specific topic area	Primary educational/ traditional psychological focus; complimentary focus on political and organizational science, policy studies	As above as end outcomes; plus process assessment of wider setting contributions
A 'vehicle' model	The problem lies within the setting, the solution in learning from individually based projects	Health promotion initiatives provide an appropriate means for highlighting the need for broader setting development; health promotion seen as a vehicle for setting change	Principle focus on developing policies and bringing about structural change using feeder activity from mass media and communication, individual education	Primary political and organizational science, policy studies; complimentary focus on educational/ traditional psychological focus	A mix of project and contextual indicators (interest particularly in the interaction and association between discrete projects and broader development)
An 'organic' model	The problem lies within the setting, the solution in the actions of individuals	Organic setting processes involving communication and participation are inherently linked to health and are thus 'health promoting'	Facilitating and strengthening collective/ community action	Sociology, anthropology, principles of community development	Organic setting indicators (e.g. levels of communication and participation; degree of staff development, etc.)
A 'comprehensive/ structural' model	The problem and the solution lie in the setting	Broad setting structures and cultures inherently linked to health and are thus 'health promoting'; health promotion as central component of comprehensive setting development	Focus on developing policies and bringing about structural change	Political and organizational science, policy studies	Over-arching setting 'development' indicators (e.g. policy and environmental impact)

to two new forms: 'knowledge' based authority derived from an acquired personal capacity, comprising experience and understanding; and a 'sapiential' (wisdom based) authority rooted in an earned belief and trust of others. A good example of this is the way in which health promoters have come to be associated with the fostering of team working.

So rather than being ideal or one-dimensional, both 'settings development' and 'health promotion' can be seen as fluid and malleable concepts that vary from situation to situation. Table 2 summarizes these factors.

### CONCLUSION: THE NEED FOR A REALISTIC AND PRAGMATIC REVIEW OF SETTINGS WORK

The settings based approach has arguably offered health promotion the conceptual base that has allowed practice to be pursued across a significantly broader canvas. As an idea, the notion of developing interventions that address the whole system in which individuals exist certainly has heuristic value and, as with most innovative ventures, the literature has tended to report on this work in a generally constructive and optimistic way. However, as Douglas recognizes (Douglas, 1998), there is a tendency for these accounts to favour the descriptive, anecdotal and optimistic story at the expense of a more demanding and critical analysis, and we believe that there may be some evidence of this within the settings literature. Our view here is that the settings field has reached a point of maturity where early optimistic and confirmatory perspectives can be gradually replaced by a more pragmatic and

critical orientation that seeks to falsify our beliefs in this area (Popper, 1962). Thankfully, this is beginning to happen. For example, in overcoming the potentially fragmented nature of settings based work, the need for partnerships across settings is being viewed as important (Galbally, 1997; Denman, 1998). Likewise, by focusing on the large scale, popular or easily accessible settings (thus potentially excluding those who do not exist or operate within these such as the unemployed, those working in relatively unregulated small and medium size businesses, young people excluded from school and those who do not access primary care), the danger of settings work exacerbating health inequalities has been identified and the need to redress this imbalance recognized (Galbally, 1997; SEU, 1998; Poland *et al.*, 2000).

This paper has sought to add to this tradition by focusing on what we believe to be two areas given relatively little explicit attention in the literature—core definitional considerations and the manner in which settings based activity is delivered in the field. Within this context, we are seeing health promoters trying to translate the ideal of settings theory as suggested by the 'affirmative' literature into both pragmatic and feasible roles for themselves, and sensitive health promoting interventions that have an impact at a significant level upon the setting. This paper offers three broad pointers towards achieving this translation.

First, it suggests the need for a more realistic and sensitive assessment of the nature and initial 'location' of settings based work. As well as the general clarification that is always a necessary product of emergent concepts and practices within the health promotion field (McQueen, 2000), the need for clarity in circumstances involving

**Table 2:** The relationship between the construction of health promotion and the nature of the setting

	Ranging from	To
Nature of the setting	Traditional hierarchical structure; centralized culture; positional authority favoured	Flexible, open structure; decentralized culture; knowledge and sapiential authority encouraged
Position of health and health promotion within setting	Health not explicitly recognized as important to the setting; health promotion as one element of wider setting	Health explicitly recognized as important to setting; health promotion as significant element of setting development
Nature of required support and type of activity	Based on traditional professional resources; emphasis on existing health promotion programme skills; works within existing 'positional' authority	New flexible professional roles; broader 'setting development' practitioners; emphasis on nurturing broader, generic skills
Scope	Pragmatic; short-term; deliverable and tangible activity	Ambitious; longer term; contribution to wider setting goals

complex health interventions is also helpfully and perhaps understandably being expressed within current evaluation literature [e.g. (Leeuw, 1995; Pawson and Tilley, 1997; Ukoumunne *et al.*, 1999; MRC Health Services and Public Health Research Board, 2000)]. For example, Ukoumunne *et al.* (Ukoumunne *et al.*, 1999) point out that it is important to define the nature of a complex organization-based health intervention and suggest that ‘healthcare evaluations often fail to recognise or correctly utilise the different levels of intervention’ [(Ukoumunne *et al.*, 1999), p. 49]. In a more positive vein, the MRC document [(MRC, 2000), p. 3] proposes the need for three preparatory phases before any evaluation of complex interventions can occur, involving the establishment and piloting of a theoretical model that ‘develops an understanding of your intervention and its possible effects’; this in turn involves ‘delineating any interventions components and how they inter-relate and how active components of a complex package may relate to final outcomes’ [(MRC 2000), p. 4]. For many, this drive towards definition may however be seen as problematic, with insensitive and overly simplistic ‘rational’ and ‘objective’ approaches being uncritically applied to complex and constantly shifting circumstances (Van Der Knapp, 1995; Sanderson, 1999; Hirschon Weiss, 1999). Moreover, it could be argued that such approaches are already over-represented in the evaluation of complex policy and organizationally based interventions (Schmid, 1997). Such commentators would favour a looser interpretivist approach that recognizes the uncertainty inherent in many complex interventions; this is defined by Sanderson (Sanderson, 1999) as involving:

‘... a much greater degree of pluralism in approaches to policy evaluation, with substantial use of qualitative methods, acknowledgement of the limitations of goal-oriented approaches and the recognition of the need to investigate the perspectives and interests of different ‘stakeholders’ in the policies and programmes being evaluated’ [(Sanderson, 1999), p. 4].

We have sympathy with this cautious statement and would not support a dash towards overly or unnecessarily simplifying the nature of settings work. However, in a similar vein to that proposed by Pavis (Pavis, 1998) in relation to community development, we believe that a greater degree of precision can be achieved, and this is addressed in this paper by the development of maps of both the range of possible settings activities and their

associated features (Table 1), and the relationship between the features of the settings and the potential of the health promoter (Table 2). This promotes clarity in relation to the starting points of settings activity, offers a view to the linkages and progression between distinct elements and the potential role for health promoters in the varied settings in which they will find themselves.

Secondly, this achievement points to the more significant need to consider the potential longer term ‘processes’ that offer progression within settings based work. It is clear that a balance needs to be struck between the high expectations often expressed within the settings literature, and a realistic assessment of what can be achieved by both health promotion as a discipline and by health promoters as practitioners in what are generally complex and difficult circumstances. There is clearly no ideal solution here. As Poland *et al.* recognize {‘a one-size-fits-all approach is often ineffective and inappropriate’ [(Poland *et al.*, 2000), p. 346]}, each setting offers different degrees of potential and each health promoter brings different types of skills, and therefore a range of types of health promotion activity could quite legitimately be pursued. What is clear though is that those who do deploy a settings model need to ensure that their work is more than simply a superficial re-packaging of traditional individualistic health education in a particular setting. In our evaluation of the *Health Promoting Health Service Framework*, we highlighted that, whilst being of most immediate value as a means of bringing about change at an operational level, there was a strong indication that isolated topic based ‘projectism’, (whether it be the passive or active variety as suggested by our model) was difficult to sustain, with many asking ‘what next?’, and the work did not result in any significant and enduring changes within the setting. If this is the case, then a quite different frame or reference is required when approaching settings based work that visualizes it as a medium- or long-term process that potentially results in sustainable and profound effects. For example, in responding to the perception of ‘premature assessment’, Sabatier (Sabatier, 1986) suggests that complex projects should ideally be developed and assessed over a time frame of 10–15 years and that this should involve the testing of the validity of the theory that defines the project (as suggested above) against the evidence of implementation (process), and a range of short-, medium- and long-term project outcomes.

The latter elements then point to the significance of supporting literature that defines a group of concepts that inform the practical application of an intervention to a setting: 'implementation' (Hogwood and Gunn, 1984; Ham and Hill, 1995; Hill, 1997), 'strategic control' (Goold and Quinn, 1990) and 'systems change' (Simnett, 1996). Three key issues shape this literature: what is to be implemented (expected outcomes), how this will be done, and how long it will take. Perhaps the stereotypical response to these questions from health promoters working in a settings context has been relatively conservative. In terms of what is to be achieved, the feeling has been that there is a demand within settings for individually focussed interventions with tangible behavioural outcomes (Holman, 1997). In relation to how, there has been a drive towards relatively formal and structured 'how to' guides that contain lists of 'pre-conditions of successful implementation' (Ham and Hill, 1995; Hill, 1997) or simple 'how to' guides that define settings based interventions [e.g. the University of Toronto's Centre for Health Promotion's *Nine Steps to a Health Promoting Integrated Health System* (University of Toronto, 1999)] supported by 'criteria based' frameworks that assess the quality of the setting as 'health promoting' [e.g. the UTCHP's *Nine Steps to a Health Promoting Integrated Health System* (UTCHP, 1999); in Scotland, *Scotland's Health at Work Scheme*; in the UK, the Department of Employment's *Investors in People* (IIP); and the Wessex 'Audit Tool']. Finally, in relation to the time frame over which such changes are expected to occur, there is a perception that there is a need for short-term 'early successes', many arguing that long-termism is a luxury that health promoters will not find in the demanding circumstances of many settings (Simnett, 1996). Given our earlier support of a pragmatic and flexible approach to shaping settings work, we do not want to suggest that such readings are erroneous or that there is an ideal form of implementation. However, the literature cited above offers insights that may support a more expansive role for health promotion in settings work.

In relation to the 'what' and 'for how long' questions, there are indications in the literature that the very principles that settings based health promotion is advocating (for example, long-term investment in fundamental structures and the nurturing of 'softer' products like communication and partnerships) are wholly congruent with those being sought by many 'mainstream'

organizations, including, for example, manufacturing workplaces. For instance, Goold and Quinn (Goold and Quinn, 1990) espouse the need for long-term 'strategic control' in industry (as opposed to a short-term orientation around finance and profit) in circumstances where the product and production processes are complex, and where there is a long time span between investment and financial results. In this narrative, it would be easy to equate long-term strategic development with profound settings based health promotion, and short-term profit with short-term health education gains. Whilst many point to a gap in compatibility between health promotion values and those that typically drive various aspects of the health service (for example the degree to which the public participate in decision making, how health determinants are constructed, the extent to which intersectoral collaboration occurs), there is some evidence within the *Health Promoting Health Service Framework* project of core organizational principles becoming aligned with those of health promotion. O'Neill *et al.* (O'Neill *et al.*, 1997) talk of the notion of 'non-utilitarian preferences', where the choices and actions of individuals within a setting are made contrary to the 'rules' that generally prevail [in the case of the National Health Service, these are perceived to revolve around the need for tangible task-based outcomes (Cox, 1992)]. In some cases within the *Health Promoting Health Service Framework* project, there were examples of a tendency for managers using the framework as a vehicle for raising the profile of such 'non-utilitarian' values. For example, two senior managers made the following comments about the framework:

'I'm aware that it's [the framework] not the only one that's advocating sort of multi-agency work and partnerships ... but these are important to me.'

'I think in terms of the things that I'm most interested in ... obviously there's environmental things, staff training and the partnership stuff, because you can't do it on your own, and who are you going to be working with to make sure that this happens, and obviously policy development ... these are the ones where I think that I'll be involved.'

It could therefore be argued that we are at the start of a process where recognition of the utility of health promotion values is rising. The literature has much to say about how implementation could and should occur. Two generalized positions are

highlighted: as suggested above, one that favours a predictive model that imposes pre-determined maxims on how to secure successful implementation; and, more flexibly and pragmatically, a second descriptive approach that seeks to uncover and act in response to specific and localized 'grassroots' circumstances (Ham and Hill, 1995). Within a context that is increasingly accepting the complex and indeed chaotic nature of social processes (Elliot and Kiel, 1996; Marion, 1999), when deployed in isolation, the prescriptive and acontextual visions of implementation have been generally discredited (Hill, 1997). Whilst recognizing 'a conflict between the desirability of a prescriptive approach and the reality of the need to recognize that implementation involves a complex process of bargaining, negotiation and interaction', Ham and Hill (Ham and Hill, 1995) favour a position that primarily favours a flexible and pragmatic orientation to implementation, supported to a lesser extent by some attention to 'normative concerns about rational goal achievement' [(Ham and Hill, 1995), pp. 112–113]. Two specific positions arise out of this discussion that help suggest a preferred position: first, that if applied in an insensitive fashion, 'top down' models of implementation, particularly when aimed at imposed outcomes, tend to be ineffective; but secondly that, to some extent, a broad context and general guidance on how implementation may best be achieved also needs to be provided. These themes were expressed within the evaluation of the *Health Promoting Health Service Framework*. There existed a belief within some groups that, at certain levels within health service administration, imposition is not seen as the most appropriate mechanism of change. For example, a hospital manager made this comment about the framework:

'something that worries me a wee bit about the framework is ... we've all been through the stages in the past where a document comes from the centre, we **have** to adopt the document ... and little thought is given to the practicalities of how it's going to be adopted and I've got this dread that this is adopted as a stratagem "thou shall adopt the strategy"!'.

However, by initially resisting the temptation to set prescriptive and ideal expectations of what parts of the framework should be deployed, how it should be implemented and what it should specifically achieve, the *Health Promoting Health Service Framework* side-stepped many of these

implementation problems. As such, there is evidence that implementation was being pursued in varied and pragmatic ways on the ground, with efforts being made to 'sell' the framework and tailor it to the needs of the setting. This position also appeared to have practical resonance with those within the actual cases. Many individuals were clearly appreciative of the fact that the framework did not belittle their professional skills and they welcomed the opportunity to use the framework in an active, selective and discriminating way. For example, a primary care practice manager contended:

'I think there is a danger that it could be adhered to very, very rigidly by some people as opposed to being a framework ... it might not be totally appropriate to every single circumstance or every single area ... it's very much horses for courses'.

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**APPENDIX 1: KEY ELEMENTS IN THE  
HEALTH PROMOTING HEALTH  
SERVICE FRAMEWORK (HEBS, 2000)**

The complex, inter-linked concepts underlying health promotion activity in health service settings have been brought together in the *Health Promoting Health Service Framework*, which is portrayed as a tree. The tree arises from an understanding of the life circumstances that are the biological, environmental, cultural, political and socio-economic determinants of health—these are the ‘roots’ of the tree.

The ‘trunk’ of the tree reflects ways of working in the health services: equity, participation, empowerment and sustainability.

The ‘branches’ relate to specific types of health promotion activity: communication and coordination; working in partnerships; environment; policy development; patient/client health promotion programmes; staff health; training and development; and research and evaluation.

Each branch contains a range of specific guidance, supported by key questions around: what is the evidence base for the activity (does this work?); critical appraisal (have we the resources, are we taking appropriate action to meet needs?); management and coordination (who is doing what and how?); and a review process (is activity evaluated, reviewed and developed?).

