



Health promotion: the Tannahill model revisited[☆]

Andrew Tannahill*

Public Health Science Directorate, NHS Health Scotland, Elphinstone House, 65 West Regent Street, Glasgow G2 2AF, Scotland, UK

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In the mid-1980s, I created a model that presented health promotion as three overlapping spheres of activity: health education, prevention, and health protection (Fig. 1).^{1–3} I had been struck by a leap in vocabulary — from ‘prevention’ and ‘health education’ to ‘health promotion’ — and understood the need to broaden out from the former two traditional terms, but ‘health promotion’ was a term with so many meanings as to be meaningless.¹

The model has been widely cited or adopted.^{4–11} It has been used in undergraduate and postgraduate teaching in and beyond the UK, and specimen essays/case studies can be bought through various commercial websites.

On the other hand, the model has been described as representing ‘simplistic linguistic juggling’.¹² I have also heard it criticized as not being a model in the sense of a particular approach to health promotion. However, I intended it as a uniting construct rather than the encapsulation of a single ideology, and as a counter to the sterile argument that health promotion and prevention should be seen as separate, even opposing, fields of endeavour (an example of a tendency in public health to waste time, energy and opportunities through a divisive ‘this or that’ mindset, when more would be gained through an integrating ‘this and that’ way of thinking). One account of the model described its origins as lying ‘clearly within a medical context’.¹³ However, I believe that it has helped people from medical or other clinical backgrounds to recognize the non-clinical dimensions of health promotion, and people from non-clinical backgrounds to see the place for clinical-type interventions as part of the overall mix.

It has been interesting to consider how the model has withstood the tides of change. Strikingly, the prevailing vocabulary has undergone another transformation, in the UK at least: just as

‘health promotion’ eclipsed older terms two decades ago, it has now been largely superseded by ‘health improvement’. Again, an abrupt shift has brought confusion: health improvement is variously seen as a field of activity, a goal, or both. I welcome the emphasis on ‘health improvement’ as a uniting goal for prevention, enhancement of positive health, and a population perspective on treatment and health care. Nonetheless, I still see value in taking ‘health promotion’ to cover the first two of these things; and the term remains in use internationally, as seen for instance in the name and work of the International Union for Health Promotion and Education.

Another semantic trend has been the application of ‘health protection’ to efforts to control infections and environmental hazards. I took the term, with a wider meaning, from the USA¹⁴ and defined it as ‘legal or fiscal controls, other regulations and policies, and voluntary codes of practice, aimed at the enhancement of positive health and the prevention of ill-health’.

A number of developments in health promotion/health improvement can be construed as practical demonstrations of the model’s spheres and domains. Taking tobacco control as an illustration, the *health protection* sphere has been exemplified by the legislation to make enclosed public places smokefree. Within *prevention*, there has been unprecedented investment in specialist smoking cessation services. *Health education* has raised awareness of the dangers of active and passive smoking, encouraged smokers to use smoking cessation services, and promoted support for tobacco control among the public and decision makers.

The *positive health* aspects of the model have not been highly visible in the tobacco control drive. In dealing with the largest single preventable cause of serious ill-health and premature death, it has been important to make a case for action based on harm. Nevertheless, smoking cessation services should highlight positive health benefits of not smoking, and foster ‘positive health attributes’ of the sorts mentioned in the description of the model’s positive health education domain.^{2,3,15}

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* Tel.: +44 141 354 2900; fax: +44 141 354 2901.

E-mail address: andrew.tannahill@health.scot.nhs.uk

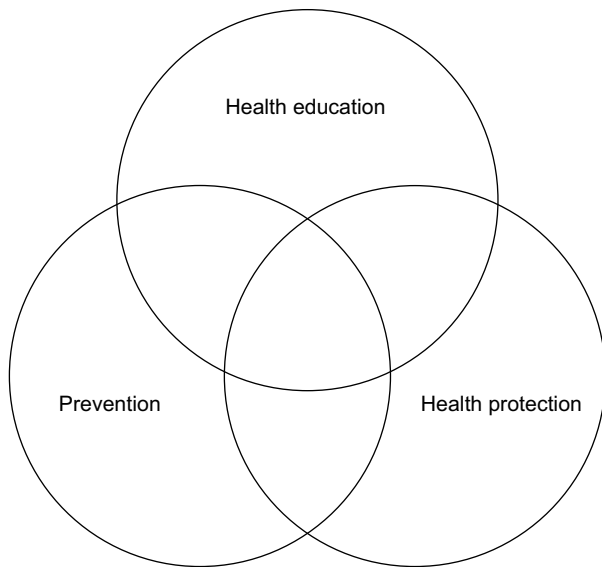


Figure 1. The Tannahill model of health promotion.

Looking beyond tobacco specifically, the positive health attributes aspect of the model has resonance in now-popular concepts such as positive psychology,¹⁶ emotional intelligence¹⁷ and salutogenesis.¹⁸ There is growing interest in how people can be helped to develop ways of thinking, ways of looking at and interacting with the world around them, coping skills and resilience that are good for their overall health. A further relevant development has been increasing attention to the place of clinical services and pharmacological treatments in prevention. Also, the explicit focus in modern-day public health policy on reducing health inequalities and improving life circumstances is consistent with health protection as cast within the model, incorporating fundamental aspects of public policy making such as housing, employment and tackling poverty.³

Such examples help to explain why the model has continued to be used in teaching and training. Moreover, its applicability to health, disease and behaviour topics, lifestages, population groups, settings and geographical areas alike is a practical strength in clarifying the scope of health promotion action with a range of students and professionals.

That said, the model does not wholly cover community-based and community-led efforts to improve health, except insofar as these are fostered through policy making, contributed to through collective health education, or manifested in preventive services. A relevant point here is that at the time the model was devised, health-related community development was presented in literature as an approach to health education.¹⁹

Another limitation of the model is that, while it encompasses *policies* for the provision of, for example, sports facilities on positive health grounds, it does not include such facilities in themselves. I considered early on whether to widen the model to incorporate not only preventive services but also services and amenities designed to enhance physical, mental or social wellbeing or fitness. I decided not to, as it would run the risk of stretching health promotion to the point of absurdity. For instance, would a cinema be a health promoting amenity on the grounds that it might contribute to a feeling of wellbeing, regardless of what food is sold there, whether smoking is permitted or what sorts of films it shows? And what about the many other ways in which people can be helped to feel good that are otherwise inimical to health? However, if we are to encourage a view of health and its improvement that recognizes positive health promotion as more than a poor second to illness

prevention and treatment, there is a case for including more explicitly services and amenities for which there is evidence of conferred benefits to wellbeing.

In summary, I think that the model was particularly helpful at a time of semantic confusion and a critical stage of development — in widening people's views, combining the well-established concepts of health education and prevention, and reinforcing these with policies, regulations etc. that make healthier choices easier and address fundamental influences on health. Its Venn diagram format has been of value in delineating the preventive and positive health dimensions and highlighting the latter, and in drawing attention to important actions in the seven 'domains' formed by the overlapping 'spheres'. It is not easy to see how the 'missing' elements identified above could be incorporated into such a diagram in a meaningful way. Furthermore, as can be seen from examples given in this paper, the types of action captured by the model are now demonstrably being viewed as essential tools in public health, health improvement and health promotion tool-boxes. All in all, I am content to conclude that the model has served its purpose. In addition, I see benefit in considering how health promotion and health improvement might be defined in complementary ways.

Taking account of points made above and other relevant modernizing considerations referred to below, I suggest that *health promotion* be defined as shown in **Box 1**.

The reference to *sustainability* in the proposed definition reflects a need for health promotion to give due priority to today's global environmental concerns — to focus on conserving resources and protecting the environment in the interests of long-term survival and health. It also relates to the challenges of achieving sustainable health promotion actions, and maintaining healthful attitudes, commitment and behaviours once adopted.

The *positive* dimension of health is highlighted, in addition to the negative (ill-health), as relevant to each of the action areas. The *prevention* component should be taken to cover appropriate action across whole populations and among people identified as being at high risk.

The three categories of action in the lead-in sentence allude to the importance of policy commitment to the promotion of health, by government and organizations in all sectors and levels of society, with agenda-setting, enabling and protecting policies flowing through strategies for action to activities on the ground. The policies, strategies and activities concerned comprise topic-focused measures, for example on tobacco or alcohol, and more cross-cutting action such as that on more fundamental determinants of health and health inequalities.

Education here includes general education as well as health education, and the fostering of empowering attributes such as resilience, self-esteem, confidence and lifeskills in addition to the development of knowledge and awareness. *Services and amenities* cover, for example, preventive services in health and social care,

Box 1. A new definition of health promotion.

Sustainable fostering of positive health and prevention of ill-health through policies, strategies and activities in the overlapping action areas of:

- social, economic, physical environmental and cultural factors
- equity and diversity
- education and learning
- services, amenities and products
- community-led and community-based activity.

and facilities in a wide range of settings that encourage, enable and support behaviours conducive to positive health and the prevention of ill-health. *Products* include those that can damage health and those that protect or enhance it.

The inclusion of *community-led and community-based activity* serves to emphasize that, while policies and strategies are key drivers for health promotion on the ground, there is a need for a 'grass-roots' and 'bottom-up' dynamic whereby empowered individuals, groups and communities are involved in identifying and prioritizing health issues and in designing and delivering solutions.

The incorporation of *equity* gives due emphasis to tackling socioeconomic and other health inequalities, for the sake of disadvantaged people, justice and, arguably, overall population health.²⁰ The definition also reflects the desirability in individual and collective wellbeing terms of valuing *diversity* in communities and societies, and trying to mitigate the health consequences of differences between individuals, groups and populations. The equity and diversity action area is applicable at subnational, national and international/global levels, with a focus on tackling inequalities and valuing differences between as well as within countries and continents.

I suggest that the new definition is a useful adjunct to the Ottawa Charter's action areas: build healthy public policy; create supportive environments; strengthen community action; develop personal skills; and reorient health services.²¹

What about *health improvement*? That term is commonly used to cover the foci and action areas set out in the new definition of health promotion. Interpreting health improvement thus, as a *field of activity*, has been helpful in widening perceptions as to how health can be improved (beyond unfortunate, overly narrow characterizations of health promotion) and in widening ownership and delivery expectations (beyond the health promotion profession). However, we should keep sight of the importance of population health improvement as a quantifiable *goal*, for *treatment and care* for established ill-health as well as for health promotion.

Box 2 presents a definition of health improvement that combines the goal and field of activity perspectives. The definition is necessarily broad, but is focused in its stressing of the *population-centered outcome goal* of health improvement as distinct from concentrating exclusively on the health of individuals. It makes it explicit that population health is improved over time by increasing levels of positive health and reducing the burden of ill-health, not just the latter. The emphasis on improving health in populations should not be misconstrued as implying that health improvement is only about action with, and for, populations or groups; the intended point is simply that action with individuals (and costs and benefits) should be viewed in the context of improving the health of defined populations.

Box 2. A definition of health improvement.

Sustainable enhancement of positive health and reduction in ill-health in populations through policies, strategies and activities in the overlapping action areas of:

- social, economic, physical environmental and cultural factors
- equity and diversity
- education and learning
- services, amenities and products
- community-led and community-based activity.

Reduction in ill-health, and *services* are intended to encompass *all* aspects of treatment and care for ill-health, not just the preventive. Similarly, principles of *sustainability*, *equity* and *diversity* apply to the aims, planning, delivery and outcomes of all aspects of treatment and care. Avoiding an over-rigid demarcation between preventive and other aspects of treatment and care is important, but we must guard against any risk of backfiring through paradoxically deflecting attention away from prevention in the round. Above all, we must keep to the fore the bigger picture of health improvement – including the focus on positive health as well as ill-health, the breadth and depth of the necessary action areas, and the consequent number and range of players that need to be involved.

I hope that these reflections are helpful, and I shall be interested to hear others' views.

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Competing interests

Andrew Tannahill devised the model of health promotion appraised in this paper.

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