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The theoretical order as a means of professionalizing health promotion

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Abstract

In Poland, the issue of required preparation and professional status of people working in health promotion (HP) is not specified in detail and existing rules are not transparent. An important aspect of professionalization of the field should be strong embedding in the theoretical framework. Furthermore, the term "theory and evidence-based" used in relation to HP and health education (HE) interventions is getting popularity. This paper is a thematic draft which discusses several issues subjectively assessed as constitutive for the professionalization of the HP field. It presents: professions related to HP; fundamental differences between HP and HE; theoretical forms in HP; the importance of theory in HP; selected theoretical concepts on disease, health and health behaviors. Particular attention was paid to the concepts that were considered the key to understanding the philosophy and specificity of HP and therefore should be the starting point in acquiring essential competences to professional performance.

Key words: **health promotion, health education, professional competences, professionalization, theory and evidence-based**

Słowa kluczowe: **promocja zdrowia, edukacja zdrowotna, kompetencje zawodowe, profesjonalizacja, oparcie na teorii i dowodach**

Ministerstwo Nauki i Szkolnictwa Wyższego

Przygotowanie do wydania elektronicznego finansowane w ramach umowy 641/P-DUN/2018 ze środków Ministra Nauki i Szkolnictwa Wyższego przeznaczonych na działalność upowszechniającą naukę.

Introduction

According to the Ottawa Charter, health promotion is a process that enables people to increase control over, and to improve, their health [1]. The core of the process is the empowerment of individuals and communities [2, 3], in which all social sectors should participate, i.e. the public sector, including organs of power, private entrepreneurs and non-governmental organizations. This process also requires the activity of the media, individuals, families, communities, and social groups and professional associations.

Initially, such widespread mobilization for health was referred to as inter-sectoral (multi-sectoral) action, later as health in all policies, and now – whole of government and whole of society approach. This is the main interpretation of modern health policy and an element of health governance [4].

Therefore, the list of actors and stakeholders in health promotion is very long, and the process should be led by professionals who have the appropriate competencies and qualifications officially authorized them to work in this field. Competencies are to be understood as a combination of knowledge, abilities, skills as well as values

and attitudes [5, 6], while formal qualifications are to be understood as a confirmation that a person has achieved learning outcomes consistent with certain standards [7]. In some countries and in the international arena (e.g. Canada, Australia, New Zealand, International Union for Health Promotion and Education – IUPHE) sets of core competencies for health promotion have been agreed, which undoubtedly aids professionalization of the field. IUPHE has implemented a system of voluntary practitioners registration and accreditation of health promotion courses that meet relevant competency-based criteria.

In Poland, the issue of the required competencies as well as the professional status of people working in health promotion are not specifically defined, and the existing rules are not transparent. For years, opinions have been clearly expressed at various national forums that professionalization of the field is necessary [8]. Professionalization usually means improving education and improving the quality of work, but also the actions of public decision makers responsible for health promotion. It is important to integrate the contractors' milieu and to define core competencies, as well as to position health promotion in the health system. The issue of health promotion professionalization in Poland, however, has not become the subject of any planned action, nor any sociological analysis, as has been the case for social work [9]. Unfortunately, it is not easy to professionalize with the obvious shortage of elementary tools – comprehensive Polish-language textbooks as well as illustrative (and educational) articles on the theory and practice of health promotion. Today you can even get the impression that the health promotion has become the theory of everything.

An important aspect of the professionalization of the field should be its strong embedding in the theoretical framework. In the last decade, in international literature, a strong emphasis has been placed on the theory in health promotion. Theory in health promotion, also in health education, public health and health care, its meaning and application, is a sign of the times [10–12]. This does not mean, however, that the theory is widely used, because – extrapolating the results of one of the studies – one can risk the claim that almost half of the implemented programmes lack basis in any theory or framework [13]. At the same time, the term 'theory and evidence-based' used in relation to the intervention of behavioural change, programmes, health promotion, health education [14–16], is becoming more and more popular. This term fits the course of the evolution of health promotion, and concerns the use of the theory of behavioural change in activities compliant with the socio-ecological approach.

This study is a problem outline, in which several subjectively assessed issues are discussed as constitutive for the professionalisation of the field of health promotion. First, the professions related to health promotion in Poland were presented. Next, the fundamental differences between health promotion and health education and theoretical forms in health promotion were discussed. Further, the significance of theory in health promotion was analyzed, to briefly describe selected theoretical concepts on disease, health and health behaviours. Particular attention was paid to the concepts of disease and health, which were considered the key to understanding the philosophy and specificity of health promotion, and for this reason should be the starting point in acquiring the skills necessary to pursue the profession. The presentation of the concept of health behaviours was arranged according to the types of health behaviours. However, the study does not contain a full presentation of the indicated theories, models, frameworks or approaches, their evolution, nor a review of all the theories relevant to health promotion, because it was created to discuss the professionalization of the field, including reflection on what it should deal with.

The basis for this study was English-language literature, which is relatively harder to access than Polish-language literature. The omission of Polish reflection on health promotion, especially of sociological thought, and therefore also many eminent authors, is not the result of neglect or lack of respect for their efforts, but only a consequence of the accepted study concept.

Profession of health promoter/specialist in health promotion and health education

The Classification of Occupations (pol. *Klasyfikacja zawodów i specjalności*, *KZS*) which was published for the purposes of the labour market in 1995, has the status of a regulation of the minister competent for labour affairs, and subject to periodic changes. In the current *KZS*, there is mention of 'specialist in health promotion and health education' (No. 229102) [17]. In 2002, 2004 and 2010 the occupation was called 'health promoter' (No. 228202), and in the 1995 version – 'specialist in health education' (No. 2229007). The psychophysical and health requirements of the former occupation of health promoter included the statement: "Individuals with significant impairment of the sensory organs (sight, hearing) and mental illness are denied access to the profession. Contraindications to performing the profession are serious speech defects and inability to accurately and fluently express oneself, especially in situations of public speaking" [18]. The section concerning speech defects has been removed from the current description of the profession, and it now says: "specialist in health promotion and health education conducts activities promoting health and a healthy lifestyle addressed to a wide social group" and "the primary goal of their work is to motivate local community for health actions, to support and develop pro-health attitudes, develop knowledge and skills in promoting one's own health and that of others" [19].

It also says that this profession can be performed by a person who completed first-cycle studies with a specialization related to health promotion and health education, or university graduates with a medical profile, public health graduates and of other specialties after completing postgraduate studies in the field of health promotion and health education. However, this description does not indicate what exactly such a person should

do. It is also not clear what their knowledge and capabilities should be, and it is of cardinal importance in the situation of enormous diversity of study programmes at various universities. It is uncertain whether the profession is open to people with a master's degree in biology, physiotherapy, pedagogy, special education, psychology, sociology, food technology and human nutrition or public health, who could obtain a postgraduate specialization in the field of health promotion and health education. And if so, is the diversity of levels and fields of education to be accepted, especially in the absence of a staff certification system? It is also not clear what the right workplace for these specialists is.

In *KZS* two further important occupations are listed, i.e. nurse – specialist in health promotion and health education (222222) and midwife – specialist in health promotion and health education (223207). Job descriptions for these people are relatively precise, and their tasks include "developing health promotion programmes for the local community" (nurse) [20] or "developing and implementing promotion programmes regarding a healthy lifestyle among children, adolescents and families" (midwife) [21]. The issue of professional preparation of these people is quite clear – in 2003–2013, a post-graduate course approved by a regulation of the Minister of Health included specialization training for nurses and midwives in the field of health promotion and health education with a strictly established education programme. Completion of the course granted them the title of a specialist in this field [22, 23], and there was no doubt as to where their place of work was.

Currently, under the Act on the Integrated Qualifications System [24], the NIPH-NIH (National Institute of Public Health – National Institute of Hygiene, pol. *NIZP-PZH*) is working on the Sectoral Qualifications Framework for public health (pol. *SRK ZP*), in which the qualifications functioning in this area will be defined. It is to be hoped that it will organize the labour and training market within the area of public health and improve the safety of the addressees of the intervention. Unquestionably, there are arguments for the creation of the *SRK ZP*; however, it will not be specific enough in terms of health promotion.

In addition, in the period of 2 January 2017–30 June 2019 a project has been carried out, titled: "Developing, supplementing and updating information about occupations and its dissemination using modern communication tools – INFODORADCA+". It is financed by the European Union under the European Social Fund – Operational Programme Knowledge Education Development 2014–2020 (pol. *PO WER*). One of the tasks of the project is to prepare descriptions for a minimum of 1,000 professions according to a strictly defined scheme and in accordance with the established methodology. Time will tell if the outcome of this project supports professionalization of the occupation.

Health promotion and health education

In simplified terms, health promotion sets itself the main aim of creating environmental, social, organizational or political conditions that would be beneficial for the health of the community, while health education aims to change the behaviour of individuals or groups of people (perhaps apologies are due for the anthropomorphism). It is known that from the perspective of an individual, a change in behaviour is often impossible, which results from various obstacles in the wider socio-political environment [25]. It happens then that health education tries to make changes in the contextual conditioning of health behaviours and to some extent overlaps with health promotion. It can also be said that the founders of health promotion became those educators who were aware of barriers to behaviour change and opposed the practice of blaming the victim. In recent years, the concept of health literacy has become more and more popular in health education and health promotion [26, 27], and the relationship between literacy and behaviours and health outcome has been more and more researched.

In principle, health promotion sees health in positive terms, i.e. as a concept that emphasizes individual and social health resources [28]. Although the concept of positive health is subject to different interpretations [29], it is the flagship of health promotion and is absent from the classic disease-oriented health education. Therefore, despite the similarities between health promotion and health education, they differ in terms of the superior aim and numerous methods of their actions, so they should not be deemed equivalent [30].

Health promotion is a practical field, but also a young scientific discipline. Health education is slightly different, and – according to the Ottawa Charter [1] – it constitutes one of the five actions of health promotion, but above all it is an independent scientific discipline with a much longer tradition than health promotion. It also has its own practical and significant theoretical achievements, especially on the basis of theories about behaviour change. It is worth noting that some of the theories used in health education were created strictly for its needs (e.g. health belief model), while other were created on the basis of psychology and pedagogy (social cognitive theory), and yet other for the needs of psychotherapy, e.g. in the context of anti-health behaviour (transtheoretical model). Despite the fact that different authors listed between 60 [31] to about 80 theories [32] concerning the origin or change of behaviour, in health education only a few of them are used constantly. And it is a complete paradox that there is no strong evidence for the most commonly used transtheoretical model to be actually helpful in changing health behaviours [33].

Looking at the achievements of the health promotion world leaders, one can say that the practical activity of health promotion is widely described, characterized and recognizable, while scientific activity takes place, in particular, in the empirical vein, through research serving a descriptive or explanatory function. These studies are carried out for both diagnostic and evaluation pur-

poses, although there are problems in determining what the evidence in health promotion is [34]. The theoretical vein of health promotion with its main goal to formulate scientific theories is relatively less developed. At the current stage of the discipline development, it is possible to speak boldly about the theory or theories in health promotion and with restraint about the theory of health promotion [35]. There are definitely more theories borrowed from different areas of science and their applications than attempts to answer the question about the nature of health promotion.

Health promotion is mainly based on behavioural and social theories derived from psychology, sociology, anthropology, management, marketing, communication, community development or political science [36, 37]. Theories about behavioural change, the same as those used in health education, are becoming immensely popular. The issue of health promoters' particular interest in behavioural theories was criticized a long time ago, because reliance on health education theories may be an obstacle to the development of health promotion and actions aimed at social determinants of health, and so at reducing inequities in health [38]. Health promotion development is additionally hampered by the concentration of behavioral actions on the so-called holy trinity of behaviours, i.e. diet, smoking and physical activity, omitting other health-related behaviours [39, 40]. For the sake of precision, it needs to be admitted that this behavioural approach is not the entire theoretical armoury. For example, it is known that 28 different theories, models or theoretical frameworks are used for the purpose of building the public health capacity, and above all health promotion [41].

Theories, models, frameworks

The theoretical basis for health promotion are, above all, different models, theories or frameworks. However, there is no absolute agreement as to how these forms differ, and individual authors use the various names to present their reflections and findings quite arbitrarily. For example, the popular PRECEDE-PROCEED planning model is essentially a framework, a scheme, a structure, not a model. In addition, the theoretical basis for health promotion are concepts and approaches, strategies, methods and hypotheses. Health promotion horizons are very wide, although at times a bit fuzzy.

A theory can be defined simply as a set of analytical principles or statements designed to put order on our observation, understanding and explanation of the world. A theory is, therefore, a systematic way of interpreting events or situations. Good theories relate to a specific issue, explain how and why certain events occur, contain a description of variables and show relationships between them [42–44]. In other words – a theory is a set of related concepts, definitions and proposals that explain or predict events or situations, defining relations between variables [45].

A model is intended to simplify a certain phenomenon. It is descriptive and can draw from many theories, it is not as specific as theory and it does not explain phenomena in depth [42–44]. Distinguishing a model from a theory – if at all possible – raises many doubts. You can probably say that a model is a 'shallower' theory.

A framework does not explain empirical phenomena either, but describes them and shows their structure by means of various descriptive categories [42]. Theoretical and conceptual frameworks are an important component of research assumptions, they serve to test the theory, and – after conducting the study – they contribute to the creation of a theory [46].

In the English-speaking literature regarding health promotion, attempts are rarely made to define the aforementioned theoretical forms and systematize the existing knowledge according to them. Also in textbooks, which in principle contain the basic content and serve to order the state of knowledge, the entire basis of health promotion, regardless of form, is most often referred to as a theory [47–49]. Therefore, the term is used in a general and rather colloquial sense. In addition, it is uncertain whether the interpretation of the theory or model is identical for social and natural sciences, which are – after all – still used by health promotion, although to a different degree. Considering such circumstances, in this study, the term theory, concept or idea was used, while when referring to specific examples of theories or models, the original terminology was preserved.

The importance of theory in health promotion

As in any other field, theory in health promotion helps to avoid two errors: narrow empiricism and focus on observation and random data collection, and consequently the unrealistic thinking that understanding phenomena based on disorderly facts could be possible [35].

Theory and practice are joined by mutual relations. Using a chosen theory and deductively reasoning (from the general level to the level of detail), one can make a diagnosis of the state of affairs, can plan and implement actions, and then – continuing to be guided by this theory – see the effects of that action. Knowing the effects, and taking into account the contextual factors, and reasoning inductively (from the detail to the general level), one can create theories [50]. So a theory allows to determine the problem, to understand the phenomenon and to indicate what, where and how something should be changed. It helps to tailor an effective intervention. It is also helpful in research design [51]. However, these are not all the justifications for using the theory. In total, there are seven reasons why theory is crucial in health promotion, and these are: it incorporates ethics and social justice into public health practice, it is a moral duty of professionals, it guides the profession, it protects against ideological take over or hegemony of some point of view, it guides and perfects practice, it builds scientific knowledge and directs research [52].

Different theories on the same subject, related to the activity of health promotion (e.g. regarding behaviour and planning), often use different vocabulary, indicate other important factors, although they may have common elements. A multitude of theories on the same subject has

both a beneficial and unfavourable effect, as it creates the possibility of choice, which is not an obvious one. Not all theories have passed the test of validity. Sometimes a theory cannot explain a given situation and is biased. Therefore, it is important to know, understand and critically analyze various theories in order to finally choose the right ones [53].

Being aware of theories, understanding them and judging them critically can be regarded as three successive levels of competency in health promotion. For example, according to the Health Promotion Forum of New Zealand, at the first level of competency, health promoters develop knowledge and understanding of theory in public health and health promotion. They may work as a team member. At the second level of competency, they already have advanced knowledge, and also critically understand the theories used in health promotion. They are a person facilitating the work of others, leading or advising them on the processes of health promotion. On the third level, the promoter has highly specialist knowledge and can critically analyze theories. This level is characterized by people capable of strategic leadership, health advocacy and expert work [54].

In health promotion, the choice of appropriate theory should result from the initial recognition of the problem and the situation, and the set goals, as well as the logical model of the programme – therefore, it is the resultant situation [45]. The choice of theory serves merely (or not so) to support work, because theories will not help to determine exactly what and how should be done. On the other hand, theories can direct and organize thinking. It is necessary to devote time to studying theory and making choices [55].

According to the CDC, the most frequently used theories in health promotion associated with physical activity include: on the individual level – health belief model and transtheoretical model, on the interpersonal level – social cognitive theory, theory of reasoned action, theory of planned behaviour, and on the community level – community organization model and diffusion of innovation theory [56]. Other examples of theories applied in health promotion at the community level include the theory of social capital, intersectionality (rooted in feminism and helpful in issues of inequality, including inequities in health), and Jack Rothman's approaches to social change (local development, social action, social planning). An example of a theory applied at the level of the entire society is the agenda setting theory. The use of many theories has been the subject of analyses and research, including systematic reviews, for example, research on the effectiveness of using less well-known theories regarding behavioural changes, such as the I-change model [57] and the PEN-3 model [58]. It is worth recalling articles on the use of diffusion of innovation in a North Karelia project [59], a model example of the health promotion programme, or the theory of change to planning and evaluation of a variety of interventions [60] and the use of the so-called intervention mapping [61].

An important starting point for working in health promotion is the choice of theory concerning disease and health, the one that will allow analysis of the perception of a given target group. People interpret differently the origin and meaning of disease and health [62], as well as symptoms, causes, duration, consequences and ways of preventing diseases [63], and causes of inequities in health [64], or their own health-related actions. They can, therefore, have their own expectations towards health promotion activities, not necessarily in line with the vision of professionals, which results from numerous publications on culturally dependent health concepts [65–67].

Concepts of disease

Formally speaking, a disease is a specific pathological process with a specific set of symptoms that may involve individual parts of the body or the entire organism, and the etiology of this process, pathology and prognosis may be either known or unknown [68].

This description expresses the traditional, pathological and biomedical paradigm that has been dominating in medicine and been extensively used for two centuries. This model is focused on setting diagnostic criteria, searching for specific clinical cases and starting treatment, but it is not trying to understand the state that the feeling of discomfort and being sick entail. It can be said that it is mechanistic [69] and it is known that it can lead to the medicalization of social life [70] and making medicine as a tool of social control [71]. In addition, it creates fertile ground for the growth of healthism, coercive measures in medicine, health terrorism [72] and disease mongering [73]. Despite the enormous popularity of the biomedical model, it began to be questioned at the end of the 1960s, and in 1977 George Engel wrote about the need to adopt a biopsychosocial model [74].

However, the biomedical model has the undeniable quality of being very simple from the ideological point of view, and – most importantly – measurable. Its domination can be strengthened by language and this is what could actually be happening in Poland. According to the Polish language dictionary (http://sjp.pwn.pl/), a disease is "an abnormal functioning of the organism or its part". Because language affects thinking, perception of reality, ethics and culture [75], it is not surprising that – in popular awareness – the lack of pain and clear symptoms may deny the existence of the disease, i.e. "a man is sick when he feels pain" [76]. A different situation occurs in English, where there are words describing the psychological, physical and social aspects of diseases, ie: illness (feeling of discomfort), disease (objectively confirmed pathology, the equivalent of 'choroba' in Polish) and sickness (being sick, social perception of the health problem), e.g. inability to perform work) [77]. No doubt, it opens up a much broader cognitive perspective.

The basic problem with using the biomedical model in health promotion is that not all people use the same criteria to assess what pathology or disease in fact is. Such diversity was clearly demonstrated by a survey of 3,280 people – laymen, doctors, nurses and parliament mem-

bers legislators from Finland. Respondents were asked to choose from a list of 60 health-related states those which they think constitute a disease. Large disproportions were found in the opinions of laymen, professionals and legislators. Doctors were more likely to think of the condition as a disease than other groups. For example, anorexia or hip fracture were considered a disease by almost all doctors and only by about 70% of laymen. There were also cases of a reversed tendency, where more laymen than doctors regarded a given condition as a disease (e.g. fibromyalgia, infertility, baldness) [78].

Profound differences in the points of view of doctors and laymen have also been demonstrated in Poland, for example in a focus group interview where doctors and male respondents mentioned completely different diseases and states thinking that they are the main health problems of men [79]. Undoubtedly, healthcare professionals have their own assessment criteria and they classify diseases in their own way, e.g. according to ICD-10. And laymen can apply their criteria and distinguish normal diseases (e.g. children's infectious diseases), real diseases (e.g. cancer), and health problems, i.e. weaker diseases (e.g. aging, allergies) [80].

In summary, the concept of disease is interpreted differently because it is assigned psychological, social, cultural, economic as well as political meanings that change over time [78]. Definitions of disease vary depending on cultures, subcultures, communities, and even within families, if we take into account different generations [81].

Over the course of history, the causes of diseases have been interpreted differently, and over the past few centuries followed the theories of germs, the triad (the epidemiological triangle), a web of causation (multiple factors), and susceptibility. In the 1980s, the socio-environmental theory of diseases became established [82], and so the earlier mentioned concepts were modified and expanded along with the development of knowledge. This does not mean, however, that the previous theories were completely abandoned. However, from a layman's point of view, the causality of diseases is considered in a more down-to-earth way, e.g. as a lack of happiness [83].

Laypeople also have a different perception of the possibilities of disease prevention and cure. Not so long ago, half of Sydney respondents believed that only child drowning, tooth decay, skin cancer, sunburns and wounds could be prevented, while most of them did not believe that deaths due to heart attacks, cervical cancer, hypertension, lung cancer or asthma could be prevented [84].

These examples clearly show that the medical model of the disease (like the medical model of health, its mirror image) simply does not work in real life. It is affirmed by many health professionals, but criticized by many others. In the course of such criticism, a new definition of evidence-based public health was proposed, which is: the process of combining science-based interventions with community preferences [85]. This concept raises the rank of anthropological concepts and the process called community-based participatory reseach (CBPR), in which existing needs are determined as a result of collaboration between researchers and the community. Knowledge gained in such a process is put to practice.

Health concepts

Neither medicine, nor sociology, nor even philosophy, have developed a scientific general theory of health [86]. The essence and meaning of health are complex and changeable over time, and it is estimated that there are about 120 definitions of health [87].

Among various attempts to systematize the theory about what health is, it is worth referring to the position that distinguishes four models of health: the medical one, the World Health Organization (WHO) model, wellness, and the environmental model [88]. This division is appealing from the point of view of the theoretical order, but does not take into account many new trends, including salutogenesis.

The traditional and leading, medical model is based on pathology and assumes that lack of disease in physical and mental aspects is health. It is the opposite of the biomedical disease model and, like it, it has been subject of strong criticism. It should be noted that in the Polish language, health is "the state of a living organism in which all functions are going well", and so in the collective consciousness, health could appear as an ideal state. Meanwhile, among Poles who are chronically ill, one-fifth (21%) assesses their health as good, and half (50%) as so-so. Only 29% of such people describe their health as bad [89]. Most, therefore, use the concept of health that is different from the biomedical or dictionary concept [90]. A similar apparent contradiction was noticed, for example, in the Netherlands [91]. Apparent, because for men, health is above all physical fitness, energy and strength. For women, the possibility of establishing and maintaining social relations. For old people, regardless of gender, the possibility of functioning and implementing tasks. And for young people – usually with a high socio-economic status – above all, psychosocial well-being [80].

The WHO model emphasizes the multidimensional character of health, describing it as: "a state of complete physical, mental and social well-being, not is merely the absence of disease or infirmity" [92]. Health promotion specifies it further, saying that health is not the goal of life, an autotelic value, but a resource for everyday life, and emphasizes the existence of the spiritual dimension of health [1, 93]. This model expresses the ideal, affirms health as a basic human right and sets a social goal for the actions of all governments. Nevertheless, unlike the medical model, it is not suitable for objective health measurements, because it would require the operationalization of variables concerning "the complete prosperity". And this is a rational allegation [94].

The WHO model was also negatively judged because of the unchanging, static nature of health. In addition, criticism results from global changes in the image of morbidity and the growing number of people who live with chronic disease, but lead a productive personal, professional and social life. In response to this issue, it was proposed to define health as the ability to adapt and to self-manage in the face of social, physical and emotional challenges [95]. In the opinion of public health and healthcare representatives, this is a promis-

ing concept [96]. WHO, for pragmatic reasons, but also under the pressure of criticism, has adopted a different definition of health, clearly based on a medical model which is used, for example, in medical statistics: "reduction in mortality, morbidity and disability due to detectable disease or disorder and an increase in the perceived level of health" [97].

The Halbert L. Dunn wellness model [98, 99] is based on a four-field grid formed by crossing the horizontal axis of health with the vertical axis of the environment. The health axes extends from death to peak wellness, where wellness means a situation in which a person advances, climbs towards a greater health potential, better functioning. Wellness is a state of good health achieved as a result of the strength of the spirit – through active pursuit of health. The environmental axis poles are extremely unfavourable and very favourable conditions. The aim of the activity should be to achieve a high level of wellness in a favourable environment (**Figure 1**).

The idea of wellness was developed by John Travis and found many supporters, especially among the middle class, which was the result of its relative wealth and free time due to the technological revolution. The Darwinian culture of fitness and wellness was born, which promised success in the struggle for survival on the strength of self-discipline and care for the body. However, it has become subject of criticism since it promotes discrimination, e.g. in the work environment, when employee wellness programmes are implemented [100], as well as in philosophical [101], political and social (e.g. feminist) contexts [102].

The environmental or socio-ecological model assumes a relationship of health with many factors of behavioural, social, environmental, cultural, economic or political nature. The origin of this model is not clear. Already in the mid-twentieth century, epidemiologists and behaviour scientists viewed behavioural, socio-cultural and environmental risk factors as a mix of health determinants. The theory of Urie Bronfenbrenner on ecological systems theory was groundbreaking. Since then, numerous approaches to health based on a conglomerate of conditions have been proposed. Essentially, all these approaches, regardless of whether they are included in WHO reports or documents, or come from the US, contain many of the same elements. For example, to illustrate the socio-environmental determinants of health, the so-called rainbow model is used, developed for WHO in 1991 by Göran Dahlgren and Margaret Whitehead [103]. On the other hand, the mechanisms of health-related actions based on this model are best illustrated by the American model of achieving the objectives of the Healthy People 2020 programme [104].

The basic content of these models are the mutual cause-and-effect relations of behavioural, social and environmental factors that are closely related and function in a broader structural, political and economic context [105]. The socio-ecological model has been the basis for health promotion from its very beginning, and today it is becoming more and more common in public health, especially when it comes to diseases with complex etiology or multiple morbidities. There is already a lot of evidence that the prevention of both infectious and non-

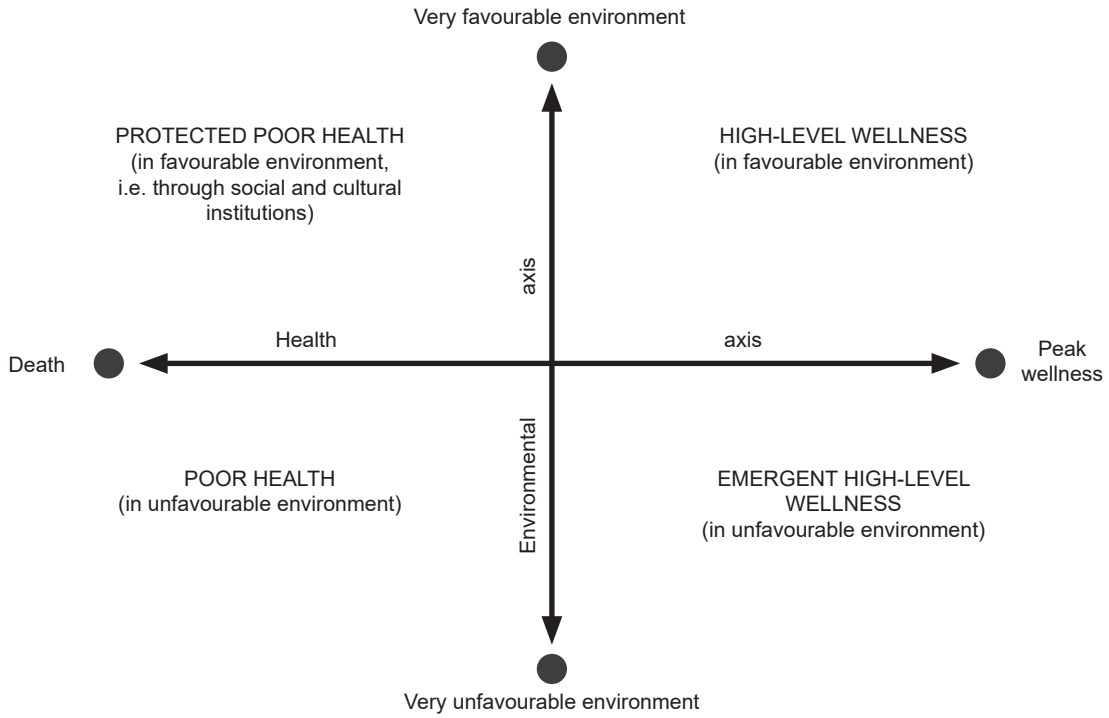

Figure 1. *Health grid.*

Source: Own work according to Dunn H.L., High-Level Wellness for Man and Society, "American Journal of Public Health" 1959; 49 (6): 786–792 [98].

infectious diseases cannot focus on changing the behaviour. It should be based on a socio-ecological model, take into account changes in the social context, also in social norms as a minimum [105, 106].

On the margin of the above considerations, it is worth thinking about the theoretical basis for measuring the health of individuals and populations. Assessment of individual health seems to be quite simple and can be done by means of anthropometric measurements, physiological or biochemical tests, as well as by means of various standardized questionnaires, such as, for example, Short Form Survey (SF-36) or Health-Related Quality of Life (HRQOL) [107] and the International Classification of Functioning, Disability and Health.

More complex is the population health assessment. Three spheres should be considered here: health outcomes and their distribution in the population, determinants of the situation as well as policies and interventions that affect the other two spheres [108]. The WHO proposes over 100 indicators for monitoring the health situation at the national and international levels, including 27 concerning the health status, and more specifically concerning diseases (e.g. mortality due to malaria, AIDS, incidence of tuberculosis, etc.), 21 – risk factors, 27 – services coverage, 27 – health system [109]. Also very long is the list of indicators that are used in the EU, which covers five domains: demographic and socio-economic situation, health status (including mortality due to specific diseases), health determinants, health interventions (health services and health promotion) [110].

Concepts of disease and health, salutogenesis

Disease and health are usually seen as opposites. However, many theorists reject this view, claiming that they are not opposite and separable states. For example, disease is seen as part of health [111] and even as a manifestation, a symptom of health [112].

It is a fact that the individual's health is a dynamic state, a process that evolves with the changes of the internal and external environment and the adaptation of the person to these changes. Health and disease are conditions that may occur alternately, but also at the same time when the existing disease does not significantly limit the life activities of the individual. For this reason, the traditional dichotomous division into absolute health and unambiguous disease is unsuitable for the interpretation of the body's condition and behaviours associated with the given situation. It is more rational to consider health and disease in terms of a scale or continuum. In health promotion such a position is visible in the salutogentic approach to health. According to Aaron Antonovsky's theory [113], health is seen as a movement on the axis between ill-health (dis-ease) and total health (ease) [114, 115]. The key factors that condition health include the sense of coherence and general resistance resources.

Concepts of health behaviours

The classic definition states: "it includes not only observable, overt actions but also the mental events and feeling states that can be reported and measured. He defined health behavior as: those personal attributes such as beliefs, expectations, motives, values, perceptions, and other cognitive elements; personality characteristics including affective and emotional states and traits; and overt behavior patterns, actions, and habits that relate to health maintenance, to health restoration, and to health improvement" [116]. But there are many other parallel interpretations [117–119].

In the concepts of health behaviours, three lines of thinking can be distinguished, where the axis is: the type of behaviour, behaviour variables and methods of influencing behaviours. The two last-mentioned items overlap and include theories about behaviour origin or behaviour change [32] and theory-based methods of behaviour change [120]. They have been omitted in this study.

The simplest concept of types of health behaviours is based on the criterion of health status assessment and includes: health behaviours that are aimed at preventing feeling unwell (illness), illness behaviour related to discomfort (illness), which involve determining what is happening and seeking a solution to the problem, and sick role behaviour, which is a response to symptoms, including activity in the role of the patient [121, 122]. This concept is complemented by such ideas as self-help [93], self-care [123, 124], self-treatment, self-medication [125], health-seeking behaviour [126, 127], and self-management [128, 129].

Another concept says that health behaviours depend on the individual perception of health, belief in its essence, and so in fact on the unconscious acceptance of a given health model. The traditional, clinical, health model is based on the assumption that the absence of worrying symptoms or injury is proof of health. People who perceive health in this way may give up any activity until clear, strong symptoms lead them to seek professional help.

The role performance model assumes that health consists in performing the roles society expects us to play at work, in our families and communities. The disease is the inability to play our social role. In people who perceive health in this way, one could expect, for example, presentism. This model is the basis for employee and student examinations, granting sick leave or medical contraindications to work.

The adaptive model assumes the possibility of positive physiological, psychological and social adaptation to changes in the environment. Lack of adaptation means the disease. In this approach, the goal of the individual who feels the problem is to seek help in dealing with a given problem or challenge.

In the eudemonistic model, health is perceived as the possibility of using personal potential, fulfillment of ambition, well-being and happiness. This state is the result of the interaction of physical, psychological, social and spiritual factors, both in personal and social aspects. The

sense of discomfort (illness) makes it impossible to self-realize, and the person does not undertake activity and withdraws from life. People prone to such a perception of health are oriented towards pro-health behaviours, satisfying relationships with other people and adaptation to changing conditions [130, 131].

Yet another concept of fragmentation health behaviours (both pro-health and anti-health) is based on the 'modus operandi'. Behaviours can be considered as autonomous activities, under complete control of the individual, or conditioned by the social and cultural context [119]. The approach that assumes that people are able to independently undertake pro-health behaviours based on habits or information received, is subject to strong criticism. As already said, more and more attention is paid to the context of behaviour, but this raises a question about the variables of this context, their scope, mechanisms and impact. The context of behaviour can be comprised of many factors that are connected and strongly interrelated. For example, complex, *not* one-off behaviours, such as alcohol consumption, eating, physical activity or smoking, are a type of social practice in which different spheres of life and various activities in the area of work, leisure, social life or shopping combine. Social practices as broad fields of human activity that are recreated, transformed and synchronized in space and time with other behaviours, are the subject of various theories [132].

Summary

Health and being healthy is more of a social construct, also a philosophical one, rather than medical, but also disease and being sick have their social interpretation. It cannot come as a surprise, then, that many ways of comprehending these domains have arisen. In Poland, however, in the practical aspect of health promotion, the biomedical and 'disease' perspective prevails, as evidenced by the analysis of school textbooks from 16 countries in 2008 [133]. Everywhere in national health promotion you can see the dominance of the disease-centred approach and health behaviourism, as well as the cult of the lifestyle, which conflicts with the theory of health promotion, scientific evidence for the effectiveness of activities, and with real life. The professionalization of the occupation of health promoter / specialist in health promotion and health education should unquestionably seek to change this perspective. A huge role here can be played by the awareness of different theories, their understanding and critical thinking – first of all, among health promotion specialists, but also among numerous stakeholders, including political decision-makers.

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