Positive Health Promotion: Orienting Health Promotion within a Wellness Framework to Improve Public Health Quality

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While health professions often purport a multidimensional and holistic view of health, these views typically do not translate into practice. In public health, best practices are not positioned to lead population-based approaches focused on a holistic perspective of health. The public health field continues largely to emphasize physical constructs and health problems rather than positive health dimensions. In order to move toward an authentic adoption of holistic health, two things need to happen: (1) more focus on a full range of health domains in proportion to physical health, and (2) a greater emphasis on optimum health versus health problems across all domains.

Health promotion efforts oriented toward wellness offer a context for shifting health approaches towards a positive framework for optimal health. The purpose of this paper is to advance holistic health and wellness by clarifying concepts and constructs for "positive" health as a means for improving public health quality. A wellness paradigm shifts health status towards optimum human potential and thriving instead of an overreliance on deficits or status quo functioning. From a public health perspective, wellness is not only limited to individual capacity but also applies to population health. Public health quality is explored as a reference point for incorporating the aforementioned concepts.

The United States Department of Health and Human Services (DHHS) states that the vision for public health quality in the U.S. is to build better systems to give all people what they need to reach their *full potential for health* (Honore & Scott, 2010). No more worthy a goal could be emphasized. Yet, with reliance upon problem identification, risk reduction, and prevention, public health practice is not positioned to lead American health culture to a state of optimum health potential. To do so would require a dynamic shift in a direction towards *positive* health instead of an unbalanced fixation upon health threats and risks. Wellness points the way, so too does true health promotion and a holistic view of individual and community health. Moving towards an authentic holistic paradigm will also require a greater focus on the full range of health domains in proportion to physical health.

This paper first explores a multidimensional perspective of health as a fundamental component for public health practice. In so doing, some of the pitfalls of current practice are examined as a method for punctuating the need for a greater emphasis towards positive health. Health promotion and well-being emerge as a means for advancing consciousness towards

holistic and optimum health. Lastly, public health quality is reviewed as a possible entry point for prioritizing changes to help people reach their full potential for health.

Touted but not actualized

The holistic image of health is central to complimentary health care delivery as well as healing (Arnold & Jansen Breen, 2006). The holistic perspective recognizes the "whole" person and is oriented towards *positive health* versus the aggregate of symptoms or the mere absence of disease. In relation to optimum health, holism is the development of the individual's potential and is achieved through the integration of multiple domains not just behavioral and physiological ones (Smith, 1983). In the eudaimonistic sense (life as purpose), health is wholeness, and to be healthy is the goal toward which the human system strives (Arnold & Jansen Breen, 2006).

Public health in the U.S. does not function from a model based on "whole" health. Notwithstanding, health professionals continue to merit holistic health as an ideal to some degree. In 1948, the World Health Organization (WHO) expanded the commonly accepted definition of health from the *mere absence of disease* to include the *complete balance of physical, mental and social well-being* as a marker for health (World Health Organization, 1948). Thus, health is equated as more than a healthy body but also includes a healthy mind and healthy relationships as correlates to well-being. In 1979, the U.S. Public Health Service and Surgeon General Julius B. Richmond recommended national strategies to enhance preventive health, health protection, and health promotion (United States Office of the Assistant Secretary for Health and,Surgeon General, 1979). Both national and global interpretations of health appear to support the notion that health is both multifaceted and requires attention towards positive aspects of health. However, the question remains whether or not the field of public health is actualizing the ideals of whole health and positive functioning.

Broadly speaking, an artificial division exists between numerous health disciplines making a holistic approach more difficult. Consider the traditional gap that exists between physical and mental health practices. The Institute of Medicine (IOM) acknowledged this fragmentation in *The Future of Public Health* (1988), a seminal report which aimed to address gaps and needs in the public health system. The report recommended that "knowledge development and policy planning in public health and in mental health, respectively, [should]

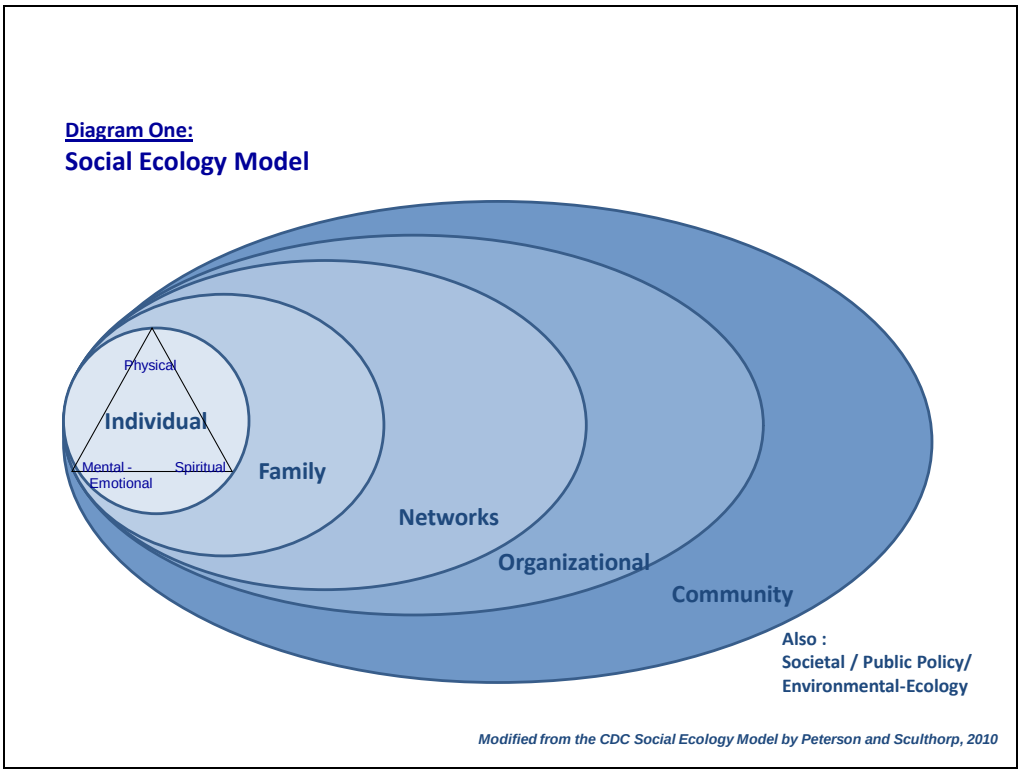
devote a specific effort to strengthen linkages with the other field" (Institute of Medicine (US) Committee for the Study of the Future of,Public Health, 1988). Eleven years later, Surgeon General David S. Satcher added that despite improvement and innovation to the field of public health, mental health is too often "relegated to the rear" of national consciousness (Satcher, 2000). Furthering the notion of holistic health, the report also emphasized the inseparable nature of mind and body. In 2003, *The President's New Freedom Commission* disseminated the message that "mental health is essential to overall health" (Hogan, 2003). Still, academic and professional disciplines often serve to preserve mental, physical and other health domains within respective silos.

Necessary linkages do not stop at mental and physical health. In 2009, the Institute of Medicine (IOM) convened a summit on *Integrative Medicine and the Health of the Public* stressing the need for true integration of health domains and not just token language. Summit objectives focused on the full range of physical, psychological, social, preventive, and therapeutic domains for optimal health throughout the life span (Institute of Medicine, 2009). Furthermore, the Bravewell Collaborative, a network of influential philanthropists and prominent physicians working to innovate the health care system, expanded the concept by contextualizing whole health as coexisting within physical, emotional, mental, social, and spiritual domains (The Bravewell Collaborative, 2010a).

Overemphasis on the Physical

In the Department of Health and Human Services *Healthy People 2010* goals, two thirds of the 28 focus areas emphasize physical health through chronic care, disability, communicable disease, health behavior, and lifestyle, with additional emphasis placed on improving health services and infrastructure. Through a strong reliance on epidemiological practice, public health is easily positioned towards referencing life through the lens of mortality and morbidity; concepts such as age-adjusted rates of death from any number of chronic health conditions abound in public health literature, popular media, and national heath goals. Moreover, in framing our nation's health, it is not uncommon to learn how physically sick people are (Wesfield, 2009). Five chronic conditions—diabetes, heart disease, asthma, high blood pressure, and mood disorders (mental)—account for more than half of all U.S. health expenditures

(Wesfield, 2009). Measurements of health behaviors, such as tobacco or alcohol use, exercise, or diet are not calculated to measure health per se; moreover, they equate to risk factors for coronary heart disease, lung cancer, alcoholism, and other diseases (Breslow, 1999).



In recent years, social determinants of health have found anchorage in varying disciplines. While not pertaining to the social dimension of health per se, this development at least reflects a greater awareness of the interactive role social factors can play in determining physical health across the social ecological spectrum. Social ecological domains (diagram 1) are the spheres of influence where indicators for health exist. With the individual at the center, health influences extend outward into other realms such as family, networks, organizations, community, and policy. Social causal factors of affliction, environmental risk, and unnatural causes are becoming more widely accepted and studied as indicators of functioning (often physical). Socio economic status, income, occupation, race and ethnicity are vastly recognized and incorporated into measurements of health determinants across both the lifespan and across the social-ecological spectrum (Wilkinson, Marmot, World Health Organization. Regional Office

for Europe., WHO Healthy Cities Project., & University College London. International Centre for Health and Society., 2003).

The Full Range of Health Domains

The WHO definition of health, which has notably become the standard, is considered an inclusive holistic model (J. J. S. Larson, 1999) because it incorporates physical, mental and social domains and references well-being. However, while this definition has become the standard definition of health in public health circles, it is not seen as the single or widely adopted definition for *holistic* health. Pressure to take the "definition several steps further" exists (Lerner, 1973). A broader and more inclusive definition would include expanded and explicit recognition of additional health domains.

Even among expanded definitions there are considerable variances. Integrative Medicine affirms health as the fulfillment of mind, body, and spirit (The Bravewell Collaborative, 2010b) and characterizes individuals as whole persons—"minds, community members, and spiritual beings, as well as physical bodies" (Snyderman, 2002). Some wellness models define health as a multifaceted concept comprised of social, mental, emotional, spiritual, and physical influences (Greenberg, 1985). The *American Journal of Health Promotion* champions the view that health is multidimensional and includes as many as 20 dimensions (O'Donnell, 2009). Some social scientists view the term psychosocial to more aptly formulate the aggregate of mental and social constructs (J. J. S. Larson, 1996). Where some models language "intellectual capabilities" and the "ability to learn" within the *mental* domain, (Greenberg, 1985) other parallel models label an entire domain *intellectual* and include educational, achievement, and career development as indicators (O'Donnell, 2009).

Despite these variations, a single theme emerges: frameworks for holistic health emphasize multiple, integrated, and specific dimensions of well-being. Furthermore, there is a contemporary resurgence in health culture (through concepts such as wellness and health promotion) to move towards a more integrated approach.

Seeing the World as Problems

Public health in the 20th century brought about many great achievements to human health and quality of life. Since 1900, the average lifespan of those living in the United States has increased by 30 years, 25 of those years attributed to public health practices. We have witnessed the elimination of smallpox and polio as well as the control of measles, tetanus, and diphtheria. Improved sanitation and clean water resulted in dramatic reductions of major causes of illness and death such as typhoid and cholera. Infant mortality has decreased by 90% since 1900, and maternal mortality has decreased by 99%. The discovery of antimicrobial therapy has helped control tuberculosis and other sexually transmitted diseases. Through risk factor modification, a significant decline exists in deaths from coronary heart disease, a decline of 51% since 1972. In addition, much progress has been attained in eliminating diseases associated with nutritional deficiency. Furthermore, tobacco has been targeted as a health hazard resulting in a decrease in the prevalence of adult smokers and preventing millions of smoking related deaths (MMWR Weekly, 1999).

The millennial advancements above are often referenced as sweeping public health achievements by virtue of their interface with prevention and also for their impact on death, illness, and disability. While the term prevention is highlighted, most achievements are framed within the context of *problems, illness or death*. Framing health outcomes as a correlate to problems leaves little room for positive outcomes or optimum health in its own right. While each of the advances improved health, they are also monitored and calculated utilizing a rubric of mortality and the medical model's focus on absence of disease. What remains unclear is whether the noted achievements also increased levels of happiness, improved well-being, fulfilled life-purpose, or translated into human thriving. Historically, public health has not prioritized such notions and in essence has turned a blind eye to constructs of positive human functioning. In the medical model, measurements are directed at illness and its consequences (J. J. S. Larson, 1999), and the absence of disease is often taken to be the equivalent of health (Seligman, 2008).

Public health's sustained reliance on the medical model continues to govern public health practice today. An important shift occurred as result of the 1988 Institute of Medicine's (IOM) report, *The Future of Public Health*. Prior to the report, the purpose of public health was often viewed synonymously with its *functions,* and as a result, public health practice was typically

described and measured by its *services* (e.g. health care programs) and by its deeds rather than its intent. (Turnock, 2004).

TABLE 1:
Three Core Functions of Public Health

ASSESSMENT *(surveillance of disease/injury)*	**POLICY DEVELOPMENT**	**ASSURANCE**
Monitoring health status to identify community health problems	Informing, educating, and empowering people about health issues	Enforcing laws and regulations that protect health and ensure safety
Diagnosing and investigating health problems and health hazards in the community.	Mobilizing community partnerships to identify and solve health problems	Linking people to needed personal health services and assuring care
	Developing policies and plans that support individual and community health efforts	Guaranteeing a competent public health and personal health care work force
		Evaluating effectiveness, access, and quality of services
		Researching new insights and innovative solutions to health problems

(Turnock, 2004)

The 1988 IOM report asserted that public health was not clearly defined, adequately supported, nor fully understood (Institute of Medicine (US) Committee for the Study of the Future of,Public Health, 1988). Based on IOM recommendations, two defining clarifications soon followed and were accepted within the public health community: the *core functions* (table 1) and *essential public health services* (table 2). The core functions delineate public health's operational breadth, and the essential services explicate the core functions by providing a framework to characterize modern public health practice.

Public health's core functions are defined as assessment, policy development, and assurance (Institute of Medicine (US) Committee for the Study of the Future of,Public Health, 1988). The differentiation between three core functions helped shape the field beyond perceptions that public health is the delivery of medical services and clarified how complimentary practices are applied and delivered (e.g. surveillance, policy, collaboration, workforce development, etc). While distinctions provided elucidation about public health

function, it also had a longstanding impact on shaping future practice, research, evaluation, and funding. The quality of such longstanding impact is problematic.

The Problem with Problems

The WHOs innovative call-to-action transcended historical and deficit based approaches to health in the 1948 definition. At the time, their new *positive view of health* seemed utopian; it represented a rhetorical and radical departure from the traditional medical model (J. J. S. Larson, 1999). No doubt, there have been significant medical and public health advances in the past century, but more than sixty years later, health practices in the United States fall short of the idealistic precept, and no discernable progress exists in carrying these views to the scientific or practical realms (C. C. D. Ryff, 1998). Health continues to be framed and measured by deficit constructs (e.g. chronic ill-health, risk reduction, disease prevention). Public health, which is generally regarded as a progressive approach, continues to miss the mark; typical indices of health status focus on a disease-model orientation of problems, illness and negative concepts instead of emphasis on positive health (C. C. D. Ryff, 1998). For example, data touted as indicators of child well-being, such as the CDC's widely cited *America's Children In Brief: Key National Indicators of Well-Being, 2010* and Duke University's *Child Well-Being Index* primarily measure health problems and risk factors (Land, 2001). Furthermore, seemingly positive terms such as prevention and health promotion are invariably linked to a disease orientation; prevention typically aims to avoid *disease*, and health promotion is usually measured as a balance against health *problems*.

In so much as *form follows function*, evaluation is necessary of whether or not current public health functions are leading the field towards the potential for optimum health. Before considering the advantages of greater emphasis on holistic health and wellness, an illustration of some of the problems that are perpetuated through current practices, deficit thinking, and language is useful.

Modus Operandi--Prevention

Prevention could be viewed as the engine of public health practice. In general terms prevention is seen as a positive construct, but, by definition, it too operates from a problem-

focused approach. Public health primarily addresses *problems* through the application of preventive strategies (Turnock, 2004) and includes measures not only to prevent the occurrence of a disease but also to arrest its progress and reduce its consequences once established (Nutbeam, 1998). Prevention is rooted in a biomedical disease model of risk reduction. Risk factor and risk behavior reduction in both individual and population efforts represent a political status quo in bringing people back to 'normal life' (Tengland, 2010). The WHO defines prevention as focusing on the *cause of disease* or mental disorder. The Surgeon General defines prevention as efforts that prevent the initial onset of a mental disorder, emotional/behavioral problem, or a co-morbid disorder (Miles, Espiritu, Horen, Sebian, & & Waetzig, 2010). In public health terminology, the word "prevention" is typically framed alongside the word "disease" and synonymously attributed to affliction. Even the prevention-based concept of increasing protective factors aims to prevent *problems* at the causal level.

Critical examination of the components outlined in the three core areas reveals an overarching emphasis on health problems, issues, hazards, and health care services that impact the broader field today. In few instances where constructs for positive health are highlighted, they are easily subsumed by problem-focused thinking. For example, "empowering people" is a positive objective, but contextualizing it with the language of "about health *issues*" frames it as a negative. "Mobilizing community partnerships" is positive, but when the goal is to "solve health problems", the emphasis is on a deficit approach. A positive adaptation would language similar statements differently, for example, "empowering people towards their full health potential" or "mobilizing community partnerships to transform community health". To the degree that form follows function, something as simple as positive language could orient health thinking towards a holistic health culture.

Contextualizing public health within deficit–level constructs continues to guide the evolution of the field. The essential public health services framework, developed in 1994 by a workgroup representing national public health organizations, serves as a guide for the responsibilities of public health systems in the U.S. today. "Since 1995 virtually all national and state public health initiatives have used the essential public health services framework in efforts to characterize, measure, and improve the performance of public health core functions" (Turnock, 2004). For example, the essential services remains a guiding framework for the

National Public Health Performance Standards Program (Centers For Disease Control and Prevention, 12/9/10). As is the case with earlier examples, the essential services framework overshadows strength based constructs with deficit-based approaches. Today, the practice of public health in the U.S. is invariably tied to the essential public health services and the correlates of the three core functions (Turnock, 2004).

TABLE 2:
Ten Essential Public Health Services

1. **Monitor** health status to identify community health problems
2. **Diagnose and investigate** health problems and health hazards in the community
3. **Inform, educate**, and empower people about health issues
4. **Mobilize** community partnerships to identify and solve health problems
5. **Develop policies and plans** that support individual and community health efforts
6. **Enforce** laws and regulations that protect health and ensure safety
7. **Link** people to needed personal health services and assure the provision of health care when otherwise unavailable
8. **Assure** a competent public health and personal healthcare workforce
9. **Evaluate** effectiveness, accessibility, and quality of personal and population-based health services
10. **Research** for new insights and innovative solutions to health problems

(Turnock, 2004)

Instruments to measure health status are:

> Notably weighted on the side of physical problems (e.g. mobility, pain, fatigue, sleep disorders, symptoms), mental problems (e.g. cognitive confusion, distress, depression, anger, anxiety), social problems (e.g. role limitations, marital problems, sexual dysfunction), and deal with only limited features of daily human activities (e.g. eating, bathing, dressing, toilet activities). Moreover, the rare excursions into positive realms, such as life satisfaction, morale, happiness, and self-esteem, reveal weakly articulated conceptual and philosophical foundations of well-being (C. C. D. Ryff, 1998).

Despite attempts to move beyond problem-focused thinking, health goals, objectives and outcomes remain largely interpreted through a negative lens, an overemphasis on physical constructs, and/or reliance upon artificial dualism between mind and body. The old ways of defining and measuring health appear to be strongly in need of examination. If the field truly seeks to promote health, more interdisciplinary focus on health assets (positive constructs for health functioning) need to become more prominent and oriented toward optimum health.

Balancing the Deficit: The Promotion Solution

Health promotion has been a diffuse concept across contemporary health disciplines since the mid 1900s, but in recent years it has reached the top of the health lexicon through national and global strategies. To date, health promotion does not function in a world of its own; it too is laden with its own challenges and language issues. A deeper review of health promotion history and evolution will uncover parameters for present day limitations and doorways for an expanded role in advancing constructs for positive health and well-being.

Health Promotion Then

The origins of health promotion may have found its way into contemporary culture as early as 1959 when Halbert L. Dunn recognized the importance of lifestyle choices in promoting wellness (Kulbok, 1997), but the genesis of modern day health promotion took root in 1974 when the Canadian Minister of National Health & Welfare, Marc Lalonde introduced a working document entitled *A New Perspective on the Health of Canadians*. Now known as the Lalonde Report, this work was widely viewed as a milestone in the transformation of health thinking and was the first public governmental report anywhere to state that the health care system is not the most important factor in determining health status (Hancock, 1986). The report suggested that four health fields exist—lifestyle, environment, health care organizations, and human biology. Lalonde suggested that acknowledgment of these fields would open the way for "great potential for the prevention of disease and the promotion of health on a much broader scale than has been previously considered" (Hancock, 1986).

The United States was not far behind to acknowledge publicly the burgeoning ideology of health promotion within the context of a prevention framework. The 1979, *Healthy People* report stated that improvements to health will not be achieved by medical care alone but instead through efforts designed to prevent disease and promote health (United States Office of the Assistant Secretary for Health and,Surgeon General, 1979). Echoing the Lalonde Report, the *Healthy People* report from 30 years ago emphasized the importance of lifestyle, environmental, and biological factors and the distinction that individuals could improve their lives through lifestyle choices promoting health (United States Office of the Assistant Secretary for Health

and,Surgeon General, 1979). However, as discussed earlier, Healthy People orientation in the U.S. has since translated such emphasis through the domain of physical health predominantly. Notwithstanding, the health promotion movement had begun.

Nothing sparked more longstanding or worldwide interest in the concept than the WHO's 1st International Conference on Health Promotion held in Ottawa Canada in 1986. Health promotion as defined by the *Ottawa Charter for Health Promotion* is "the process of enabling people to increase control over and to improve their health" (Nutbeam, 1998). As a result, health promotion is characterized as a global movement to build healthy public policy, create supportive environments, and develop personal skills (World Health Organization, 2009). The Ottawa Charter shifted principles for health promotion from individual foci and behaviors to determinants of health, and for many, it became the foundation of a *new public health movement* (the subtitle of the statement itself) (de Leeuw, 2006). Building upon the WHO definition of health as a state of complete physical, mental, and social well-being, the Ottawa Charter emphasized that individuals and groups must be able to identify and realize aspirations, satisfy needs, and to change or cope with the environment. To this end, health is a *positive concept* seen as a resource for life and not as the objective of living. As a resource, health promotes the identification and realization of aspirations, the satisfaction of needs, and the ability to cope with change. Therefore, health promotion is more than the responsibility of the health care sector, but goes beyond healthy lifestyles to *well-being* (World Health Organization, 2009).

The Global View at Present

Since 1986 additional global health promotion conferences have been held in Adelaide, Sundsvall, Jakarta, Mexico, Bangkok, and Nairobi, each one building upon and refining the principles in the original Ottawa Charter. Statements and Declarations have focused on health promotion beyond the individual, disease-oriented, behavior-change model (de Leeuw, 2006). Attention is focused on cultural components, social determinants, equity, and economies. In addition, the need for local to global policy level interventions is punctuated, for example, ecological accountability and sustainable development (World Health Organization, 2009). The Bangkok Charter for Health Promotion in 2005 emphasized global health and health promotion as a vehicle for health equity.

With a positive conception of health as a value, promotion as described above often aims to empower "the worst off, giving them tools to change their lives in order to make society more egalitarian" (Tengland, 2010). The global empowerment perspective readily targets marginalized and vulnerable groups, inequality and equity, and social and economic determinants of ill health (Tengland, 2010). Health for all—a WHO term used within health promotion language—is defined as the attainment by all the people of the world of a level of health that will permit them to lead a socially and economically productive life (Nutbeam, 1998). This approach requires systemic thinking, international solidarity, and mechanisms to promote health equity, and achieving it requires addressing determinants associated with risk and threats to health with little mention of optimal health among nations.

The Parameters of Promotion

If a state of complete wellbeing is the true benchmark of health, a natural fit for achieving it would be health promotion. Yet, the world of health promotion remains riddled with conceptual barriers, a lack of positive measures for advancing the field, and a lack of emphasis on optimum health.

The Prevention-Promotion Paradox

One challenge to the field is a conceptual one: the line of demarcation between prevention and promotion often overlap and is blurry at best. From the Lalonde Report where promotion was first emphasized as a tool to promote health and prevent health problems, to more recent distinctions that promotion goes beyond the prevention of problems to include social and economic productivity and enhanced quality of life (Nutbeam, 1998), the concepts of prevention and promotion continue to be used interchangeably. Adding other terms often attributed to health promotion behavior (e.g. health habits, positive health practices, preventive health behaviors, health protective behaviors, and healthy lifestyle) only serve to compound the issue (Kulbok, 1997). According to the WHO's Health Promotion Glossary, "disease prevention is sometimes used as a complimentary term alongside health promotion" (Nutbeam, 1998). Yet there are "enormous conceptual and philosophical differences between the two" (Miles et al., 2010).

Distinguishing between prevention and promotion is sometimes difficult, especially when prevention activities focus on enhancing protective factors. Preventing problems by enhancing protective factors can simultaneously serve to promote health. In this context, health emanates from a proactive way of thinking, and prevention and promotion are viewed as companions (Johansson, Weinehall, & Emmelin, 2009). However, health promotion in the purest sense "does not consider any identified problem", whereas prevention and protective factors do (Miles et al., 2010). Discerning the differences between the two is a fundamental requirement if true health promotion efforts are going to be advanced.

In 1994, the IOM published an influential report titled *Reducing Risks for Mental Disorders: Frontiers for Prevention Intervention Research*. The report provides clarity by emphasizing that health promotion is driven by the enhancement of health and well-being whereas prevention operates from an illness model based on reducing problems, disorders and risk (Miles et al., 2010). This distinction is paramount. While working toward prevention can result in improving health through the avoidance of problems, true health promotion seeks to optimize health and the full potential for living (Breslow, 1999). Therefore, health promotion focuses on the achievement of positive health outcomes, and "can…go beyond problem reduction and work toward achieving optimal functioning (Miles et al., 2010). In 2009, the IOM added that "mental health promotion can be distinguished from prevention of mental disorders by its focus on healthy outcomes, such as competence and well-being, and that many of these outcomes are intrinsically valued in their own right" (Miles et al., 2010). Thus, in the practice of public health, advocating for policies that support autonomy, personal growth, social actualization, and life purpose reflect qualities of competence and well-being instead of a weighted focus on preventing or mitigating risk.

Measuring Up

The classic definition of prevention, rooted in the epidemiology of the natural history of disease, has strongly influenced the definition and measurement of health promotion behavior (Kulbok, 1997). Conceptualizing health promotion through the lens of prevention or in a manner short of optimum health will by default lead to measurements of health that do not emphasize positive health in its own right. This is the catch-22 staring the field of public health in the face.

While the 1979 *Healthy People Report* acknowledged a triad of national strategies for health through preventive health, health protection (e.g. immunizations, hygiene), and health promotion—disease prevention appears to remain the number one national strategy for measuring health status. Consequently, the most current *Healthy People* goals (2020) reflect this mindset (Table 3). While comprehensive and improved upon from 2010, the 2020 focus areas punctuate a disproportionate emphasis on medical constructs, disability, disease, prevention, and physical health. The impact of the Department of Health and Human Services (DHHS) *Healthy People 2020* objectives cannot be understated; they often stand as a guide and influence parallel health objectives chosen by states and municipalities.

Table 3
Health People 2020 Focus Areas

Access to Quality Health Services	*Genomics	Nutrition and Weight Status
*Adolescent Health	*Global Health	Occupational Safety and Health
Arthritis, Osteoporosis and Chronic Back Conditions	*Health Communication and Health Information Technology	*Older Adults
*Blood Disorders and Blood Safety	*Healthcare Associated Infections	Oral Health
Cancer	**Health Related Quality of Life and Well-Being	Physical Activity
Chronic Kidney Disease	Hearing and Other Sensory or Communication Disorders	*Preparedness
*Dementias, including Alzheimer's Disease	Heart Disease and Stroke	Public Health Infrastructure
Diabetes	HIV	Respiratory Disease
Disability and Secondary Conditions	Immunizations and Infectious Disease	Sexually Transmitted Diseases
*Early and Middle Childhood	Injury and Violence Prevention	*Sleep Health
Educational and Community Based Programs	**Lesbian, Gay, Bisexual, and Transgender Health	**Social Determinants of Health
Environmental Health	Maternal, Infant and Child Health	Substance Abuse
Family Planning	Medical Product Safety	Tobacco Use
Food Safety	Mental Health and Mental Disorders	Vision

***Objectives are new to 2020 Focus Areas**
****Objectives are under development**

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Despite a template steeped in deficit and biomedical thinking, two notable changes were made to 2020 goals compared to previous Healthy 2010 focus areas: one is the inclusion of

"Health Related Quality of Life and Well-Being" and the other is a focus on "Early and Middle Childhood". Identified as a topic area "under development", the explicit reference to quality of life provides a doorway into a more expansive view of health. During the next ten years Healthy People 2020 will evaluate measures for monitoring health-related quality of life and well-being (U.S. Department of Health and Human Services, 2011).

The second change worth noting is "Early and Middle Childhood". Of import is the recognition that early developmental ages are essential physical, cognitive, and social-emotional foundations for lifelong health. The words of the Surgeon General in 2000 exemplify the point:

> When we think about a healthy start, we often limit our focus to physical health…but…mental health is fundamental to overall health and well-being. And that is why we must ensure that our health system responds as readily to the needs of children's mental health as it does to their physical well-being…Fostering social and emotional health in children as a part of healthy child development must therefore be a national priority (U.S. Public Health Service, 2000).

While the constructs within 2020 objectives do not focus specifically on positive health, delineating these developmental ages is a hallmark for the field of public health in America. The aforementioned two new focus areas are (in the grand scheme of things) small but significant steps towards orienting health consciousness unto a wellness paradigm.

An important determinant of how we look at health promotion [and measures of health] is the way health is defined (Green, 1988). The WHO definition of health has been criticized throughout the years for a variety of reasons, one being that a broad approach to health creates problems for measuring "complete" well-being. Traditionally, epidemiologists have not studied the positive end of the health spectrum extensively (Mackenbach, 1994). Early and prevalent opposition to the definition changed over time as its 'ideal' aspects seemed more measurable (J. J. S. Larson, 1999). In as much, the WHO definition ultimately led to some new measures reflecting the paradigm (Sheldon Greenfield & Nelson, 1992).

Part of the reason for wider acceptance was the implementation of large health studies (e.g. RAND Health Insurance Experiment) which utilized the WHO definition to measure health status. As a result, new physical, mental and social constructs became available and paved the way for developing more practical norms for social and mental wellbeing. The WHO definition prompted medical practice to treat individuals as social beings whose health is affected by social behavior and interaction (J. J. S. Larson, 1999). In recent years there has been more willingness

by physicians and policy makers to expand the range of indicators of health. Going beyond traditional clinical indexes has opened the door for additional variables for emotional health, social interaction, and cognitive function (Epstein, 1990). Subjective indexes can provide important health information that may not be evident from physiologic measurements and at times may be more reliable than the clinical, biochemical, or physiologic indexes on which doctors have traditionally relied (Epstein, 1990).

Simple and health promoting changes to markers for well-being have the potential to shape health culture, ideology and scope of practice towards optimal health, but doing so will require embedding positive concepts into current public health practices. Balancing physical constructs with measures of well-being provide a more holistic assessment of individual health. Wellness signifies positive characteristics such as positive functioning (strengths), positive emotions, and positive social interactions (Schueller, 2009). Interpreting health positively encompasses "diverse aspects of *flourishing*, such as leading a meaningful and purposeful life as well as having quality ties to others and how these core features of the well-lived life affect biology" (C. C. D. Ryff, 2000). Flourishing is defined as a state in which an individual feels positive emotion towards life and is functioning well both psychologically and socially (Keyes, 2003). From a multidimensional perspective, physiological substrates of "positive states of mind" constitute key future directions for explication of mechanisms that underlie positive human health (C. C. D. Ryff, 1998).

Within the past 20 years, the burgeoning field of positive psychology has advanced constructs for measuring positive health and well-being. Indicators are both subjective and objective. Subjective evaluations for well-being rely on both cognitive and affective measures. Cognitive measures of well-being are reflective and can contain evaluations across many social ecological domains including work, family, one's community as well as individual assessments of life satisfaction and contentment. Affective measures reveal that individuals scoring high in well-being demonstrate a high amount of positive affect (and low levels of negative affect). Affective measures of well-being are important markers for positive emotion, which can be an indicator of success, and as well as lead to better social, occupational, and physical functioning (Schueller, 2009). (Schueller, 2009)

On the other hand, objective measures of well-being center on the content of a person's life versus subjective evaluations and include education, literacy, life span, and resources (e.g. income) (Schueller, 2009). To date, public health has been less focused on advancing subjective measures for positive health, but the field has been a leading force in advancing objective measures of well-being associated with physical health (e.g. healthy diet, physical activity, personal hygiene, etc) (Tang, 2005) On the other hand, when it comes to social determinants, focus typically goes to social inequalities in the population (e.g. education, income, poor housing, unhealthy air quality, health insurance coverage) as a foundation for reducing health disparities (Centers for Disease Control and Prevention, 2011). Such efforts are applaudable and remain an essential foundation for public health, but within such an equation (e.g. inequalities and disparities) is there room for positive health? The founder of salutogenesis, Aaron Antonovsky, would encourage us to organize efforts around the "salutogenic" question of *what creates health* and the search for the *origin of health* rather than to look for the causes of disease in the pathogenic direction (Lindstrom, 2006). In salutogenic terms, regardless of what point a person (or a community) is situated on the healthy/dis-ease continuum, the basis for all health promotion, action and research should be to focus on life-giving or salutary factors that move in the direction of positive health (Antonovsky, 1996).

Positive measures can also cross into and infuse with current biomedical practices. A combination of three independent variables—subjective, biological, and functional—were proposed by Martin Seligman, former president of the American Psychological Association, in 2008 to predict health targets associated with longevity, health costs, mental health and prognosis. The variables could be used to advance the global notion of positive health while simultaneously studying medical disorders. Such strategies would raise interdisciplinary awareness while supporting research associated with positive constructs. Subjective measures specify when a person feels "great" and are defined by high end measures of several psychological states (e.g. positive physical well-being, vitality, absence of bothersome symptoms, sense of durability, internal health-related locus of control, optimism, high life satisfaction, positive emotion). Biological measures include the positive ends of physiological and anatomical structure distributions (e.g. body mass index, blood pressure, temperature, pulse rate, complete blood count, liver function). Functional measures interpret how well an individual

functions (speed of gait, choice reaction time, positive physical demands of one's chosen lifestyle: work, love and play). The importance of the aforementioned measures would serve to strengthen the need for collaboration across the often compartmentalized fields of physical and mental health by measuring targets of high positive physical health and high positive mental health (Seligman, 2008)

In addition to the necessity of positive measures, forwarding the notion of health promotion also requires a more thorough review of what optimal health is. The natural framework for true health promotion is a wellness paradigm because it is based on positive adaptation.

Optimal Health:
Conceptualizing Health Promotion through a Wellness Paradigm

Reordering health consciousness towards the positive moves us closer to the question, "*What is the potential for health*?". By virtue, health promotion efforts to this end move us beyond status quo functioning or ordinary productivity and aim for thriving people in thriving communities. The concept of flourishing exemplifies the point. Flourishing individuals have excellent emotional health, miss fewer days from work, and have few physical limitations in their daily lives (Keyes, 2003).

Positive adaptation does not stop at the individual but extends towards positive institutions and community wellness. At the group or community level, positive adaptations centralize around civic virtues and the institutions that move individuals towards better citizenship: responsibility, nurturance, altruism, civility, moderation, tolerance and work ethic (Csikszentmihalyi, 2000). From the perspective of community health, even if we were to succeed at getting rid of all chronic diseases and socially disabling conditions (e.g. racism, sexism), we would still only be at zero. A positive adaptation challenges institutions to orient mission and vision around the question "*What will take human beings <u>above</u> zero*?"

Positive Health

Similar to the origins of health promotion in the mid 1900s, positive health emerged as an idea through pioneering work of early psychologists (Rogers, Maslow, Johoda, Erikson, etc) during the same time period (Seligman, 2005). Within the past 15 years, the concept of positive

health emerged as a viable and empirically validated branch of psychology. The term *positive health* is often used synonymously with *positive psychology*, and its recent popularity results from a restorative approach to correct the field's historical fascination with the pathological end of the psychological spectrum (Lent, 2004). Positive psychology is oriented towards positive human functioning, scientific understanding, effective interventions, and is focused on thriving individuals, families and communities (Csikszentmihalyi, 2000).

Positive health includes both mental and physical components and the ways they influence each other (C. C. D. Ryff, 1998). To underscore the point, positive health is wholly incongruent with mind-body dualism. Furthermore, since positive health is a function of human potential, it is best construed as a "multidimensional dynamic process rather than a discrete end state" (C. C. D. Ryff, 1998). As a holistic concept, its emphasis is on living a good life and on life-expression across multiple domains of existence (C. C. D. Ryff, 1998). Positive health and positive psychology provide a necessary and solid foundation for true health promotion efforts oriented towards wellness.

Well-being:

When the WHO definition of health was introduced, it highlighted well-being without furthering the notion of what well-being meant. However, in the 1960s empirical research led to greater and more widely accepted definitions of well-being. As a result, two parallel concepts emerged—hedonic and eudaimonic well-being (C. C. D. Ryff, 2004). Distinction between the two concepts is integral to the advancement of a wellness paradigm.

> ***Hedonic well being*** is rooted in the notion of pleasure and refers to emotional well-being, including an individual's level of happiness and satisfaction with life (Public Health Agency of Canada, 2011). Accordingly, its focus is on the experience of pleasant feelings or on the balance between positive and negative effect (Lent, 2004).
>
> ***Eudaimonic well being*** is more than personal happiness but is characterized by the quest to actualize the human potential and to realize one's true nature (Lent, 2004). In this sense, it is related to the idea of functioning in life or personal engagement and growth [and] it refers to an individual's ability to participate in activities for their intrinsic value and to foster positive relations with others (Public Health Agency of Canada, 2011)

In the simplest of terms, the notion of *the good life* is considered eudaimonic versus the hedonic notion of just *feeling good* (Lent, 2004). Each view, while having different philosophical foundations, remains an important reference for well-being and is perfectly situated towards measuring a positive health orientation.

The influence of positive frameworks for health are emergent across multiple disciplines and professions. In 2008, an initiative supported by the Robert Wood Johnson Foundation embraced "good health in its own right" (Peterson, October, 2010). An interdisciplinary team comprised of public health, cardiology, psychiatry, psychology, epidemiology, exercise, and science fields are presently studying "health assets" rather than focusing on prevention, diagnosis, and the treatment of disease. The project aims to identify positive health approaches to enhance overall well-being (Robert Wood Johnson Foundation, 2011).

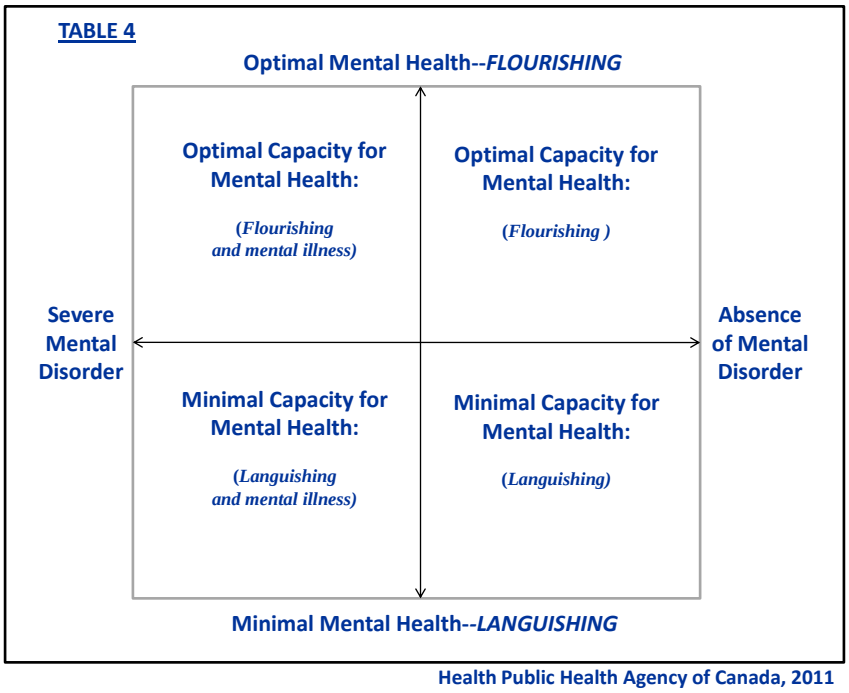
The concept of positive health and optimum functioning is making inroads into health promotion strategies around the globe, especially with regard to mental health promotion. New promotional perspectives are central to efforts in places like Australia, New Zealand, and Canada (Miles et al., 2010). For example, consider recent innovations from the *Public Health Agency of Canada* to establish national, operational concepts for positive mental health, out of which they developed two definitions:

> Mental health is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality.
>
> Mental health is the capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity (Public Health Agency of Canada, 2011).

The definitions above cut through the confusion of overlapping and competing definitions of mental health and were chosen by virtue of having at least one validated instrument to measure positive mental health nationally (Public Health Agency of Canada, 2011). Furthermore, Canada adopted a two-continuum model of mental health and mental disorder (Table 4), rejecting the traditional view that mental health and mental illness exist as

opposite end points on a single continuum (Public Health Agency of Canada, 2011). The distinction between two continua is fundamental to orienting health concepts towards optimum functioning. On the *mental health continuum*, the two endpoints represent optimal mental health and poor mental health. On the *mental disorder continuum*, one end point represents extreme severity of symptoms of mental illness and the other complete absence and no mental disorder.

(Public Health Agency of Canada, 2011)



A dual continuum transcends the traditional linear view and frames mental health independently from mental illness. In addition, the two continuum model delineates how it is possible for optimum mental health to exist while simultaneously experiencing mental illness. The two continuum model for positive mental health is an excellent framework for structuring positive health in general. With a wellness paradigm optimum health is a progression towards higher levels of functioning. Health and illness are not mere opposites upon a linear continuum but can exist simultaneously. For example, poor health can exist without the presence of disease, or some diseases can be experienced and a person remains healthy (J. J. S. Larson, 1999).

Consider young Cody McCasland, a boy born with Sacral Agenesis, a rare condition which caused deformities to his spine while in the womb. At 15 months he had both legs amputated. Six years later (photo below), Cody is the epitome of wellness and thriving. Wellness is always a positive state and illness a negative state (Greenberg, 1985). One could be tempted to frame Cody's health status negatively. Doctors warned Cody's parents that he might not live due to the many complications that accompany his condition including kidney problems. At age seven, Cody had undergone 15 surgeries including a dislocated hip; stomach, gall bladder and intestinal problems; and a hernia. In addition, Cody suffers from breathing difficulties and asthma. Yet, within his physical limitations, Cody is healthy and leads a quality life. Cody takes part in class activities with other children, he is an inspiration to other amputee children and soldiers, and he is a boy scout **(social health)**; he is an dynamic optimist and has health-oriented goals **(emotional and mental health)**; he raises money for the Challenge Athletes Foundation to help disabled athletes, and he spreads the message that disabilities don't need to equal a sedentary life **(spiritual health—life as meaning)**; and Cody runs, swims and rock climbs; plays soccer, golf, and ice hockey; and practices karate **(physical health)** (Daily Mail Reporter, 2009). As a double amputee, Cody did not become depressed, angry, or isolated; rather, from a holistic perspective his health potential is enhanced and integrated: Cody is thriving and well despite the appearance of physical illness.

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At this point the question could be raised, "*How can we translate an individual experience such as Cody's into population-centered (positive) public health?"* The answer is not easily derived, yet the paragons of positive health and well-being envisage the potential for community-level wellness. "The path…for medicine and public health inevitably lies largely in reorienting a substantial amount of interest and energy toward raising the general levels of wellness among all peoples." (Dunn, 1959). In turn, community wellness should strive to

balance the promotion of individual wellness with the collective goals of the community (Schueller, 2009).

A return to the salutogenic concept helps contextualize positive health at both an individual and community level. Antonovsky's health promoting model of salutogenesis is based on the premise that chaos and stress are problematic negative events in the lives of *all* people. Through a construct known as *generalized resistance resources* (GRRs), individuals (families, communities, etc.) have the potential to deal with the inevitability of life stressors and challenges to a greater degree. GRRs are biological, material, and psychosocial factors and can include knowledge, experience, self-esteem, healthy behavior, commitment, social support, cultural capital, intelligence, traditions, money, or view of life (Lindstrom, 2006). However, the ability for people to use GRRs to construct coherent life experiences is more important than the resources themselves. GRRs lead to a strong *sense of coherence* (SOC)—an "orientation toward the world which perceives it…as comprehensible, manageable, and meaningful" (Antonovsky, 1996). A strong SOC is a significant factor in moving one towards health and is the "capability to perceive that one can manage in any situation independent of whatever is happening in life" (Lindstrom, 2006). For example, when communities or individuals with a strong SOC are confronted with a stressor they will (1) wish to or be motivated to cope (meaningful); (2) believe that the challenge is understood (comprehensible); and (3) believe that resources to cope are available (manageability) (Antonovsky, 1996). The combination of cognitive, behavioral, and motivational elements are universal and add merit to salutogenesis as a model transcendent of culture-bound constructs.

Coherence remains an important concept for health promotion and community wellness because it supports concepts embedded in the Ottawa Charter of 1986 which states that health promotion is a process which enables people to gain control over their health determinants to improve health and thereby live an active and productive life (World Health Organization, 2009). From the perspective of positive health, the Ottawa definition can be viewed in three stages. First, recognize the background (the determinants); second, set the objective (live an active and productive life); and third, engage the activity (the enabling process) "where the determinants are used to reach the objective in a dialectic relationship between people, the setting, and the enablers (Lindstrom, 2006). Similarly, the salutogenic framework focuses on three facets: (1)

the focus is on problem solving/finding solutions; (2) it identifies GRRs to help people move in the direction of positive health; and (3) it "identifies a global and pervasive sense in individuals, groups, populations, or systems that serves as the overall…capacity for…coherence" (Lindstrom, 2006). Salutogenic thinking is a powerful framework for exploring how individuals or groups can rise above life's circumstances and thrive towards the positive end of the health continuum regardless of life's circumstance.

Research has demonstrated that a relationship exists between SOC and self-rated health, health behaviors, psychological distress, sickness absence, mental and physical symptoms, subjective well-being and happiness, and self esteem(Volanen, 2004). In addition, among men and women, psycho-emotional resources (e.g. strong social relationships and support, childhood living conditions) as opposed to socio-economic circumstances have been shown to correlate with SOC (Volanen, 2004). SOC is strongly associated to positive subjective states of health, especially mental health, and is a health promoting resource which serves to strengthen resilience (Eriksson, 2006).

Salutogenesis is an important approach for health promotion, a wellness orientation, and public health research. Since wellness is a progression and not an end in itself, a wellness framework encompasses the ability for human thriving, living life fully (Haight, Barba, Tesh, & Courts, 2002), and leading a life of purpose (C. C. D. Ryff, 1998). While the positive end of thriving is akin to Maslow's pinnacle self-actualization concept (peak experiences) (Haight et al., 2002), thriving also encompasses the effective mobilization of individual and social resources in response to risk or threat leading to positive mental, physical, and/or social outcomes—not just a return to equilibrium, but orientation towards thriving (Ickovics, 1998). Framed like this, wellness and thriving *are* the modality and *become* the construct. Health promotion is focused on positive adaptation compared to a primary focus on thwarting or mitigating disability or disease. The Ottawa Charter identified holism as an essential issue in developing strategies for health promotion (World Health Organization, 2009). The wellness model orients life toward holistic and multidimensional levels of being. Health promotion needs to be oriented towards wellness and positive health if the goal to help individuals and communities reach their true and full potential will be actualized.

Reclaiming the Spirit

Among holistic health concepts spiritual health repeatedly emerges but remains the least understood and most elusive, fractionated, and subordinate within public health and American society. Yet special attention to spiritual health is important for three reasons. First, there is increasing evidence of the important role spiritual health plays in overall health; second, spiritual health is so rarely seen as a valid health measure; and third, when spiritual health is recognized it is often arbitrarily and incorrectly embedded within the sphere of social health.

Across many different fields of inquiry there is growing recognition that spirituality—broadly defined as a concern for the meaning and purpose of life—is a fundamental part of the human condition (Pink, 2005). Developing a deep understanding of the purpose and meaning in life supports all aspects of physical and emotional health (Duke Integrative Medicine, 2009). For some, spiritual health is a belief in a unifying force; for some, nature; for others scientific laws; and for others a godlike force (Greenberg, 1985).

Defined by the Bravewell Collaborative and other integrative medicine frameworks, health equates to the fulfillment of the needs of mind, body and spirit (The Bravewell Collaborative, 2010b). The 6th Global Conference on Health Promotion in Bangkok (2005) included the following in their charter: "health promotion…offers a positive and inclusive concept of health…encompassing mental and spiritual well-being" (World Health Organization, 2009). Duke University incorporates spirituality into their wheel of health as one of seven fundamental spokes (Duke Integrative Medicine, 2009). Clinical psychology reports that spiritual values have a definitive influence upon mental well-being (J. J. S. Larson, 1996), and there is now substantial literature connecting spirituality to physical health (Hill, 2003). Referring again to Dunn, wellness and optimal health do not exist independent from spiritual health. "No person can be well physically if he is sick spiritually…if we are to move in the direction of high level wellness for man and society, we cannot ignore the spirit of man in any discipline" (Dunn, 1959).

Despite language espousing the value of spirituality, "systematic reviews of empirical literature indicate that religion and spirituality are understudied variables in health-related research in a number of disciplines" (Hill, 2003). "Western biomedicine, of which epidemiology is part, is still wrestling with a body-mind dualism that defies consensus; thus, for most

epidemiologists any resolution of a body-mind-spirit pluralism is simply beyond consideration" (Levin, 1994). A lack of spiritual inquiry stems from at least two basic assumptions: spirituality *cannot* be studied scientifically, and/or spirituality *should not* be studied scientifically—neither of which is scientifically sound. Since the 1990s, the quantity and methodological quality of research has improved, and a wide range of psychometrically sound instruments are available for measuring spiritual/religious variables. In addition, research into spiritual territory often relies upon subjective variables making replication and observation difficult. In the eyes of some scientists the subjectivity of the unseen (spirit) equates to ineffable evidence; however, this stance is a philosophical one and does not negate qualitatively derived and meaningful research (Miller, 2003).

The topic of spirituality/religion and measures for operationalizing concepts are broader and deeper than this paper affords, but some attention to spiritually/religion is essential. Less emphasis is placed on distinguishing spirituality from religion (although a distinction does exist); moreover, it is more important to briefly underscore the positive impact that spirituality/religion has upon health. Religion has been shown to reduce the likelihood of disease and disability and increase perceptions of health, energy and vitality (George, 2000). Individuals with an intrinsic religious orientation have been associated with better mental health, including self-esteem, life meaning, family relations, a sense of well-being, and lower alcohol and drug use. (Hill, 2003) Studies have demonstrated that religion is associated with improved recovery from physical and mental illness and is strongly related to longevity (George, 2000).

The National Institute of Healthcare Reform emphasizes that central to both spirituality and religion is the *search* for the *sacred*. "Search" equates to identifying, articulating, knowing, understanding, and embodying; and "sacred" refers to divine being, higher power, or ultimate reality (George, 2000). A number of mechanisms exist connecting spiritual striving to wellness. Spiritual strivings liken to empowerment, perseverance and provide stability, support and direction during critical times. Studies have demonstrated a relationship between spiritual striving and a greater purpose in life, better life satisfaction, higher levels of well-being, and less conflict among goals (Hill, 2003).

Establishing spirituality as an independent construct like physical and mental health is an integral component to a holistic paradigm based on wellness. Lumping spiritual health into a social index is insufficient and inaccurate; spirituality's unique emphasis on the sacred is a clear distinction between other social and personal phenomena (George, 2000). Evidence has demonstrated that spirituality and religion are distinctive dimensions (from other psychological and social constructs) that add unique explanatory power to predict mental and physical health (Hill, 2003).

DISCUSSION

Within the past 100 years, the public health system in the U.S. has been responsible for helping the population achieve improved physical health outcomes by addressing sanitary conditions, fighting infectious diseases, and improving individual health behaviors. In addition, public health infrastructure has adapted to improve health systems in the past 25 years by clearly defining core functions and essential services within a broad and varied field. Disease prevention continues to govern ideological thinking and scope of public health practice as the majority of targeted health interventions in the U.S. aim to prevent or mitigate risks associated with health problems. Health promotion activities are becoming more prominent but are invariably coupled with prevention.

Based on a review of the literature, he value of a positive and holistic approach towards health functioning is essential for many reasons. First, even with a robust list of millennial health achievements associated with reduced disease and mitigated health threats, little is known about whether or not Americans are happier or living lives of greater purpose in association with noted health advancements. How have the millennial advancements improved individual and collective well-being or spiritual uplift? Taking whole health into account references inextricable, mutual, and multiple dimensions of existence.

Secondly, measuring positive aspects of whole health identifies qualities of living otherwise left ambiguous but none-the-less indispensible to human potential. The field of positive psychology has recently begun to raise the eyebrows of academics around the globe with concepts and constructs associated with quality of life, hardiness, optimism, a well-lived life, and

flourishing. A new field of empirical research and scientific inquiry is becoming both tenable and fundable.

Third, by viewing health positively and holistically, health becomes a function of *what is possible* instead of mere functioning. A dual continuum for health punctuates the concept that it is possible to flourish regardless of where one falls on the continuum. Having a physical limitation or mental disorder is not indicative of ill-health per se; individuals can flourish across multiple spheres of *being* and adjust to increased levels of wellness regardless of a seeming handicap. The value of a positive orientation places emphasis on health as opposed to dysfunction.

Lastly, positive health and holistic health are values. Public health has inadvertently valued physical health and health problems above other dimensions. A positive health orientation flips the paradigm towards health assets and health potential. "The dictionary defines values as '*social principles, goals, or standards held or accepted by an individual, class, or society*" (Scales & Leffert, 2004). Values are the guideposts that individuals internalize to create a framework for their thinking and their behavior; values are the context that creates possibilities (Scales & Leffert, 2004). As demonstrated by the salutogenic approach, positive values can promote health at the individual, institutional, and community level.

Implications for Leadership

The field of public health is known for leading health advances. In fact, some people consider contemporary public health practice to be in a third generational revolution. The first revolution addressed sanitary conditions and the second addressed individual behaviors, communicable diseases, and premature death. The third revolution, on the other hand, recognizes health as a key dimension of quality of life (Kickbusch, 2003). At present, a third revolution is in its infancy, and the 21st century is an open field. Determinants of health remain a central component to public health strategies. At the same time, emphasis upon the analytical dimensions of population health research need to be coupled by the cumulative experience of health promotion practice (Kickbusch, 2003). From the perspective of leadership, positive health remains a burgeoning concept correlating with 21st century health innovation.

Health promotion has earned a foothold in public health thinking in recent decades, but *positive* health promotion as referenced from the literature reveals an approach to health unparalleled in previous generations. Were public health to adapt to a positive and holistic health orientation the quality of public health would not only be augmented but the field could also pioneer new avenues for integrating disciplines and advancing new constructs for measuring health status. Such an approach would be transformational, to say the least.

To advance positive health, public health needs transformational leaders. Leadership [in the 21st century] requires making adjustments to our values, thinking and priorities; a willingness to accommodate new realities; and taking advantage of emerging opportunities (Williams, 2005). As previously discussed, *traditional* health promotion sometimes leans toward disease prevention and sometimes leans toward health protection without steadfast orientation in any one direction. To advance and integrate a positive health agenda, leaders will need to transform traditional public health views by challenging status quo thinking and explore new ways to integrate positive constructs into deeply engrained risk-focused ones. Transformational leaders will need to wear the banner of positive health promotion in order to educate and inform health professionals and the population about advances in positive health functioning. A positive health orientation naturally embraces holistic health. As pointed out in the literature, traditional practices gravitate towards physical constructs and biomedical thinking, and health disciplines tend to function in silos. Transformational leadership is an essential component to enhancing collaboration between fragmented health sectors, communities, and eliciting support for often neglected health domains such as spirituality and the true integration of disciplines.

Furthermore, influencing the scope of public health practice towards a positive and holistic orientation will require understanding complex problems and systems thinking. Positive health is not a silver bullet, and it would be false to assume that positive constructs alone will solve the world's health problems. But new and empirical research is demonstrating positive health equates to improved health outcomes and to that end remains a promising concept. A balanced approach yields wisdom. Scientists have begun asking questions like:

- Does positive health extend lifespan?
- Is health care expenditure lower for people with positive health?
- Do people in positive health have a better prognosis when illness finally strikes?

- Does positive health associate with better mental health and less mental illness? (Seligman, 2006)

Questions, as posed above, should not be left to scientists and researchers alone, but need be asked by leaders across various health disciplines seeking to improve health outcomes of individuals and communities alike. Perhaps, through the initiation of new questions, ideas, research, and health activities grounded in the whole person and optimal functioning, new future-oriented solutions will be realized that otherwise would remain clouded by health problems and outmoded practices. Poignant and timeless, the father of the wellness movement, Halbert Dunn, wrote the following in 1959:

> To most of us, this concept of positive health is 'seen through a glass darkly,' because our eyes have been so long turned in a different direction, concentrating fixedly on disease and death. When we take time to turn our gaze in the opposite direction, focusing it intently on the condition of good health, we see that wellness is not just a single amorphous condition, but rather that it is a complex state made up of overlapping levels of wellness. As we come to know how to recognize these levels objectively, more or less as we now diagnose one disease from the other, we will realize that the state of being well is not a relatively flat, uninteresting area of "unsickness" but is rather a fascinating and ever-changing panorama of life itself, inviting exploration of its every dimension (Dunn, 1959).

American health culture has not fully embodied the ideals Dunn proposed 50 years ago; yet his innovative perspective is an invitation for a visionary approach to public health today. Such a transformational perspective yields calls for political will and a long-range view.

CONCLUSIONS / RECOMMENDATIONS

Once, a man found Mulla Nasruddin searching for something on the ground outside of his house. On being asked, Nasrudden replied that he was looking for his key. The man also joined in the search and in due course asked Mulla, "Where exactly did you drop it?" Mulla answered, "In my house." "Then why are looking here?" the man asked. "There is more light here than in my house," replied Mulla. *-Sufi Parable*

Sometimes it feels as if the field of public health functions much like Mulla searching for his keys outside because it is easier. Public health seeks to enhance health, yet rarely does it focus on measuring optimal health across multidimensional domains. Public health could both supplement and advance its search if it were to devote anywhere near as much time to positive health as it does to health problems.

In November 2010, the DHHS published a forum document, *Priority Areas for Improvement in Public Health*, with the primary objective to identify ways to improve public health quality. In turn, *quality* in public health is defined as the degree to which policies, programs, services and research for the population *increase desired health outcomes* and conditions in which the population can be healthy (Honore & Scott, 2010). Central to the document is the notion that public health quality will help all people reach their *full potential for health*. Ironically, holistic health, positive health, and positive constructs did not find their way into the final document. Health promotion was referenced, but there was no reference about how promotion should be interpreted or applied. Based on the literature, the following summary recommendations enhance notable gaps in both the DHHS quality improvement document and in the field of public health in general.

I. Advance a definition of health that includes "whole" health across multiple health domains

The WHO definition of health served the scope of public health practice for 63 years, advanced measures into social spheres for health, and framed health in a positive light. Yet despite *referencing* well-being, the WHO definition *does not define* well-being. Definitions of health and their operationalization have the potential to shape research, surveillance, policy, program development, the delivery of services, and the design and implementation of health promotion activities (Public Health Agency of Canada, 2011) Public health quality will be improved and the field advanced if (1) health domains are

expanded to include a multidimensional framework, and (2) well-being is clearly defined to include the potential for optimum health.

- **Recommendation:**
  The United States Department of Health and Human Services and the Institute of Medicine would benefit by a national and guiding definition for health reflective of the "whole" person and not limited to the World Health Organization's concept of physical, mental and social well-being alone. Holistic health is multidimensional and should include at minimum physical, mental, emotional, social, and spiritual domains of functioning.

- **Recommendation:**
  The United States Department of Health and Human Services and the Institute of Medicine would benefit by developing a national and guiding definition of "well-being" with clearly defined concepts punctuating human health potential focused on optimum health.

II. Advance a model of true integration of health disciplines

The full scope of public health requires a broad and connected interdisciplinary approach. Public health quality will be improved by authentic linkages and collaborative research to integrate a pluralist notion of health across the full spectrum of health domains. The 1988 IOM Report addressed fragmentation between the public health and mental health fields but did not address additional health domains. The field of positive psychology is advancing a positive health agenda without significant collaboration with public health (in the U.S.). Spirituality as a domain of health functioning continues to remain overshadowed by physical and mental health.

- **Recommendation**:
  The Secretary of Health and Human Services in collaboration with the Institute of Medicine would benefit by promoting knowledge development, policy planning, and collaborative research with disciplines representing multidimensional health domains including public health, medical science, social science, positive psychology, integrative medicine, community psychology, religion and spirituality.

III. Advance health promotion within a positive health context

To enhance optimum health and improve life quality, health promotion efforts need to focus on positive health. Distinguishing between prevention and promotion will improve public health quality by providing clarity between terms that are often used interchangeably. Clarification between the two concepts will assist in forwarding

positive measures and will advance the field of positive health and wellness as well as enhance prevention efforts aimed at preventing and mitigating risk. "As a side effect of studying positive human traits, science will learn how to buffer against and prevent mental, as well as some physical, illnesses (Seligman).

- **Recommendation**:
  The United States Department of Health and Human Services would benefit by setting clear conceptual distinctions between disease prevention and health promotion to the extent that (a) disease prevention works to minimize health problems and is assessed through the measurement of health issues, risk, and problems, and (b) health promotion involves optimizing health to improve the quality of life and is assessed through the measurement of positive health.

- **Recommendation**
  The National Prevention, Health Promotion, and Public Health Council would benefit by including in its annual report to Congress the conceptual differentiations between prevention and health promotion.

IV. Advance a dual continuum model for health similar to the one adopted by Public Health Agency of Canada for positive mental health

Placing health on a dual continuum reinforces the notion that health does not exist linearly between death and optimum health. Rather, it is possible to have illness but achieve well-being and optimal health across multiple health domains. A dual continuum will advance public health quality by orienting health consciousness towards well-being and a logical construct for health potential. While the Canadian model specifically references mental health, a similar model could be construed that models health holistically demonstrating levels of flourishing or languishing across physical, mental, emotional, spiritual and social substrates of health.

- **Recommendation**
  The United States Department of Health and Human Services in collaboration with the Institute of Medicine would benefit by developing a dual continuum model integrating whole health and demonstrating an orientation towards optimum health.

- **Recommendation**
  The National Prevention, Health Promotion, and Public Health Council would benefit by explicitly addressing positive human functioning as a value base and promote the possibility for human thriving across the continuum of health at all developmental ages.

V. Advance positive constructs to measure well-being

A broad and current gap exists in positive measures for health at the national level which would, if assessed, would contribute to measuring, reporting, and enhancing population health information and enhance public health quality improvement. Healthy People 2020 focus areas include the evaluation of health related quality of life and well-being measures. To this end, additional life satisfaction indexes utilized by other nations (e.g. Canada, Australia, Ireland, Britain) are in use and available for replication. Waiting until 2020 (*as referenced in Healthy People 2020*) to assess measures for well-being only delays the advancement of existing, validated constructs which could be employed to measure national well-being in the U.S. Positive constructs would serve public health quality by providing enhanced, quantitative, qualitative, and positive measures of well-being associated with physical, mental, emotional, and spiritual dimensions of health across the social ecological spectrum. An emphasis at the community level to gather asset-based information would also help balance an overreliance on "needs" while supporting positive health and natural supports as resources. [Refer to *Appendix A* for examples of measuring positive health across the social-ecological spectrum.]

- **Recommendation**
  The United States Department of Health and Human Services in collaboration with the Centers for Disease Control and Prevention and the National Public Health Performance Standards Program would benefit by implementing a national well-being survey utilizing existing constructs utilized by other nations.

VI. Advance public health learning to include positive health models and constructs across public health agencies and leadership institutions

According to public health's core functions, a competent workforce is central to *assurance*, effective policies and plans that support individual and community health are central to *policy development*, and monitoring health status is central to the *assessment* process. In order to build upon an existing knowledge base and improve the scope of public health through its "third revolution", public health practitioners need to be trained in innovative and validated concepts. Positive health promotion remains poised to carry the field into new areas of information, financing, partnership, and policies; and thus remains a valid model for educational purposes.

- **Recommendation**
  The American Public Health Association, the Association of Schools of Public Health, and the National Association of County and City Health Officials would benefit by including positive health promotion, holistic health, and optimal health models as components of training, leadership, and workforce development.

The concept of well-being has appeared in routine health dialogue for more than six decades, but public health practice and health culture have not embraced the notion wholly. Public health could do so, but innovations and conceptual interpretations of health would need to translate throughout core ideologies and scope of practice. As an interdisciplinary field, the transition would not need to be difficult since public health is positioned to work with partners from numerous disciplines. From a policy level, leadership could further the notion simply by emphasizing existing literature, research, and constructs; and examples from disciplines that emphasize and promote positive and holistic health.

Public health has been in the forefront of revolutionary health change for centuries. Health historians sometimes correlate the 19th century with the identification of disease, the 20th century with the treatment of disease, and the 21st century with the prevention of disease. Yet, holding disease prevention as the millennial hallmark for health advancement in the 21st century could be considered outmoded if positive health promotion were to take hold. From the perspective of innovation and leadership, the field of public health has the opportunity to advance the concept of positive and optimum health potential through true health promotion efforts. Such an orientation could very well pave the way for a century of human flourishing and public thriving.

[end]

Appendix A:

Examples for measuring health across the social ecological spectrum

Individual and Family Domains

- ***Thriving Indicators Project*:** The Search Institute developed a list of 15 thriving indicators (constructive behaviors, postures, commitments) that societies value and youth need. Building upon positives assets versus negative ones, thriving indicators. Measures include positive emotionality, hopeful purpose, spiritual development, school supports, etc. (Search Institute, 2010)
- ***40 Developmental Assets***: Studies of more than 2.2 million young people demonstrate that the more assets a youth has the less likely they are to engage in risk behavior. The 40 developmental profile is a framework built on 20 internal assets and 20 external assets. Embedded in the Developmental Assets model is the notion that all people need to be asset champions (in youth's lives)—not just parents; this includes youth themselves as well as the whole community (Search Institute, 2011)

Network and Community Domains

- ***Asset Based Community Development*** (ABCD): ABCD is an asset-based approach towards building community capacity, participatory research, student leadership, and asset mapping tools (Asset-Based Community Development Institute, 2009).
- ***Asset Mapping:*** Community mobilizing utilizes resources, skills, and talents of individuals, associations and organizations to map a broad range of asset-based categories in the community to mobilize health and social cohesion. Categories include assets of individuals, associations, organizations, the physical assets in community (built environment), economic assets, and culture assets. Tools available through I&DEA. (Improvement and Development Agency's Healthy Communities Programme, 2010).
- ***Mobilizing for Action through Planning and Partnerships*** (MAPP): Community assessments are part of the National Association of County and City Health Officials's (NACCHO) MAPP process. The *Community Themes and Strengths Assessment* is an asset based tool for data gathering relative to community-based strengths (NACCHO, 2011)
- ***Community Capitals Framework (CCF):*** The CCF is a approach to analyze how communities work and revolve around three core themes: vital economy, social inclusion, and healthy ecosystem. The framework is oriented around seven capitals for building community assets. The capitals are as follows: built, financial, political, social, human, cultural, and natural (Iowa State University: Department of Sociology).

Policy

- ***National Wellness Index***: The Public Health Agency of Canada has identified almost 50 instruments for measuring positive mental health. Due to the increased need for a national wellness index in the U.S., the full list is detailed below (Public Health Agency of Canada, 2011)

  ***Instruments used in Canadian Community Health Survey* (CCHS)**
  1. Psychological Well Being Manifestation Scale (WBMS)
  2. Quality of Life
  3. Life Satisfaction Question (0-10 scale)

4. Stress and Coping Scale
5. Coping Strategies Indicators (CSI)—*not used in CCHS*
6. Ways of Coping-Revised (WOC-R)—*not used in CCHS*
7. COPE
8. Spirituality Module
9. Sense of Belonging to Community
10. Social Support (MOS)
11. Social Provision Scale—*not used in CCHS*
12. SF-36 (the vitality index)
13. Satisfaction With Life Domains (10 questions)
14. Satisfaction With Life Domains Scale (20 questions)—*not used in CCHS*
15. Sense of Coherence (SOC)
16. Rosenberg Self-Esteem scale
17. Sense of Mastery
18. Happiness and Interest in Life

Instruments measuring well-being in national surveys

19. Perceived Well-Being Scale (PWS)
20. Personal and Social Well-Being Used in European Social Survey (ESS)
21. Multicultural Quality of Life Index (MQLI)
22. The Comprehensive Quality of Life Scale (ComQol)
23. The Australian Unity Wellbeing Index
24. Well-Being Scale
25. National Survey of Black Americans
26. Ryff's Psychological Well Being Scales
27. The Social Well-Being Scale (Keyes 1998)
28. Mental Health Continuum Long Form
29. Mental Health Continuum Short Form (MHC_SH)

Short Instruments—Happiness and Life Satisfaction

30. The European Values Survey (EVS) 1999/2000
31. The Second Wave of the National Survey of Families and Households (NSFH2)
32. National Survey of Midlife Development in the U.S. (MIDUS)
33. A 15-year Prospective Cohort Study on Nationwide Sample of Adult Finish Twins
34. Australian National Survey of Mental Health and Well-Being
35. Satisfaction With Life Scale (Diener)

New Instruments (also covering social support measures)

36. The Warwick-Edinburgh Mental Well-Being Scale (WEMWBS)
37. Four-Item WHOQOL Positive Feeling Measure
38. The WHO-Five Well-Being Scale
39. Duke Social Support Index
40. Social Network Instrument From National Comorbidity Survey (NCS)
41. Social Support Items From the American Changing Lives Surveys (ACL)
42. Perceives Social Support
43. The Social Support Questionnaire
44. Sense of Mattering
45. Cairney's Proposal for Social Support
46. Three-Item OLSO Scale

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