

Discourses in the European Commission's 1996–2000 Health Promotion Programme

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Abstract

This article is a discourse analysis of 'The Community Action Programme on Health Promotion, Information, Education and Training 1996–2000'. The analysis uses six stages to discourse analysis. A religious discourse is used to construct the Programme and a military discourse is used to construct its implementation. These discourses are embedded in a scientific discourse. This analysis reveals that despite rhetorical endorsement of the concept of empowerment in health promotion, this Programme disempowers through vagueness, clear hierarchies of power and an emphasis on scientific methods of evaluation. The analysis also reveals that there has been a shift in blame in recent health promotion policy, the reflection is now on the collective as opposed to individual behaviour.

Keywords

discourse analysis, European Union, health promotion

Introduction

KNOWLEDGE and insight into health policies are required by health psychologists to help them gain an understanding of the context in which they find themselves working. This knowledge can be useful for pushing forward ideas by linking the idea to a particular policy or for challenging current policy and bringing about policy changes. This article discusses one of many policies relevant to health psychologists working in the field of health promotion.

Members of the European Union face similar health problems such as inequalities in both health status and health service provision between different geographical areas and social groups, variations in service use and health problems related to lifestyle and economic issues. This has prompted efforts to promote health on a European-wide scale.

The European Parliament has always had some involvement in the field of health and in a range of policy areas with implications for health. However it was the Maastricht Treaty 1992 that provided it with the necessary legal base to develop a coherent public health policy. The policy aimed to achieve its objectives through research, health information and education and the incorporation of health protection requirements into the Community's other policies. There was a requirement that the Member States should co-ordinate their policies and programmes in these areas. There was also a guideline that the Commission may take any useful initiative in this respect. The harmonization of the laws and regulations of the Member States was however specifically excluded (Holland, Mossialos, & Permanand, 1999).

Holland et al. (1999) pointed out that at first the policy was criticized for being too vague in its definition of the specific responsibilities of both the Member States and the Commission in achieving the objectives laid down and in policy implementation.

At the June 1997 Intergovernmental Conference in Amsterdam, agreement on the new Treaty resulted in a revision in which the Amsterdam Treaty ought to contribute to health protection, for example by having a public health input into policies such as tobacco subsidies and agriculture which had been legislated in primarily economic terms. The new

Treaty acknowledged a broader definition of public health in the European Union along with a greater role for the European Parliament and Council of the European Union. A role which had previously been described as 'the prevention of disease' was extended to 'improving public health' (Holland et al., 1999).

A consequence of the Maastricht Treaty on the European Union was the establishment of 'The Community Action Programme on Health Promotion, Information, Education and Training 1996-2000' or the 'Health Promotion Programme' as it is often called (European Parliament and Council, 1996).

The above offers some insight into the complexities of establishing a health promotion policy. When one questions the meaning of health promotion policies and their impact on health behaviours further complexities are revealed. Lupton (1997) pointed out that the practices and discourses of public health are not value-free or neutral but socially contextual, highly political and change in time and space. She argued that the institutions of public health and health promotion often overtly display signs of the State's attempts to shape the behaviour of its citizens. Lupton was interested in how the discourses in health promotion invite individuals voluntarily to conform to their objectives, to discipline themselves and to turn the gaze upon themselves in the name of health, often evoking feelings of guilt, anxiety, repulsion and blame. Lupton argued that public health and health promotional discourses and practices privilege a certain type of subject who is self-regulated, 'health'-conscious, middle-class, rational and civilized and who has a body that is contained and controlled.

Lupton (1997) also noted that communication in the health promotion world is far from a two-way process. She highlighted the ease of slipping between simply informing the public about health matters and implicitly forcing them to take up what are considered healthy behaviours. For example, she noted that once a health message has been disseminated, health promoters discharge their responsibility and the emphasis turns to the individual to act upon this knowledge to prevent illness. If the target audience does not respond to the message and change their health behaviours then according to mainstream health promotion models of

behaviour, they have adopted defence mechanisms or maladaptive coping responses or they lack the required level of personal control and feelings of self-efficacy.

Lupton (1997) argued that health promotion texts are full of assertions concerning the importance of adopting appropriate language and discourse strategies to achieve the goal of manipulation often based on emotional appeals. She pointed out that the health promotion texts outline ways to achieve more 'effective' health communication campaigns by carefully 'targeting' or 'segmenting' the audience, emphasizing 'positive' behaviour change and 'current rewards' and using commercial marketing strategies to attract audiences' attention. Lupton (1997) argued that this approach still dominates health education and health promotion concepts.

The following study analyses the discourses in the EC's Health Promotion Programme to find out whether Lupton's observations are evident. It attempts to offer an understanding of how discourses may influence behaviour and what implications the discourses may have for the practice of health promotion.

Method

Text

The 1996–2000 Health Promotion Programme was described in a series of five annual Work Programmes. They were published in the *Official Journal of the European Communities*. More recently the Work Programmes have been published on the Internet.¹ It is the role of the European Commission to ensure the Work Programmes are carried out. The Commission services are in charge of the administration and an allocated budget. Each Work Programme describes the yearly aims and objectives. Each Work Programme starts with a general introduction, followed by sections on Budget, Implementation of the Programme, Priority Areas and Other Priority Areas. The 1996–2000 Health Promotion Work Programmes were analysed. The Budget section was not analysed.

The analytical process

The aim was to analyse the language used in the EC's Health Promotion Programme. This Programme was defined and enacted in law by

the European Parliament. Therefore it can be said to be part of the wider social process of legitimization and power in the western world.

By using a Foucauldian approach to discourse analysis, an attempt was made to understand the availability of discourses in the Programme and how these discourses may influence how people think or feel and what they may do (see Parker, 1992). A Foucauldian approach to discourse analysis also offers insight into how the discourses in the Health Promotion Programme enable and constrain individuals. Foucauldian discourse analysts define discourse as 'sets of statements that construct objects and an array of subject positions' (Parker, 1994, p. 245). Thus the constructions make available certain ways of seeing the world and certain ways of being in the world. From a Foucauldian viewpoint, there are implications for subjectivity and experience when discourses are taken up by individuals. These implications were explored. The Foucauldian perspective also helped the understanding of the relationship between the discourses and the practices of the European Commission.

Discourse analysis is not a research method with a rigorous set of formal procedures to guide it. Emphasis is placed on the reading and interpretation of text backed up by quotations from the text. According to Potter and Wetherell (1987) the first step is said to be the suspension of belief in what is normally taken for granted in language use (as cited by Coyle, 1995). There have been some attempts to offer systematic guides on conducting discourse analysis. Potter and Wetherell (1987) offered a 20-step guide. Parker (1992) outlined seven criteria for discovering discourses along with three auxiliary criteria concerned with institutions, power and ideology. Recently, Willig (2001) has produced a six-stage guide.

These six stages of discourse analysis set by Willig (2001) were used to analyse the discourses in five years of the EC's Work Programme on Health Promotion. These stages allowed the discursive resources and the subject positions of the EC's Work Programme to be unravelled and mapped. The implications for subjectivity and practice were then explored.

The first author read the texts several times in order to become familiar and engage with the text. Discourses were identified and developed

with the other authors. The discourses are described using quotations from the Work Programmes. Quotations are followed by the Work Programme year and line numbers in brackets.

Results: the six stages of analysis

Stage 1: discursive constructions

This stage aimed to find the discursive objects of the text. It also looked at how the discursive objects are constructed through language. Five discursive objects in the EC's Work Programme on Health Promotion were found.

Health promotion Health promotion is constructed as enabling. For example, it 'enables people to adopt and maintain healthy lifestyles and healthy behaviour' (1996, lines 6–7). It promotes 'the creation of sustainable environments and alternatives conducive to health' (1996, lines 7–8). It increases 'individuals' and communities' control over their health and its improvement' (1996, line 8).

Health promotion is represented as being made up of structures and strategies. At a European level, these structures and strategies are presented as being diverse:

Each country has its own health promotion structures and strategies. The diverse health promotion policies of the Member States will need to be described, compared and disseminated. Some Member States have listed their top ten priorities in the field of public health. (1996, lines 34–36)

Some structures and strategies in health promotion are better than others, 'An analysis and comparison of Member States' nutritional policies will be carried out to illustrate each country's strengths and weaknesses' (1996, lines 51–52). Some of health promotion's structures and strategies needed improvement, 'Attention will also be paid to improve knowledge of mechanisms for devising health messages and assessing health information methods' (1997, lines 15–16).

Certain 'risk factors' are constructed as health promotion's enemy. In particular risk factors that cause the leading health problem in Europe, cardiovascular disease (CVD).

However health promotion is presented as not being afraid because it has a strategy to deal with this because there 'is scientific evidence and practical experience allowing us to reduce these problems by introducing measures to combat certain risk factors and promote health behaviour' (1996, lines 55–57). The proposed strategy is a 'cardiovascular prevention awareness week'. However when discussing specific risk factors such as alcohol, the language is not as war-like. It is collaborative and diplomatic, 'In relation to alcohol, a meeting bringing together representatives of the scientific community, of the alcohol industry and wine producers, of NGOs active in the field, of health promotion bodies ...' (1996, lines 76–80). In 1998, the discussion of alcohol and health was continuous. Therefore, health promotion is constructed as being patient and persistent in its goals. By 1999, the 'drafting of a Commission communication on alcohol and health is planned' (lines 10–101). By 2000, the final results of the European Comparative Alcohol Study were planned to be available (lines 98–99).

Evidence-based knowledge The Programme portrayed the idea that there is a bank of a certain kind of knowledge outside the sphere of health promotion that it needs to grasp, form models of good/best practice and share. Projects that used this knowledge and share it were given priority. For example, 'The development and dissemination of the best health education experiments and methods tailored to different population groups and different settings will be fostered' (1998, lines 18–19).

Traditional scientific knowledge is constructed as being the only and at the same time the best knowledge available to health promotion, 'scientific review and analysis of health promotion intervention activities in Europe will be carried out' (1997, lines 136–137).

Evaluation is represented as the means by which health promotion could contribute towards evidence-based knowledge, 'Evaluation and quality assurance will be developed as an integral part of the programme' (2000, line 36).

Health promotion experts The experts had various mechanisms at their disposal to achieve

these aims. It was planned to publish a 'Who's who in public health' (1996, line 91) and a directory of training schemes in public health and health promotion (1996, line 105). This club being European, had to manage different languages. Therefore a multilingual glossary of public health terms was supported (1996, lines 93–95). In line with the spirit of a club, an annual 'major prize competition for health education' was funded in 1996 (lines 87–89). It used 'modern communication technologies' to organize its members (1998, lines 157–158). By establishing a European Master's Degree in Public Health in collaboration with a 'maximum number of universities' (1997, line 124), the club's status could be raised. It is constructed as a benevolent club that shares its knowledge by arranging summer schools and training courses in public health (1998, lines 145–153).

The Health Promotion Programme (the Commission and the Commission services) The Health Promotion Programme and by default those who co-ordinate it—the Commission and the Commission services—are constructed as being modern, insightful and concerned with the best (this construct will be referred interchangeably as the Programme and the Commission). For example, in 1997, an aim of the network of health promoting schools was 'the dissemination of best practices' (line 109). In the same light, another aim for 1997 was the 'development and dissemination of the best health education experiments and methods' (lines 20–21). This also reveals an emphasis on the Programme being scientific with the mention of experiments. This is further revealed by another aim—'Scientific review and analysis of health promotion interventions activities in Europe will be carried out (1997, lines 136–137).

The Programme is represented as being modern. For example, in 1996 we see that the Commission is ready for a 'new approach' (line 9). In 1999, there was 'support for the up-dating and large use of an Internet information base' (lines 107–108). In 2000, there was an aim to produce a state-of-the art dietary guideline in Europe (lines 90–91).

It aims to collate facts through traditional methods, such as, surveys and feasibility studies. For example, 'A survey of similar work . . . will be carried out' (1996, lines 36–37); 'The

Commission intends to carry out feasibility studies on the setting up of a permanent body (the European Health Observatory) responsible for monitoring and evaluating the health data and indicators in the Community area' (1996, lines 41–43).

The Programme makes use of targeting. It targets certain populations, setting and actions or issues. This can be seen in the subheadings of the Programme and also within the text, 'Priority areas and key functions will be specified in order to launch targeted actions' (1997, lines 32–33).

The Programme is constructed as insightful. For example, 'Unlike the earlier Programmes (cancer, AIDS, drugs), it focuses not on diseases but on health determinants (1996, lines 4–5). It is presented as a Programme that is aware of a project leaders' potential burdens. In 1996, it stated that new application forms had been designed that 'put more emphasis on project descriptions and less on administrative information' (line 19). In 1997, it stated it would 'contribute to analyzing the institutional difficulties encountered in developing health promotion' (lines 30–31).

The Programme is represented as being concerned with value. First, value for money, for example 'the projects implemented will need to be evaluated from both the technical and the financial angle' (1996, lines 29–30). Second, European-added value, 'All projects must have a transnational dimension and should involve as many Member States and EEA countries as possible' (1998, lines 47–48). It is also represented as being concerned with efficiency, 'special emphasis will be placed on the evaluation of how the projects are indeed benefiting the European Union and its citizens' (1997, lines 44–45). In 2000, the final year of funding, an aim was to 'ensure that the experiences gained and the benefits from the investment incurred in activities and networks are fully utilized in future developments relating to health promotion and public health' (lines 3–5). The Programme is also concerned with maximum impact. It is stated that the projects need to be evaluated with the question—'How could the results be more widely disseminated?' (1996, lines 30–31).

The Programme is not a long-term provider. It encourages sustainability. This can be seen in

the networks, 'Once firmly established, the networks shall find other sources for funding as bodies cannot be financially supported on a long-term basis' (1999, lines 23–25).

The Commission is presented as a networker whose role is to create links, 'Interlinkages with other relevant Community programmes will be strengthened, and partnerships with the private sector, NGOs and international organizations developed' (1997, lines 33–35). The links are also of a global nature, 'In order to appreciate the global nature of health promotion, participation in the XVI World conference on Health Promotion due to be held in Puerto ...' (1998, lines 71–73).

Recipients of health promotion

1. The public

The public who receives health promotion can be divided into several groups. There is the general European citizen, which is largely represented as belonging to a community. There are also 'vulnerable or disadvantaged groups' (e.g. 1997, line 14) and targeted groups, such as pregnant women, the elderly and young children (1998, lines 81–82). Groups are seen as disadvantaged as a result of 'their vulnerability or social exclusion or of social and cultural differences' (1996, line 50). The use of 'their' implies some responsibility for and ownership of being 'disadvantaged'. Interestingly, behavioural risk factors are not given any possession or ownership. For example, the text describes 'the issue of alcohol' (1999, line 104) and 'the issue of body weight' (1997, line 73). It does not refer to any action, such as excessive consumption of alcohol or food. Recipients of health promotion are constructed as being at risk of, simply 'alcohol'. It is almost as if alcohol is a free-floating issue that the public has no control over. It is not represented as a behavioural factor. Yet at the same time, the public is constructed as being at risk of other factors such as 'social exclusion' that groups can be empowered to control.

The Commission gave priority to projects that gave 'control over' individuals' and communities' health (e.g. 1997, line 30). This implies that the now 'enlightened' Commission is handing back 'control' of health to people, just as a

diplomat hands back control to a newly independent country. A strategy for helping a specific issue that affects 'the well being of people' (body weight) is to set up a 'scientific expert group' to organize a conference on 'this matter' (1997, lines 74–77). However, this strategy is far from 'empowering' which is another aim of the Commission—'Attention will be paid to ... including means and methods for empowerment and citizen's participation in health development' (1998, lines 64–66). In fact, it treats people like the objects of a scientific study. Likewise, another contradiction is the aim of 'facilitation of exchange of information and experience' as a strategy for 'empowering' citizens (1999, lines 71–72). In 2000, with the aim of the development of 'heart health', a 'high profile conference for public health experts, health professional and policy makers is scheduled' (lines 93–96). There is no mention of involving European citizens. Describing the conference as 'high profile' is more indicative of a concern with health promotion's status than 'empowerment' or 'exchange of information and experience'.

Similar to traditional scientific study, the Programme also aims to observe and monitor the recipients of health promotion. In 1996, the Commission planned to carry out 'feasibility studies on the setting up of a permanent body (the European Health Observatory) responsible for monitoring and evaluating health data and indicators in the Community area' (lines 41–43). Also health promotion interventions that European citizens receive were to be subject to a 'scientific review and analysis' (1998, line 155). These strategies are not in tune with giving individuals and communities control over their health.

2. Health promotion practitioners

These include health care professionals and those 'in the front line of health promotion (e.g. teachers, educators, social workers)' (1996, line 23). This group is represented as in need of health promotion knowledge and guidance. The Programme aims to 'familiarize' this group with health promotion (1997, line 23). The knowledge has to be co-ordinated and similar. Any variation in knowledge has to be regulated and made similar. This is evidenced by the proposal

for a European Master's degree in public health and the statement that at the moment degrees are 'extremely variable' (1996, line 108–112).

This group is also represented as subjects of a science. The Programme states that projects should 'pay attention to the role of health care personnel' in health promotion. It also indicates a top-down approach in which health promotion 'experts' filter knowledge to practitioners who in turn pass this knowledge to European citizens. This is further seen in the aim of using 'modern communication technologies' to 'increase information exchange within the European health promotion community and with the public' (1998, lines 157–159). Clearly, the health promotion community (or 'experts' and practitioners) and the public are seen as two different entities that need some form of modern technology to communicate. This conjures up an image of health promotion experts existing in one box and the public in another, both far removed from each other yet 'modern technology' is going to somehow bring these groups closer. This aim in fact sums up paradoxical intentions of the Programme. It indicates that the health promotion community is separate from the other community to which it refers (i.e. the public community). It also demonstrates inconsistency: on the one hand, the Programme is concerned with disadvantaged groups, yet chooses a method to communicate with this group that is no doubt not readily available to them.

Stage 2: discourses

This stage aimed to locate the various discursive constructions of the objects within wider discourses. Three discourses were identified. On the one hand, a religious discourse is used to construct the Programme. Yet a military discourse is used to construct its implementation. These discourses are embedded in a scientific discourse.

Religious discourse The constructions in the Health Promotion Programme resonate with a religious discourse. The Programme is constructed as insightful, almost enlightened on a mission or crusade with a message to spread. In order for the spreading of the message to be effective, organization of believers has to take place. One way the Programme is organized, is

by training health promotion practitioners to spread the message, in a similar way to disciples spreading Christianity. Just like a religion, it is concerned with sharing and giving. In a similar vein to extreme interpretations of religious literature, there is a clear emphasis and distinction on what is good and bad. Those who partake in what is considered good will be given the 'best' and they will reap the benefits in terms of good health and interventions that are based on scientific findings. Not wasting, patience and control are clearly valued. However the religion of the Programme is constructed as being new and modern. It is represented as different to traditional religions, in that as long as followers believe in the principles of health promotion, differences can be accommodated. It is inspiring rather than over-protective and not unconditionally generous.

Military discourse By contrast, the construction of health promotion having an enemy draws upon a military discourse. The health promotion experts are represented in the same way politicians and diplomats handle potential threats of war. Experts meet to decide structure and strategies to combat the enemy. Members of the public are not invited to these meetings. The decisions are then instructed to health promotion practitioners, just like soldiers at 'the front line'. It is interesting that a clear picture of risk factors and their harm is presented (but not behaviour associated with risk factors). However, the structures and strategies to deal with the risk factors are not clearly presented. This is also evident in times of war, when the enemy is clearly known to the public. However the structures and strategies to deal with the enemy are mostly secret.

Just as in times of war, health promotion is concerned with 'targeting'. Health promotion is seen as having useful assets at hand to help its cause—control, exchanges of information, diplomacy and modern technology. These assets are also useful in a war situation. In times of war, we often see vulnerable people, the victims of the enemy. These serve to justify the war. In a similar light, the Programme presents a picture of vulnerable and disadvantaged groups. The enlightened Programme is willing to let these vulnerable groups join the 'good' side if they defect and denounce the enemy.

Scientific discourse Knowledge and evidence are conceptualized as being scientific in the Health Promotion Programme. Health promotion is represented as needing knowledge and evidence to implement its principles. As it is concerned with the best, only knowledge and evidence that are based on traditional scientific methods will suffice. There is no mention that any other kinds of knowledge exist. Therefore there is an emphasis on traditionally scientific methods of collating information, such as monitoring, observing and experiments. Just as in science, these methods produce facts that are often unquestionable. Even the objects of health promotion's study, people, are called 'matter' as in the field of science (1997, line 77). In a similar way to the scientific world, the Programme attempts to organize key players in such a way that the world of the experts is separate from its subject area and clear boundaries are evident. This is supposed to encourage objectivity. The five-yearly Work Programmes are very similar. In fact, they are very repetitive, thus giving an impression of being replicable and reliable which are qualities endorsed by a scientific discourse.

Stage 3: action orientation

This stage took a closer examination of the discursive contexts within which the different constructions of the object are used. It asks—what is gained from constructing the object in this particular way at this particular point within the text?

By locating health promotion within a religious discourse, health promotion is seen as something that is good and charitable. An incentive to being involved in health promotion is the moral high ground. By presenting health promotion as being concerned with linking and networking, it is seen as desirable as others also want to be involved. By presenting itself as insightful, new and modern, it cannot be accused of being 'out of touch' as some religions have been. Nor can it be accused of wasting money. Therefore it removes itself from the image of the 'nanny state'. Due to the fact that patience is seen as a virtue and the targets so difficult to hit, and so many in number, expectations can be lowered when all targets are not met by the deadline set many years before.

The religious discourse creates a feeling of

being on a mission that could motivate those working in health promotion and give them reasons for their work. Likewise the military discourse could incite action. As a result of the war discourse, strategies to promote health do not have to be explicit. By presenting factors such as social exclusion as belonging to vulnerable groups, responsibility for bad health is taken away from other sources of power such as the European Parliament. It could even lead to a situation in which these groups are blamed for being socially excluded. The military discourse sees the Commission as handing back control and also responsibility to vulnerable citizens. This represents the solution to social exclusion, empowerment, as being fair and honest. Empowerment implies that those who lack power can be given it by some undefined, almost miraculous means.

By employing a scientific discourse the facts produced from scientific methods are unquestioned. Therefore, potentially, there should be minimum resistance. The experts could be seen as knowing what they are doing and responsibility for health could remain with the experts. The scientific discourse also means that certain types of projects are funded that focus on traditional scientific methods of collecting data. Yet when there is a top-down approach to data collection, the aim of empowerment is contradicted. This approach also disempowers as it excludes needs, wants and feelings from data collection, monitoring and surveillance. The scientific discourse also justifies monitoring, surveying and observing citizens as these methods are represented as necessary to promote health.

Stage 4: positionings

This stage took a closer look at how the constructions of the discursive objects and the wider discourses offer subject positions. The construction of the public as receivers of health promotion positions the public as passive. The scientific discourse reinforces this passive positioning. The public is represented as a well-known object of study that has been well researched and a subject on which there are lots of available facts that now needs to be put into practice. The military discourse positions the public as being in danger yet safe and protected as the Commission has the war under its control.

Although there is mention of the individual's existence, the focus of health promotion's attention is on groups and communities. Therefore the individual is positioned as belonging to a group or a category. The groups and communities are constructed as being diverse. For example, health promotion targets disadvantaged groups, pregnant women, the elderly and children. The very description of 'disadvantaged groups' who need to be empowered positions these groups as victims who have been given a chance, because the Programme is going to allow this empowering to take place. The groups are positioned as homogenous. There is no mention of differences within groups. For example, there is no mention of language or cultural differences that exist in the different 'disadvantaged' groups in the European Union. Language differences are only mentioned in relation to the experts of health promotion. This again positions the public as passive through this symbolic omission that implies the public does not have a voice.

Being constructed as insightful positions the Commission as superior. Having structures and strategies available, and being constructed as an instigator of action, constructs the Commission as being organized, dynamic and innovative. The admission that improvements are needed constructs the Commission as having a human quality, of being adaptable, flexible and amenable to change. Being constructed as a body that is involved in networking, linking and building partnerships positions the Commission as being influential. Both the military and religious discourse position the Commission as being benevolent and a protector, a Crusader even. The discourses imply action is being taken for the sake of the public to prevent it from harm. The Commission's emphasis on efficiency and not wasting money positions it as being frugal, a quality needed in wartime and valued by some religions.

The military and religious discourses and the construction of health promotion practitioners as in need of knowledge positions the practitioners as instruments of policy who need to be tuned before they can perform well.

Stage 5: practice

This stage explores the ways in which discursive constructions and the subject positions

contained within them open up or close down opportunities for action.

Positioning the public as passive legitimizes the use of traditional scientific methodology to study health promotion. Being constructed as protected might actually make people less likely to take responsibility for their health behaviours.

Positioned as superior means that any actions the Commission takes in the name of health promotion is legitimized. Their superiority also makes their action unaccountable. It also may mean that the Commission becomes out of touch with the reality of people's lives they are trying to improve.

As instruments of policy, health promotion practitioners are not likely to question their 'masters' upon whom they rely for their expertise and legitimization of their posts. Being constructed as organized, dynamic, innovative, influential and benevolent with a human quality makes questioning or criticizing the Commission's legitimacy difficult because to do so would mean being the opposite of these qualities. Being constructed as frugal makes the Commission even more admirable as it claims a range of qualities and great things with limited resources. However the admiration may be short-lived as the reality may be that many more resources are needed to achieve the goals of health promotion in the European Union. Thus there is a risk of a gap between the reality and the desired outcome which could lead to failure to have an impact on the health of European citizens.

Stage 6: subjectivity

The final stage traced the consequences of taking up various subject positions for the 'participants' subjective experience.

Not taking part in the advocated health promoting behaviours may lead some individuals to feel guilty as they have not shown enough gratitude to the benevolent experts. Being positioned as victims may reinforce any feelings of low self-esteem which in turn lead some individuals to behave like victims. Thus, any efforts to empower such people will be redundant and meaningless if people feel they are seen and treated as victims. The lack of acknowledgement of individual differences may make some individuals feel like rebelling and expressing their individuality in unhealthy

behaviours. On the other hand, being positioned as in danger may scare some individuals who may consequently develop obsessive attitudes towards substances such as alcohol and issues such as body weight.

Being positioned as superior and benevolent may make some members of the Commission feel proud. Any questioning of their knowledge or aims to do good may leave them feeling offended. This superiority means that information and knowledge only flow one way—top-down. It means there are no mechanisms for a two-way flow of information and knowledge. This may frustrate health promotion practitioners as they see the realities of health promotion efforts at grass roots level and yet they may find questioning the structure and strategies problematic as this would question their existence.

Discussion

In the present study, the discourses in the EC's 1996–2000 Health Promotion Programme have been analysed in order to offer an understanding of how discourses may influence behaviour, and what implications they may have for the practice of health promotion. Three discourses have been identified: a religious and a military discourse, both of which are embedded in a scientific discourse. This analysis has supported Lupton's (1997) argument that health promotion is not value-free or neutral and is highly political. The Programme has taken into consideration two critiques of health promotion. It disassociates itself from the right-wing critique that sees health promotion as a preaching 'Nanny State' and acknowledges the 'radical' critique that sees poverty, inequity and social exclusion as the root causes of poor health (see Lupton, 1997).

The Programme intends to improve knowledge and practice in the field of health promotion. Yet the dominance of the scientific discourse could prevent advancement. This discourse only values one type of research and evaluation. It values research that positions people as subjects to be observed and measured and it values evaluations of outcomes. Thus no allowance is given to how people feel about certain issues in health promotion. Meanings and values placed on health and definitions are

not explored. In omitting to define health or refer to different meaning of health, the Programme remains vague. This vagueness further disempowers because the promises of improvement can never be pinpointed. Ironically this vagueness is not conducive to traditional scientific evaluation as success and failure cannot be measured if what you are measuring is not clearly and operationally defined.

The analysis has also offered insight into how the discourses in health promotion might invite individuals or particular communities to conform to the health promotion objectives and discipline themselves and turn the gaze upon themselves in the name of health. The scientific discourse presents health promotion facts as unquestionable and the military discourse clearly describes an enemy. Thus it could be that fear and the feelings of vulnerability themselves make people gaze inwards. Also engaging in health promotion is represented as desirable, modern and morally good. This may also encourage people to gaze inwards and follow health promotion advice.

Yet at the same time in presenting poor health as related to poverty, inequity and social exclusion, the Programme has shifted the blame as the individual is no longer at risk from the self in terms of lifestyle behaviours (see Ogden, 1995). In fact the Programme seems to mystify any relation to health being related to individual behaviour. People are considered 'at risk' of factors such as alcohol rather than the issue being behaviour towards the substance. It is almost as if the 'insightfulness' of the Commission precludes any political incorrectness such as reference to individual behaviour and health promotion. The concept of surveillance that Lupton (1997) discussed is evident in this Programme. However the reflection is rather on the collective rather than the individual. While it is promising that the multi-determinants of health have been recognized, it seems that health promotion policy makers are unrealistic about the interplay of how these factors contribute to ill-health. The real source of poverty and exclusion have not been addressed. Likewise a total backing away from behavioural factors that contribute to health, may also be unhelpful.

Despite the fact that this analysis has pointed

to a discourse of empowerment with no real substance, it is nonetheless encouraging to see such discourses in use. In order to continue progress in health promotion policy, the next step should be looking at ways to truly 'empower'. Health psychology has the potential to bridge this gap. First, methods such as discourse analysis could offer an approach for policy makers to analyse their policies and reflect on their intentions. Second, health psychologists could act as bridge between policymakers and the public to help break down the clear distinctions of power that are evident. In this way, they would act as facilitators helping both parties to understand each other's needs.

This analysis aimed to map the discursive world of the EC's Health Promotion Programme and trace possible implication for practice and experience. It needs to be pointed out that this analysis is itself a discursive construction based on the experiences of the authors who have been involved in an evaluation of the EC's Health Promotion Programme (Marks & Sykes, 2001). This experience would have influenced the analysis. Likewise, those involved in writing the Programme may not be aware of the identified discourses, nor recognize them. This approach assumes that there is no one version of the world and that 'no version of the world remains dominant forever because the social construction of reality through discourse is characterized by change and transformation' (Willig, 2001, p. 121). During 1996–2000, the EC's Health Promotion Programme aimed to empower and improve the health of European citizens. As attempts to do this were made within the constraints of a power hierarchy, it may transpire that these aims will not be achieved unless further efforts are made to empower and reduce inequality. This may lead to a new wave of discourses in health promotion. It will be interesting to compare this analysis with analyses of future Programmes such as the next EC's Health Promotion Programme 2003–8.

Note

1. See <http://www.europa.eu.int/>

References

- Coyle (1995). Discourse analysis. In G. Breakwell, S. Hammond, & C. F. Schaw (Eds.), *Research Methods in Psychology*. London: Sage Publications.
- European Parliament and Council. (1996). Decision no. 645/96EC—Adopting a programme of Community action on health promotion, information, education and training within the framework for action in the field of public health (1996–2000). *Official Journal of the European Communities*, 39, 1–8.
- Holland, W., Mossialos, E., & Permanand, G. (1999). Public health policies and priorities in Europe. In W. Holland & E. Mossialos (Eds.), *Public health policies in the European Union* (pp. 1–48). Hampshire: Ashgate Publishing Limited.
- Lupton, D. (1997). *The imperative of public health: Public health and the regulated body*. London: Sage Publications.
- Marks, D. F., & Sykes, C. M. (2001). Evaluation of the European Union Programme of Community Action on Health Promotion, Information, Education and Training 1996–2000. *Health Promotion International*, 17, 105–118.
- Ogden, J. (1995). Psychosocial theory and the creation of the risky self. *Social Science and Medicine*, 40, 409–415.
- Parker, I. (1992). *Discourse dynamics: Critical analysis for social and individual psychology*. London: Routledge.
- Parker, I. (1994). Reflexive research and the grounding of analysis: Social psychology and the psychocomplex. *Journal of Community and Applied Social Psychology*, 4, 239–252.
- Potter & Wetherell (1987). *Discourse and social psychology. Beyond attitudes and behaviour*. London: Sage Publications.
- Willig, C. (2001). *Introduction to qualitative research in psychology: Adventures in theory and method*. Buckingham: Open University Press.