Using health promotion frameworks to effectively address health inequalities

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Health promotion frameworks have been criticised as, paradoxically, exacerbating health inequalities.[1] First, critics assert that while the roles of institutional, economic, social and environmental factors in health inequalities are recognised by health promotion workers, strategy implementation invariably concentrates on the relatively 'soft targets' of biological and behavioural risk factors.[2] Such selective strategy implementation is said to promote the health of the rich, who are less constrained by structural factors, much more than it does the poor.

Second, health promotion practice tends to be generally apolitical. However, political stuctures are primary determinants of the magnitude of health inequalities – mediated through 'social contracts' between the government and the citizens.[3] For example, despite increasing evidence linking racism with health inequalities,[4] the apolitical framework and practice of health promotion makes it unlikely that the 'new' public health would accord racism a dedicated research effort or prevention strategy.

Third, health promotion activities are criticised as being formulated in relation to social structure of Western societies. Consequently, when these activities (e.g. 'health promoting schools'[5]) are implemented in developing societies, they work more effectively in regions with socio-economic characteristics comparable to the originating 'template' societies. Fourth, as stated in the Jakarta Declaration, "… above all poverty is the greatest threat to health".[6] Despite this, many critics assert that the health promotion movement appears to have adopted a 'policy of inaction' vis-à-vis poverty alleviation.

Addressing these criticisms requires prompt action at the conceptual, policy and implementation levels.[7] Conceptually, a predominantly 'functionalist' (i.e. a conservatively explanatory sociological orientation and a data collection method),[8] apolitical, health promotion framework is inadequate for addressing health inequalities. Instead, there is a need for workers to adopt a 'social change advocacy'[9] paradigm, which may involve framing policy alternatives to the health, political, and economic status quo (e.g. a human rights approach to globalisation[10]) in such a manner that it would be acceptable to most stakeholders.

At the policy level, while improving absolute health status of the poor and redressing health inequities are important, growing socio-economic differentials in primary avoidable morbidity and mortality should be accorded greater focus. At the implementation level, practitioners need to lead civil society 'from the front', advocating programs and 'healthy' policies that modify individual lifestyle and behaviour and improve socio-economic conditions, particularly of the poor. Fortunately, the NSW equity project and Flemish Institute are among many health promotion bodies addressing health inequalities locally and globally.

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