

Health promotion, advocacy and health inequalities: a conceptual framework

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SUMMARY

Advocacy has often been described as a key strategy for the achievement of health promotion aims, but multiple and conflicting definitions and usages exist. The concept itself may be unnecessarily intimidating. Advocacy work can take place at the level of both 'cases' and 'causes'. Two main goals underpin health advocacy—protection of the vulnerable (representational advocacy) and empowerment of the disadvantaged (facilitational advocacy). This paper attempts to integrate existing models and definitions into a conceptual framework for considering the role of advocacy

in addressing health inequalities. It argues that we need to pay some attention to the diversity of values and goals of health promotion if we are to understand which models and approaches to health advocacy apply and in what context. This paper concludes that advocacy for health fulfils two functions: as a form of practice and as a useful strategy for a discipline which has to be self-promoting as well as health-promoting in order to survive in the competitive political environment of contemporary health work.

Key words: advocacy; health inequalities

Traditionally, the ethic of the health worker is to be the protector and advocate of the patient. Today, advocates for the wellbeing of whole populations are needed (International Union for Health Education, 1992).

INTRODUCTION

As the above quotation implies, health promotion is arguably one of the most ambitious health-related enterprises of the 20th century, and advocacy is seen as one of its key strategies. Health promotion has been described, from a global perspective, as a necessary and timely reconsideration of public health rather than a new and separate discipline (Kickbusch, 1986), but in practice the two may differ at the practitioner level. Health promotion practitioners are to be found working in a wide range of agencies and sectors: their efforts

can be directed towards improving the health of entire populations, defined communities or groups, and single individuals (Mechanic, 1999). In recent years, health promotion has increasingly sought a role in the development and implementation of healthy public policy at the local, national and global level (WHO, 1988). This has been, in part, a response to the perceived over-emphasis on curative medicine and the behavioural approach to disease prevention that has characterized much health policy development (Kickbusch *et al.*, 1990). Health promotion is therefore a multi-level, multi-sectoral and multi-disciplinary activity. It also evinces characteristics of a visionary movement, concerned with equity and justice in society as well as environmental protection on a global scale (WHO, 1991; WHO, 1997).

Although it seems that few areas of contemporary life lack the potential for health promotion

activity, the breadth of vision, arena and practice within the discipline raises questions of control and power that are not always addressed explicitly (Adams and Pintus, 1994). Seedhouse, for example, points out that while health promotion may be done on request, it may also be carried out without the intended recipient or recipients asking for it (Seedhouse, 1997). We therefore need to pay some attention to the underpinning values and contexts within which models and approaches to health promotion advocacy are applied.

Advocacy has been recognized as one of three major strategies for achieving health promotion goals, the others being enablement and mediation (WHO, 1986). The World Health Organization (WHO, 1995) describes advocacy for health as a 'combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or programme'. Such action may be taken by or on behalf of individuals and groups to create living conditions conducive to health and the achievement of healthy lifestyles (Nutbeam, 1998). Two main goals underpin health advocacy: that of protecting people who are vulnerable or discriminated against; and that of empowering people who need a stronger voice by enabling them to express their needs and make their own decisions (Scottish Health Service Advisory Group, 1997). The potential for advocacy as a way of tackling health inequalities seems obvious, but the concept is not universally accepted. Critics of advocacy perceive a sharp contrast between health promotion rhetoric of community participation and co-operation, and the paternalistic role of advocacy in constructing people as uninformed, ill-educated and in need of the services of interventionists who claim to know better (Wenzel, 1999). Given the scope of health promotion practice, it is perhaps not surprising that multiple meanings are attached to the term 'advocacy' throughout the literature. Such contrasting usages are explored below in an attempt to conceptualize the field, mapping such complexities as the diversity of advocacy goals and ideologies or philosophies of practice, the range of levels at which practitioners work and how these disparate elements relate to the issues surrounding health inequalities.

In Britain, after years of official neglect, reducing inequalities in health is now a matter of urgent public policy concern (Department of Health, 1998a; Scottish Office Department

of Health, 1998). The priority attached to this matter by the current government was signalled by the commissioning of an independent inquiry (Department of Health, 1998b). Despite a lengthy research tradition in this area (which in itself is an important component of advocacy for health), existing accounts for health inequalities are not yet fully developed, and much remains to be discovered about the mechanisms that create and sustain them (HEA, 1999). Structural, material and psycho-social explanations and interpretations have all contributed to a rich and steadily expanding body of knowledge, a full discussion of which is beyond the scope of this paper. Arguments for the causes (and effects) of inequalities in health may be located mainly within the social structure/environment or mainly within the individual, although the links between the two are not in doubt. Individualistic explanations of health inequalities, in terms of unhealthy lifestyles and choices, still exist, although epidemiology and the social sciences have produced extensive evidence of the harmful impact on health of poverty, deprivation and social exclusion at both individual and population levels (Wilkinson, 1996; McIntyre and Hunt, 1997; Bartley *et al.*, 1998; Popay *et al.*, 1998; Townsend, 1998; Davey Smith *et al.*, 1999). This paper offers a conceptual framework that could be used to reflect on the polysemic role of advocacy in health promotion and its potential for addressing health inequalities.

DEFINITIONS AND MODELS

At its simplest, advocacy may be defined in terms of the activities it encompasses: for example, the representation of under-privileged groups, such as those who are disadvantaged or sick, with the aim of promoting their rights and/or redressing imbalances in power. This has been characterized as 'case' advocacy (Rees, 1991). Advocacy is also seen as a lobbying activity within public health and as such has a long history. In recent years this usage has become increasingly common within the health promotion literature. This approach acknowledges that barriers to health can lie beyond the control of individuals, and that structural factors need to be addressed if health inequalities are to be reduced. This has been characterized as 'cause' advocacy (Rees, 1991). Both types can be categorized as representational advocacy. However, health promotion explicitly

espouses values of democratic participation, community development and empowerment, wherein disadvantaged individuals or groups are enabled to represent themselves and lobby for their own health needs. The role of advocacy here is best categorized as facilitational rather than representational—providing individuals and communities with the skills to tackle and redress inequalities in health.

Other definitions and models of advocacy within health promotion exist. For example, advocacy may be seen as a confrontational activity, challenging powerful anti-health interests such as the tobacco lobby (Wallack *et al.*, 1993; Altman *et al.*, 1994; Chapman and Lupton, 1994; Wallack and Dorfman, 1996). Alternatively, advocacy may operate as a conduit or channel, mediating and negotiating between opposing forces in the interests of positive health, abandoning adversarial positions in order to develop a common agenda and find mutually achievable goals (Nutbeam, 1993). Advocacy may also have a capacity building function, providing support for disadvantaged individuals and/or communities to gain control over and improve their own health by becoming effective policy advocates (Schwartz *et al.*, 1995). Kickbusch argues that the aim of public health is to improve the health of communities through employing all three: advocating for healthy public policies and supportive environments; mediating between different interests in society to benefit health; and enabling communities and individuals to achieve their full potential (Kickbusch, 1995).

A CONCEPTUAL FRAMEWORK FOR ADVOCACY ON HEALTH INEQUALITIES

Defining health advocacy solely in terms of activity neglects to make explicit a number of key elements mentioned earlier, for example, the way practice is shaped by the different domains and levels at which advocacy can operate (individual/group or policy/social structure), potential tensions in the goals of advocacy (representation or facilitation) and how such goals are related to the practitioner's own philosophy of practice. It also neglects to make explicit which particular explanatory models of health inequalities are being used. The distinction Seedhouse makes between medical and social health promotion can be used, albeit somewhat simplistically, as

a basis for considering practitioners' work on health inequalities (Seedhouse, 1997). For the sake of simplicity, Seedhouse's additional conceptual models of 'good life promotion', 'go for it health promotion' and 'mix'n'match health promotion' will not be considered here. 'Medical health promotion' seeks to prevent or ameliorate disease, illness and injury, drawing on 'objective' evidence (the benefits of not smoking, eating less fat/drinking less alcohol, taking regular exercise) to prevent clinically defined conditions. 'Social health promotion' seeks to change the world and challenge the injustices that cause ill health by improving the lives of the least well-off members of society. In a paper with considerable significance for health promotion practice, Lomas (Lomas, 1998) argues that public health as a discipline has been 'colonized' by the individualist ethics of medicine and economics. He believes that the emphasis on screening, immunization, lifestyle change and risk factor modification obscures the need to '(wo)man the barricades in the name of radical social system change for health'. This suggests that 'medical health promotion' may therefore be the dominant model, which has implications for the ways in which practitioners will seek to tackle health inequalities.

Figure 1 seeks to integrate such elements within a conceptual framework that provides a more explicit way of locating advocacy practice in health promotion. Four different types of advocacy are identified. It is suggested that these are shaped by the domain within which health promotion advocacy takes place (case or cause); the goals and philosophy of the practitioner; and the freedoms and constraints associated with their professional role. Advocacy work will also be influenced by the particular conceptualization of health inequalities being used. The axes of the matrix are best regarded as continua along which practice can be located, rather than mutually exclusive and oppositional poles: depending on context, it is possible that one form of practice may shade into another. The right-hand half of the matrix relates to representational types of advocacy: the left to facilitational types.

Representation

Straightforward representational advocacy operates at the level of cases rather than causes, and individual health promoters are likely to practise this type frequently. The goals of the health promoter may be traditionally prescriptive, in

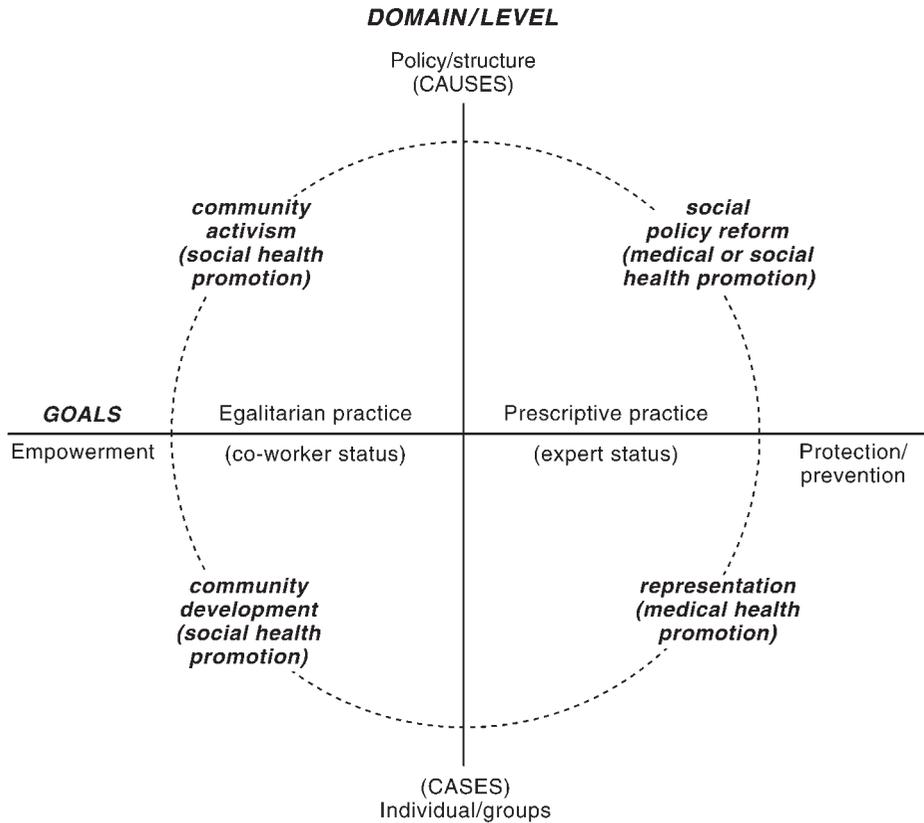


Fig. 1: A conceptual framework for advocacy in health promotion.

advocating for education and behaviour change to improve the health of individuals and groups and thus reduce health inequalities through a lifestyle approach (medical health promotion). Alternatively, the main concern may be to represent the rights and health needs of those unable to speak or act for themselves to agencies and service providers (social health promotion). Most advocacy in the fields of mental health and learning disabilities is of this type and is covered by an extensive literature. In both cases, the status of the health advocate is likely to be that of an 'expert'. Baric, for example, has traced the rise of the advocate planner, possessing expert knowledge and concerned with promoting the interests of threatened or deprived groups or communities (Baric, 1988). This type of representational/authoritarian advocacy is driven by the perceived need to protect or defend such interests. Baric suggests that this may be necessary when the increasing sophistication of planning techniques

means that individuals and communities are unable to participate effectively in planning processes for health, even if given the opportunity. Depending on the context within which they work and their professional background, health promoters may also seek opportunities to move from such traditional advocacy to more facilitational forms. Protective, representational advocacy may therefore draw on either medical or social health promotion approaches to health inequalities.

Community development

In this type of health advocacy, the goals of health promotion are enablement rather than protection/prevention. The practitioner's status is likely to be that of a facilitative co-worker employing an egalitarian philosophy of practice. Advocacy activities are orientated towards 'case' level work with individuals and groups, identifying their needs and seeking to address these

at the local level (Jones, 1999). An extensive and growing literature exists as testimony to the popularity of community development. This approach seeks participation and empowerment, which suggests that this type of advocacy would use a social health promotion approach to health inequalities. This is not necessarily the case. Farrant documented the increasing use of community development work, together with its underlying contradictions and tensions (Farrant, 1991). She drew attention to the historical roots of community development in colonialism where, far from being inherently radical, it was employed to safeguard and further the interests of the ruling class and reduce the burden on colonial administrators. From this perspective, the drive for community participation can be viewed as part of a medically driven, professional prescription for community manipulation. Working with communities may in practice translate as working *on* communities—advocating for change at the grass roots level but the change agenda is decided by professional interest, not the community ‘voice’ (i.e. medical health promotion). Facilitating community definitions of health and health problems is therefore a key role for the advocate who wishes to practice social health promotion. Health promotion work on community development may evolve into empowerment for action, which for some is the ultimate goal of practice (Wallerstein, 1992; Wallerstein, 1993).

Community activism

This type of advocacy moves beyond facilitating community definitions of need to enabling communities to challenge the causes of poor health more directly at the policy-making and structural level—i.e. social health promotion. Although the advocate operates at the level of ‘causes’, his or her goals remain facilitative and empowering. This model of advocacy seeks to provide communities with political advocacy skills (Schwartz *et al.*, 1995) rather than individualistic skills to make ‘better choices’. Gillies argues that greater levels of local community involvement in setting agendas for action, and in the practice of health promotion, result in greater impacts on that community (Gillies, 1998). The rise of citizens juries are a recent example of how representative community participation can make decisions about health-related policy (Macdonald, 1998), although lack of congruence between national and local policy concerns may undermine the legitimacy

of healthy public policy-making at local level. Advocacy for health inequalities within this model therefore needs to incorporate coalition-building activities, forming links with other communities and with organizations at local and national levels—acting locally but thinking globally (Hancock, 1990). Alliance building across sectors (Milio, 1987) to promote health and tackle inequality is a necessary component of this type of social health promotion advocacy. de Leeuw has characterized such advocates as social entrepreneurs in health promotion (de Leeuw, 1999): work at this level of practice requires them to act outside their own organization or in individual roles rather than as organizational representatives. This requires a freedom of action and decision making not constrained by the need for political acceptability and sensitivity.

Social policy reform

Health promotion work that seeks to redress health inequalities at the level of the social structure and to influence policy making can be categorized as health advocacy for (social) policy reform. From this perspective, health inequalities are the outcome of ‘causal chains’ that run to and from the basic structure of society (Department of Health, 1998b). This type of advocacy is likely to require knowledge of local and national political systems and other complex mechanisms. Work at this level demands that the advocate practitioner possesses a degree of ‘expert’ knowledge and authority in order to have credibility. Examples of this type of prescriptive advocacy may focus on legislative reform relating to the availability of products perceived as antithetical to health such as tobacco, alcohol or illegal drugs, or on the prevention of environmental hazards and pollution, etc. The ‘champions’ of this type of social change in the interests of public health are unlikely to be lone health promotion specialists working within local health or social services, but are clearly drawing on a medically orientated view of health promotion [e.g. (Altman *et al.*, 1994)]. Although inherently ‘top down’, this type of practice is not incompatible with radical change models, as the targets for health advocacy are often the powerful vested interests of multinational corporations more interested in profit making than population health, and the governments that support them.

Alternatively, advocacy at this level may take a broader social perspective on health inequalities.

Much of the literature detailing the role of poverty and deprivation in structuring health inequalities within society draws on the theme of social transformation through policy change as the most effective way to tackle such issues (Wilkinson, 1996; Alcock, 1997). Only interventions at the level of the social structure are believed capable of reducing social and economic inequalities: the issue of health inequalities is fundamentally a matter of social justice (Department of Health, 1998b). Labonte suggests that this type of advocacy may be the solution to the limitations of community organizing, as it targets policies and policy makers in order to achieve radical social change (Labonte, 1997). Well known for his work in the field of community empowerment, Labonte makes the case for structural and policy-level health promotion advocacy [(Labonte, 1999), p. 172] when he says:

If we can prescribe blithely on health-promoting behaviours, we should not shuck such prescriptions when it comes to health-promoting economic or environmental conditions.

The strategic influencing of governments and large organizations to reduce health inequalities through changing their policies and practices demands considerable capacity and freedom of action unconstrained by the need for political acceptability. Health promotion advocacy at this level is likely to require cross-sectoral alliances.

DISCUSSION

The literature suggests that advocacy to reduce health inequalities is likely to draw on either medical or social conceptualizations of health promotion work, although there may well be some blurring of boundaries. It is not possible to state categorically that (x) type of practice will always occur in (y) type of context. Whilst facilitational advocacy seems more likely to draw on social models of health promotion, this does not exclude the possibility of the individualistic influence of medicine. Representational advocacy may draw on either social or medical conceptualizations of health promotion, although this is rarely made explicit in the literature. The framework in Figure 1 aims to make clear the continuum from conservative to radical politics and practice that characterize the discipline and shape advocacy for health.

Carlisle suggests that advocacy has the capacity to bridge different political–philosophical positions as well as the gap between the world of policy makers and the lives and experiences of health promotion’s ‘clients’ (Carlisle, 1998). This may be the case, but there remain a number of factors that limit the potential of health promotion advocacy for tackling inequalities in health. Firstly, while it is now beyond doubt that social and structural factors are instrumental sources of health inequalities, it will probably be difficult for some health promoters to escape the traditional individualistic imperatives of the discipline. Work at ‘higher’ political levels may be beyond their individual and organizational remit. Secondly, community organization, development and activism are valued for their grass roots nature but are limited in scope. Critics of the approach have pointed out that, by locating the potential for tackling health inequalities within communities, governments are attempting to solve their own pressing problems with regard to the increasing costs of the welfare state (Wainwright, 1996). Community development and action thus risk becoming a misdirected panacea for inequities at national and global level. However, although more radical proposals for redressing health inequalities at the level of social policy may appear to have greater potential for social change, they run the risk of rejection as unacceptably top-down. Depending on their content, such proposals may be interpreted as left-wing attempts at prescriptive social engineering, or as right-wing, anti-democratic medical authoritarianism.

Although the literature indicates a multiplicity of meanings, plurality of practice, diversity of practitioners and conflicting ideological underpinnings, the model in Figure 1 suggests that there is no one ‘right’ type of health advocacy. The tendency to assume that ‘bottom up’ types of practice are inherently preferable to ‘top down’ initiatives is open to question. Such arguments can unwittingly run counter to advocacy for social change in the interests of social justice and greater equality in health. The framework outlined in Figure 1 suggests that both (social) empowerment and (medical) expertise models are needed—‘upstream’ and ‘downstream’ advocacy for redressing health inequalities. Advocacy is not value neutral at any level or in any arena of health promotion although, in practice, it is not always apparent that the values in question may be contradictory at the different levels. Health

promoters therefore need to be explicit about the explanatory frameworks of health inequalities they utilize and how these affect the type of advocacy they choose—or are expected—to practice. Practice is located within the specific context of perceived needs of communities and capacities of health promoters. The above framework does not seek to suggest that health advocacy practice is necessarily fixed: if advocacy is to be effective, the boundaries between different types of practice need to be mutable to allow for changing contexts. Given sufficient room for manoeuvre, representation can shift towards empowerment; individual and community-based initiatives geared towards skill development can lead to communities expressing their own needs and working to achieve change. Coalitions and alliances between groups and communities can be supported to engineer a critical mass with the power and will to lobby for policy change.

Finally, although advocacy for health is clearly a major contemporary issue contributing to the development of health promotion practice, it is also enmeshed within the project of advocacy for health promotion as a discipline. As advocacy is always associated with the pursuit of justice, it provides a powerful legitimizing rhetoric for a still youthful discipline with—perhaps—ambitions of becoming a profession (Oakley, 1998). It also provides an emancipatory framework with which to challenge the restrictive definitions of health employed by biomedicine. The role of health advocacy is to influence governments and national/international agencies in beneficent and health-promoting ways, and to raise the profile of health-promoting organizations, ensuring that their voices are heard and taken note of (IUHPE, 1999). Both health promotion and public health are currently involved in a form of self-advocacy, obliged to re-invent themselves as ‘investments’ in times of tough global competition for finite resources (Labonte, 1999; WHO, 1999). Ironically, the lack of concrete and universally accepted definitions for the terms ‘health’ and ‘health promotion’ that so irritates critics is probably the factor which provides sufficient flexibility and scope for such reinvention. Advocacy for health therefore fulfils two functions: it is both a form of practice and a useful strategic tool for a discipline which has to be self-promoting as well as health-promoting in order to survive in the demanding contemporary environment of national and international health work.

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