The role of health promotion: between global thinking and local action

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Introduction

Readers of this journal are likely to be familiar with the dictum ‘think globally, act locally’, and have observed how it often plays out at health promotion conferences with ‘big picture’ ideas from keynote speakers alongside preferred presentations on local projects. In fact, this is the theme for the 2007 conference of the Australian Health Promotion Association.* The gap between global thinking and local action can leave some health promoters feeling motivated, but at other times, or other people, feeling frustrated. This paper suggests that the gap between big ideas and local practice is a significant limiting factor for health promotion in addressing health inequities, and that the maxim ‘think globally, act locally’ does not provide a sufficient guide for this task.

This paper, a discussion and opinion piece, suggests that we need to more clearly specify what is needed to fill the space between big ideas and small practice.

The health promotion approach

As illustrated by international and national textbooks, journals and conferences, health promotion has developed a substantial repertoire of conceptual and analytic methods and intervention tools that underpin much research and practice. For example, the health promotion problem-solving and planning approach identifies potential points for intervention on the basis of the determinants of health and analysis of contributing factors.2 On this basis, structural factors, such as the poorer quality of social, physical and economic environments, can be identified as significant determinants of health differentials and meaningful points for interventions.2 Such ‘upstream’ structural factors can be described as ‘causes of the causes’, with behavioural factors identified as playing a more mechanistic role as immediate causes. To produce changes in factors that influence health problems, including structural factors, health promotion has sought to influence public policy, facilitate action across sectors

Abstract

Issue addressed: The persistence of health inequities provides an ongoing challenge for health promotion. The dictum ‘think globally, act locally’ fails to recognise the significance of infrastructure and policy in linking global issues and local practices as a means of addressing health inequities.

Methods: Commentary and opinion.

Results: Through analytic tools and methods, health promotion has much to contribute to facilitating health-improving changes in social, economic and physical environments. Local actions provide excellent illustrations of organisational change and intersectoral action, and present the possibility that such actions could be widely implemented. While this has occurred on some issues, this is not usually the case. Political support, policy and infrastructure are required to link global ideas and local actions and overcome the impasse. Media advocacy is one example of an approach with potential to make these links and mobilise political support.

Conclusions: Reframing media and political discussion, away from the dichotomy of individual responsibility and government intervention and towards acknowledging the social context of human behaviour, could contribute to policy and social environments with greater capacity to address inequities.

Key words: Health promotion practice, media advocacy, organisational capacity, health inequities.

So what?

Health promotion needs to beg, borrow and build political and media advocacy skills if it is to go beyond local demonstration projects and have the capacity to promote population health and address health inequities.
Beyond health services, and mobilise community action, as well as employ more conventional activities, such as community education, health literacy programs and health service delivery.\textsuperscript{3,4} Given that these tools and methods are well known among health promoters, to what extent have they been used to promote health generally and address inequities at local, State and national levels in Australia?

**Acting locally**

Drawing on a range of publications, including articles published in this journal, it appears that Australian health promotion has applied a broad repertoire of interventions at the local level to address health inequities.\textsuperscript{5} These include:

- Interventions tailored to the cultural and social characteristics of specific target groups, such as Aboriginal health promotion programs.\textsuperscript{6}
- Interventions focused on problems specifically associated with disadvantage, such as food insecurity,\textsuperscript{7} as has occurred through VicHealth in a substantial program conducted over the past few years.\textsuperscript{8}
- Intersectoral approaches to tackling issues beyond the traditional scope of health, such as community safety, housing and food supply. Examples include Housing for Health\textsuperscript{10} (being implemented) and the Penrith Food Project.\textsuperscript{9}
- Programs that directly assist disadvantaged groups to access individual and community resources, such as Food Aid\textsuperscript{7} or service navigation and referral.\textsuperscript{10}
- Actions designed to make changes within particular settings, such as schools, communities and organisations. Setting-based approaches provide a means of working intersectorally, as illustrated through Health Promoting Schools\textsuperscript{11} and working with police to address alcohol issues.\textsuperscript{12} Such setting-based approaches can be particularly effective in addressing environmental, policy and behavioural factors in an integrated and reinforcing way, and contribute to enhancing organisational capacity.\textsuperscript{13}

In many of these examples, health promoters have applied recommended best practice principles in designing and implementing programs to address inequities.\textsuperscript{3}

Nevertheless, local programs are frequently of short-term duration and conducted at a low level of intensity in a small number of localities. This very small level of investment in local programs is arguably, in many cases, below the threshold required to produce perceptible or sustainable effects.\textsuperscript{14,15} For example, community development programs are rarely funded at a level where they could be implemented over longer timeframes and on a scale that could logically lead to community changes sufficient to influence health determinants. Studies on the actual intensity of intervention and level of investment required to produce measurable changes for different populations are few, and comprise a major gap in health promotion research and practice.

Local practice provides good illustrations of what is possible in organisational change and intersectoral action, and opens the possibility that such actions could be widely implemented. However, the sophistication of methods and approaches available and tested in local health promotion practice is not reflected generally in the scientific evidence base.\textsuperscript{16} As a scientific discipline, health promotion recognises the need to build research evidence on the effectiveness of interventions. While evaluations of health promotion programs have indicated that they can be successful in reaching diverse target groups, engaging communities and stimulating environmental changes,\textsuperscript{3,17} there is not a robust evidence base on addressing health inequities. The range of different immediate and intermediate outcomes expected from different types of health promotion actions make it difficult to compare effects and apply conventional systematic review methods across programs.\textsuperscript{18} Limitations in the evidence base may be one of the factors restricting the widespread adoption and implementation of health promotion actions, although other social and political constraints discussed below undoubtedly play a role.\textsuperscript{19}

**Thinking globally**

At a global level, health promotion has successfully built an international constituency of researchers, policy makers and practitioners that has achieved consensus on the scope and breadth of action required to promote and redress health inequities. The Ottawa Charter, Jakarta Declaration and Bangkok Charter\textsuperscript{20} are well-known statements of principle and approach. The Commission on Social Determinants of Health, formed by the World Health Organization in 2005, provides an example of a macro-level strategic initiative that is seeking to influence national policy agendas.\textsuperscript{21}

These broad-ranging approaches recognise that health can be influenced through global trade as well as national economic, agricultural, transport, urban planning and taxation policies and practices. Such approaches propose a role for politicians, lawmakers and industry in promoting health. Examples of national actions by such groups in Australia include: the production of unsaturated margarines and low-fat food items, which have the potential to contribute to reduced fat intake in the population;\textsuperscript{22} regulatory changes that have drastically reduced exposure to tobacco smoke in public places; and political commitment that was instrumental in mobilising resources for HIV/AIDS prevention programs.\textsuperscript{17} Recent interest in obesity prevention within law faculties in Australia provides a current example of cross-disciplinary opportunities to mobilise action.\textsuperscript{21}

**Between the local and global**

Analyses of these success stories, and comparisons with less successful efforts, have indicated that political and policy commitment, organisational management support, infrastructure and workforce capacity are essential preconditions for success.\textsuperscript{17,24} That is, there is a set of middle-range mechanisms and systems that are needed to facilitate global or national policy, support local actions and create links between them.
Where such policies, management and infrastructure supports are in place, health promoters and public health practitioners can be in a position to address social and economic determinants. However, local health promoters frequently perceive that they are not well positioned to address social factors,25 that their context lacks organisational and management support, and that this detracts from the quality and scale of program implementation and overall effectiveness.26

Government, industry and professional groups are not always responsive to public health issues and health differentials, and the infrastructure for health promotion in Australia remains small and relatively fragile.17 In these circumstances, responsibility for addressing social determinants and inequities may be beyond the reach of many health promoters, including policy makers within State government jurisdictions.

The gap between global thinking and local action has been recognised over many years by many people.27 Recently, responses to the Bangkok Charter have reflected on the connection between the global vision and daily professional activities, and identified its contribution to reflective practice and personal motivation.28 In 1999, St Leger noted that the possibility for local actions to influence global action was something frequently taken on faith within health promotion.29 Ten years previously, McQueen acknowledged that the maxim of ‘think globally, act locally’ actually reflected prevailing and contradictory views – both recognition of global influences on health and a focus on individual actions.30 In contemplating how health promotion and public health incorporate prevailing culture, he anticipated the current social climate, where health promotion and continues to reflect contested world views.

What can health promotion do to create supportive policy and infrastructure?

In Australia, in a social climate where media and politicians emphasise individual responsibility and caution against the nanny state, it seems difficult to build structural approaches to promoting health and addressing health inequities. For example, a newspaper article, reporting on qualitative research on child care staff’s perceptions about the positive role they can play in promoting healthy eating and active play, framed the story as a warning against the nanny state, with the front page headline ‘Kids forced into fitness’.31 ‘Commonsense’ theories on promoting health, such as those promulgated by many politicians, media representatives and some community members, frequently assert the primacy of individual responsibility. For example, through appealing to ‘common sense’, national leaders have recently identified parents as responsible for children’s TV viewing and eating patterns and used this as a way of deflecting any serious discussion about regulatory approaches to food advertising on TV and reducing risks for childhood obesity.32 Paradoxically, such views may lead to more disadvantaged people rejecting health messages through feeling overwhelmed, distrustful or finding them irrelevant.33 The way an issue is framed can position its significance, direct understanding about causes and formulate specific types of solutions.35 Public health media advocacy is a tool that can be used to frame issues in new ways, and thus potentially change community views and affect government policy.17,34,35

One potential contribution in the present situation would be to seek to reframe media and political discussion away from individual responsibility and towards acknowledgement of the interaction between choice and environment. For example, it is possible to find new angles and new devices to point to social influences on obesity prevention.16 The classic graphic adapted from Puska (see Figure 1) provides a clear picture of the potential for social and economic environmental factors to alter the gradient posed by everyday environments for people as they seek to make healthy choices.37 Environmental support is particularly critical in supporting more disadvantaged groups and communities, as more privileged and educated groups have greater material and social resources to overcome barriers.

Media advocacy is a familiar strategy in health promotion theory, but less frequently used in local practice. One reason for this is that many health promoters are employed through government services and require complex approval processes to make media statements. Health promotion may need to increasingly build partnerships with groups with better media access. For example, the establishment of the Parents’ Jury by Diabetes Australia and The Cancer Council provides a significant avenue for advocating for changes in food marketing to children through greater regulation of TV advertising and reduced point-of-sale promotions in supermarket checkouts.38 While not specifically oriented to inequities, such changes have the potential to reduce pester power for all parents, especially those who have less disposable income and no choice but to take children shopping with them. Media advocacy cannot, by itself, reverse dominant individualistic ideology or blind-spots regarding social influences on health, but is presented here to highlight the possibility of building and applying a repertoire of mid-range strategies to link local actions and big ideas.

![Figure 1: Individual and environmental changes as complementary approaches (adapted by Campbell, 2001).](Image)
Conclusion

Persistent health inequities continue to challenge how health promotion constructs interventions and the small scale of operations that characterise the field. These challenges relate to the disjunction between global ideas and local practice and the small scale and local level of much health promotion. Linking global ideas and local actions requires political, policy and infrastructure support. Media advocacy is a familiar and appropriate tool for tackling this disjunction and potentially creating a more conducive climate for policy and structural changes with the potential to address inequities. To respond to this challenge, health promotion and health promoters may need to increasingly incorporate media and political approaches through forming alliances with groups with scope for advocacy.

Disclaimer

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