Reducing social inequalities in health: public health, community health or health promotion?

Valéry Ridde

Abstract: While the Consortium on 'Community Health Promotion' is suggesting a definition of this new concept to qualify health practices, this article questions the relevance of introducing such a concept since no one has yet succeeded in really differentiating the three existing processes: public health, community health, and health promotion. Based on a literature review and an analysis of the range of practices, these three concepts can be distinguished in terms of their processes and their goals. Public health and community health share a common objective, to improve the health of the population. In order to achieve this objective, public health uses a technocratic process whereas community health uses a participatory one. Health promotion, on the other hand, aims to reduce social inequalities in health through an empowerment process. However, this is only a theoretical definition since, in practice, health promotion professionals tend to easily forget this objective. Three arguments should incite health promoters to become the leading voices in the fight against social inequalities in health. The first two arguments are based on the ineffectiveness of the approaches that characterize public health and community health, which focus on the health system and health education, to reduce social inequalities in health. The third argument in favour of health promotion is more political in nature because there is not sufficient evidence of its effectiveness since the work in this area is relatively recent. Those responsible for health promotion must engage in planning to reduce social inequalities in health and must ensure they have the means to assess the effectiveness of any actions taken. (Promotion & Education, 2007, (2): pp 63-67)

Key words: social inequalities in health, public health, community health, health promotion, definition

There has been much debate around the definition of health practices. Some authors have referred to vague and fluctuating definitions (Gagnon & Bergeron, 1999, p. 257), whereas others have managed to turn this controversy into a research area in and of itself (Fassin, 2000a). According to Bourdieu (2001), it is perfectly normal for scientists working in the same field of knowledge to be in perpetual disagreement. Traditionally, a dichotomy persists in expert opinion discourse between public health and community health, with the former being considered older than the latter. Health promotion emerged more recently, carrying a formal status since 1986. Additionally, three expressions are commonly employed to describe health interventions: public health, community health, and health promotion.

Upon being invited to contribute to this themed issue on community health promotion, the author’s immediate reactions were two-fold. First of all, there was a desire to discover how the Consortium managed to define this new concept. The answer can be found at the beginning of this issue, although the communiqué issued by the Consortium at the beginning of 2006 (Nishtar et al., 2006) still leaves one perplexed1, and makes the present article all the more pertinent. Secondly, the author questioned the relevance of introducing a new definition for health interventions, since no one has yet really succeeded in defining the three processes that already exist. Introducing a new concept without having ever really succeeded in clarifying older ones puts us at risk of being subjected to critics’ accusations, branded as ‘windbags’ (Fassin, 2000a, p.71). It can also lead to more confusion than clarification, as was the case in Canada when the term ‘population health’ first appeared. The objective of this article is, therefore, to attempt to differentiate the three types of health practices generally encountered in the literature and in the field, in order to situate the term ‘community health promotion’ and demonstrate that health promotion must take the lead in the fight against social inequalities in health.

An attempt to differentiate practices

Following the example of Rootman et al. (2001), it was considered useful when attempting to establish definitions to distinguish between the process and the goal of a practice. Examples drawn from the author’s personal experiences and knowledge of Canadian, French, and African practices are used to support the arguments presented here.

End Goal

Public health and community health generally share a common goal: improving the health status of people, taken as a group and not individually. Many examples could be given of public policies from around the world that share this objective. Curiously, and since it is rare enough to merit specific attention, the first health policy of Quebec

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had a similar goal; however, it was framed negatively: the policy proposed 19 objectives to "reduce health problems" (Ministère de la santé et des services sociaux, 1992). This was later revised based on national public health priorities to "make substantial gains in health matters" (Ministère de la Santé et des Services sociaux, 1997), which serves as a reminder of the debate on the 'positive' versus the 'negative' definitions of the concept of health.

The definition traditionally found in public health training manuals follows Winslow’s proposal from 1920 and defines public health as the art and science of promoting health, preventing disease and prolonging life (Fournier, 2003). This article, however, advocates a definition that goes beyond the famous three ‘Ps’ and focuses more on process than on the goals of promotion, prevention and protection, which were the foundation of public health priorities in Quebec from 1997 to 2002. Thus, more in-depth reflection on the teleological level is needed in order to understand the ultimate purpose of health promotion activities. A real paradigm shift is boldly proposed by affirming that health promotion seeks not only to improve the health of the population, but above all to reduce the gaps in the health status among population subgroups. Indeed, the Ottawa Charter states that, "Health promotion focuses on achieving equality in health. Health promotion action aims at reducing differences in current health status" (OMS, 1986). This paradigm shift also makes it possible to differentiate health promotion from previous endeavours to establish definitions, since Conill and O’Neill (1984) proposed the objective of community health to be the improvement in the health status of the population, making no mention of social inequalities in health. This distinction seems essential, since most interventions that do not specifically aim at reducing disparities almost always end up aggravating them, even when the goal of improving the health of the population is achieved (Fassin, 2000b, p. 33). This was the case for the residents of Montreal (Lessard, 2003). Adopting this definition means questioning beliefs, which are a central notion in the Khunian concept of a paradigm. Health promotion is thus conceived as an under-taking whose ultimate purpose is social change. If a new ‘new public health’ (Horton, 1998) needs to be created in order to achieve this, then so be it. Perhaps this may not be necessary, as will be explained below, since the Ottawa Charter of the new public health already contains the objective of reducing inequalities.

### Process

In contrast to the view of Conill and O’Neill (1984) who believe that community health can have two poles, one technocratic and the other participative, the author maintains that these two poles actually constitute the distinction between the implementation process in public health and the one in community health. The process of implementing public health interventions seems to correspond to a technocratic top-down approach. If public health stakeholders agree with their counterparts in community health on, for example, encouraging individuals to change their lifestyles or behaviour, the former will use more coercion than the latter in attempting to achieve this change. Terms such as ‘risk factor’ and its corollary ‘victim blaming’ (Lupton, 1995) are characteristic of public health, where the health system, health education and prevention are the biggest budget recipients. In France, the history of public health (Abenhaim, 2003), as well as the quarrels about the creation of the National Institute for Prevention and Health Education (INPES), and the recent legislation in 2004 on public health, are all very indicative of this approach, which is centered on prevention and the health care system, and is run by a centralized or decentralized administration. Epidemiology and an evidence-based approach are the cardinal tools of public health, with physicians occupying a central place in the system. There are some authors who directly refer to the work of Weber and even maintain that the only authority really known to public health is rational-legal, based on law (Jalfré & Olivier de Sardan, 1999, p. 364). Regardless of whether this is representative of the history of public health, Fassin’s analysis (2006) of the “double model of constraint and normalization, authoritarian control and moralizing intervention” in South Africa is the technocratic process paragon since “on many occasions public health has served the racist political project of South African authorities” (p.211). In Africa, health promotion is a relatively unknown concept (Nyamwaya, 2005); public health has the monopoly on words and practices for numerous reasons which would take too long to explain here (Ridde & Seck, 2006).

Community health practitioners, on the other hand, place population participation at the centre of their interventions and the emic point of view is supported. Certain health centres in the United States were pioneers in community medicine practices in North America in the 1960s (Lefkowitz, 2007), as were those of social medicine in certain health centres in South Africa in the 1940s (Fassin, 2006). There is recognition of the relationships between certain individual practices and the triggering of particular pathologies. At the same time, emphasis is placed on understanding the social and structural conditions that can give rise to such practices. Members of the community participate in defining the problem, finding solutions and implementing them. Epidemiology and statistical tools are not ignored, but they are not the only methods used, and the epistemological approach is more constructivist. Planning models using this triangulation of methods (Green & Kreuter, 1999), such as the model applied in Quebec from 1980-90 (Bergeron & Gagnon, 1994), and the one in Belgium (Bantuelle et al., 1998), are good examples of the community health process.

Health promotion interventions are based directly on the approach outlined in the Ottawa Charter. Actors thus attempt to implement a process that provides populations with the means to ensure greater control over and improve their own health (OMS, 1986). This is the concept of ‘empowerment’, which is a guiding value in health promotion but will not be discussed here for reasons of space.

Empowerment actions and interventions appear to produce highly effective results in health improvement (Wallerstein, 2006). Evidently, this approach has its critics; in Lupton’s view (Lupton, 1995, p.60), the rhetoric of empowerment serves to obscure public health professionals’ investment and interventions by persuading certain groups to develop their competencies and exercise control over their lives.

The attempt to differentiate these three types of practice is summarized in Table 1-again, this is only an attempt. The distinctions must not be perceived as being set in stone and these characteristics are only highlighted a priori in order to force the traits necessary for creating a Weberian ideal type.

### Table 1. Attempt to differentiate public health, community health, and health promotion

<table>
<thead>
<tr>
<th>Process</th>
<th>End Goal</th>
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<tbody>
<tr>
<td>Public health</td>
<td>Technocratic</td>
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<tr>
<td>Community health</td>
<td>Participatory</td>
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<tr>
<td>Health promotion</td>
<td>Empowerment</td>
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*Source: Author*
Health promotion must address social inequalities in health

In 1988, the Director General of the WHO was already concerned that, “public health has lost its original link to social justice, social change and social reform” (Hancock, Labonte et al., 1995). Twenty years later, this fact remains the same. Furthermore, health promotion must recover its original role and challenge social inequalities in health. Stakeholders need to understand that health planning is not simply a technical exercise, but can also be a tool for bringing about social change. This responsibility for action and advocacy must be entrusted to those in the field of health promotion. Besides the fact that public health practice, which is several centuries old, has not been able to eliminate the inequalities in health that persist to this day (Mackenbach, 2005) – and which have been measured statistically ever since the 17th Century – three arguments, among others, may be used to support this case. The first two arguments are based on the ineffectiveness of the approaches that characterize public health and community health, i.e., actions generally centred on the health system and health education, for which effects are now well-known. The last argument in favour of health promotion is more political in nature since there is not yet sufficient evidence of its effectiveness, due to the fact that work in this area is very recent (Hills, Carroll et al., 2004).

The Health System

For a very long time, and even today, people have believed that the health system is able to improve the health of the population and reduce disparities in mortality rates among sub-groups. The former French Minister of Health thought that the duty of public health basically involved nothing more than modernizing the organization of health services (Mattei, 2002). Section 2 of the Public Health Act, promulgated in France in 2004, states that the reduction of inequalities in health may be achieved through health promotion and by developing access to care and to diagnostics throughout the country, which no doubt explains why 97% of the health budget is allocated to the care system (Abenhaim, 2003). Budget allocation is not any better in Quebec. The expression ‘health promotion’ only appears in French legislation twice: in the above-mentioned section and as a reminder of the mission of the INPES, the latter mission, however, has not resulted in the word ‘prevention’ being replaced by ‘promotion’ in the name of this public entity. According to French researchers, health policy essentially views the reduction of social inequalities in health in France from the angle of primary access to care (Pascal, Abbey-Huguenin et al., 2006, p.118).

Nevertheless, numerous studies have shown that if the health system and medicine can have an effect on the health of individuals needing care, they have no or very little effect on population health. Due to lack of space, this subject cannot be developed here, but readers are referred to the classic references on the topic (McKinlay & McKinlay, 1977; Ashton & Seymour, 1988). Furthermore, the health system and medicine can also have harmful effects on the health of individuals. In France alone, it is estimated that 18,000 people die each year from the side effects of medication (Abenhaim, 2003). In the United States, medical errors cause 98,000 deaths annually (Institute of Medicine, 2000).

Given the limited evidence of the health system’s effects on the population, what evidence is there that the system reduces social inequalities in health? Although work on this topic is rare, recent research carried out in the province of Manitoba in Canada sheds some light on the subject. As is the case elsewhere in Canada, the health system in Manitoba is largely funded and administered by the public sector. A study on the data of the hospital use from 1986 to 1996 seems to show an equitable health system usage since the poorest, who a priori have the greatest needs, spent 40% more days in hospital and represented 30% more of hospital admissions than the richest. This difference in use, which favoured the poorest, remained constant over a period of ten years. However, examining the disparities in mortality rates for this same period shows that, not only does the situation remain unfavourable for the poorest, but the gap has widened to their detriment (Table 2). In other words, although health system usage has been equitable (in terms of need, rare evidence contradicts the “inverse care law”), social inequalities in health have not been reduced. There was also evidence that a 40% reduction in hospital beds has had no effect on population mortality indicators.

Table 2. Inequalities in the use of the health system and mortality in Manitoba, Canada

<table>
<thead>
<tr>
<th>Indicators</th>
<th>1986</th>
<th>1996</th>
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<tbody>
<tr>
<td>Number of days in hospital</td>
<td>1.40</td>
<td>1.38</td>
</tr>
<tr>
<td>Admission rate to hospital</td>
<td>1.31</td>
<td>1.32</td>
</tr>
<tr>
<td>Mortality rate from all causes</td>
<td>1.21</td>
<td>1.42</td>
</tr>
<tr>
<td>Pre-mature mortality rate</td>
<td>1.39</td>
<td>1.85</td>
</tr>
</tbody>
</table>

Source: Adapted from Ross et al. (2005)

Health Education

The second argument concerns the impossibility for health education alone to successfully reduce social inequalities in health. Raising this issue is especially crucial for France and the United States, where health education continues to play a dominant role in overall health strategies (O’Neill & Stirling, 2007). Developing interventions that reduce inequalities in health would be no mean feat, and it could even be claimed that this would constitute a logical contradiction. Rose (1985) explains the importance for prevention activities to target the population as a whole rather than just high-risk groups. He maintains that when a risk factor is normally distributed in a population, reducing its influence will bring about greater change in the general health status of the population than if interventions are solely directed at high-risk groups. Conversely, to complicate matters even further, it is a known fact that when interventions targeting harmful health behaviours are directed at the population as a whole, these interventions appear to have a much greater impact on the most favoured social groups (Whitehead, 1995), thus contributing to increasing inequalities. Some specialists transpose Rose’s propositions to social inequalities in health (Douglas & Scott-Samuel, 2001; Marmot, 2001). For these experts, the determinants of individual differences are dissimilar from the determinants of disparities among population sub-groups. Targeting interventions to increase average life expectancy or to reduce disparities therefore remains tricky. Based largely on English research findings, Paquet and Tellier (2003) affirm that, even if the whole population adopted healthy lifestyle habits, overall life expectancy would increase, but the health gradient among social classes would still persist. In summary, on the one hand, in order for health education to be effective, it is better to act on the population as a whole in order to improve overall population health; this, however, carries the risk of increasing inequalities. On the other hand, interventions targeted directly at individuals or certain sub-groups, rather than at the overall population, can provoke increased feelings of exclusion and there are high risks of stigmatization.
Health Promotion

The third argument for reducing social inequalities in health through health promotion is more political in nature than the two preceding arguments. The argument is inextricably linked to the commitment of professionals working in the field of health promotion. The ineffectiveness of public health and community health in reducing disparities in health can be partly explained by the fact that neither one has been willing to take up this challenge, whereas the new public health has boasted of its novel approach in taking all health determinants into consideration. Fassin argues about the existing difficulty getting beyond the rhetoric and refers somewhat harshly to windbags who do nothing (2000). According to Gepkens and Gunning-Schepers (1996), interventions which were meant to reduce inequalities in health tended to be based more on the traditional and reductionist approaches of health education than on new proposals of holistic action based on the five pillars of health promotion. Now, almost twenty years later, health promotion must reclaim its original role and become a catalyst for raising questions about the permanence and invisibility of social inequalities in health, at least in France, claims Drulhe (2000). It appears that this moral and ethical necessity is not yet really taken seriously (De Koninck & Fassin, 2004; Ridde, 2004a, 2004b; Bernier, 2006). This would explain why public health and community health still take precedence over health promotion, as is evidenced by the call for experts of the French Public Health High Commission, which excludes specialists in health promotion.

Why should health promotion bear the burden of redressing inequalities in health instead of public health or community health? Simply because the field of health promotion has judiciously ensured that it has a Charter which includes this objective, whereas the other two fields do not. In the 1978 Declaration of Alma-Ata, inequalities in health were formally acknowledged, but the reduction of inequalities in health, at least in France, claims Drulhe (2000). It appears that this moral and ethical necessity is not yet really taken seriously (De Koninck & Fassin, 2004; Ridde, 2004a, 2004b; Bernier, 2006). This would explain why public health and community health still take precedence over health promotion, as is evidenced by the call for experts of the French Public Health High Commission, which excludes specialists in health promotion.

This attempt at differentiating the three types of practice serves to underline the vital role of health promotion in reducing social inequalities in health through the cardinal value of social justice and the use of empowerment as a fundamental process. From a practical point of view, this means that questions need to be raised in two areas. Firstly, health promotion planners must now examine the objectives they set to ensure these objectives are not aimed only at improving the overall health of the population. At best, this only replicates inequalities and, at worst, it exacerbates them. Secondly, once the objective has been reviewed and the actions initiated, there is a need to gather and evaluate the evidence of their effectiveness in reducing social inequalities in health; this will in result open new theoretical, conceptual, and practical fields of work (Ridde, Delormier et al., 2007).

Conclusion

This attempt at differentiating the three types of practice serves to underline the vital role of health promotion in reducing social inequalities in health through the cardinal value of social justice and the use of empowerment as a fundamental process. From a practical point of view, this means that questions need to be raised in two areas. Firstly, health promotion planners must now examine the objectives they set to ensure these objectives are not aimed only at improving the overall health of the population. At best, this only replicates inequalities and, at worst, it exacerbates them. Secondly, once the objective has been reviewed and the actions initiated, there is a need to gather and evaluate the evidence of their effectiveness in reducing social inequalities in health; this will in result open new theoretical, conceptual, and practical fields of work (Ridde, Delormier et al., 2007).

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Notes

i. Due to limited space, a detailed analysis of the communique will not be given, but certain key elements should be noted in the context of this article. Firstly, in French, the expression ‘promotion de la santé communautaire’ is liable to create more confusion than its English equivalent, ‘Community Health Promotion’. In French, the placement of the caesura in the expression could lead to a reading that is diametrically opposed to the Consortium’s mandate. Thus it could refer to either promoting community health, or to promoting health with emphasis placed on the role of the community. Secondly, the communique itself leads one to believe that it is this latter sense that is meant by the members of the Consortium. However, the arguments are not really convincing and do not sufficiently permit community health promotion (CHP) to be distinguished from health promotion (HP), as outlined in Ottawa in 1986. The values and the strategic and operational parameters that are described are those of HP, unless it is thought that HP does not concern communities. The term CHP is sometimes not used in full so it is unclear whether CHP or HP is meant; for example: “This initiative recognizes that health promotion...” (p.53); “It is essential to include health promotion in policies...” (p.53). Lastly, the Consortium has decided to “promote the application of participative methods” (p.54). If the distinction proposed in this article between the process used by community health (participatory) versus that used by HP (empowerment) is accepted, confusion will reign because participative methods are the hallmark of community health. Consequently, the Consortium will be promoting community health practices and not health promotion practices centred on the community. There is much confusion that needs to be cleared up. That is the purpose of this special issue and the author is happy to contribute to a better understanding of community health promotion (Nishtar et al. 2006, p.54).

ii. See the edited author’s special issue in the Canadian Journal of Program Evaluation, 2006, vol. 31 (3).

iii. This section develops ideas broached in another article (Ridde, 2005).

iv. Research to gather the evidence of the existence of health inequalities is much more common than research on how to reduce inequalities. France is among the countries that is most behind in this area in Europe; Quebec does not fare much better. At the same time, France, paradoxically or consequently, is the country where disparities in health between manual and non-manual workers are the greatest in Europe.