

Contents

<i>List of Figures</i>	ix
<i>List of Boxes</i>	x
<i>List of Tables</i>	xi
<i>Foreword</i>	xiii
<i>Acknowledgements</i>	xvii
Introduction: Localising the Global	1
An overview of the book	4
1 Health Promotion: Concepts and Context	6
Health, equity (social justice) and empowerment	7
Health promotion roles	9
Health promotion tensions	10
Setting the historical context	15
From biomedicine to health behaviourism	17
Health promotion on the ascendancy	19
Health promotion in decline	20
The new millennium	23
2 Health Promotion Practice: Power, Empowerment and the Social Determinants of Health	25
Power: The capacity to create or resist change	25
Health promotion: Power, empowerment and the practitioner	29
The 'domains' of empowerment	30
The concept of 'community'	37
Health promotion competencies and ethics	38
Health promotion and the social determinants of health	43
Social determinants of health in health promotion practice	44
The politics of policies affecting the social determinants of health	51

vi *Contents*

3	Pathways to Local Empowerment	53
	Why a continuum? A brief history	53
	The empowerment continuum	54
	Personal action	57
	Small groups	58
	Community organisations	59
	Partnerships	61
	Social and political action and beyond	65
	Health activism	68
4	Working to Build Empowerment: The Local Challenge	73
	Engaging with people to address local concerns	73
	Building local partnerships	81
	Building community capacity	82
	Influencing health policy	84
	The steps to influencing health policy	87
	Evaluating local empowerment	94
5	Pathways from the Local to the Global	103
	Unhealthy contradictions: The emergence of global production chains	103
	Explaining globalisation	106
	From the international to the global	108
	Of debts, structural adjustment and neoliberal globalisation	111
	Maybe yes, maybe no, mostly no: Interrogating globalisation's dominant health 'story'	116
	An unhealthy tale of winners and losers	122
6	Working to Build Empowerment: The Global Challenge	127
	Health as security	128
	Health as development	130
	Health as global public good	139
	Health as commodity	141
	Health as human right	150
	The health imperative of redistribution	155
7	Glocalisation: Health Promotion's Next Grand Challenge?	159
	Saying no is necessary but not sufficient	159
	Relocalising the economy	162

Democratising the global economy	166
Globalising the economy as if poverty, health and the environment mattered	174
What can health promoters do?	178
Revalorising the idea of empowerment: A closing caution	182
<i>Bibliography</i>	185
<i>Index</i>	204

1

Health Promotion: Concepts and Context

All diseases have two causes: one pathological, the other political.

(Aphorism attributed to the nineteenth-century public health activist Rudolf Virchow)

The meaning of health promotion remains dynamically ambiguous. In the words of the Ottawa Charter for Health Promotion (World Health Organization 1986), 'health promotion is the process of enabling people to increase control over, and to improve, their health.' A recent content analysis of the most influential health promotion definitions in the literature found that their major discriminating feature was indeed 'the extent to which it involves the process of enabling or empowering communities' (Rootman et al. 2001). O'Neill and Stirling (2007) usefully characterise this as health promotion's discursive meaning, its broad penumbra of 'the promotion of health' within which its more organised set of practices occurs. These organised practices, in turn, are defined by Green and Kreuter as 'any planned combination of educational, political, regulatory and organizational supports for actions and conditions of living conducive to the health of individuals, groups or communities' (Green & Kreuter 2005). If the fulminating Ottawa Charter definition is the idealised 'what', the more technocratic approach to planned change is the pragmatic 'how'.

In the 20 years since the Ottawa Charter, no health promotion declaration has as succinctly and evocatively laid out the field of practice. The Charter identified five foci of the health promoter's work:

1. Develop personal skills (whether traditional forms of lifestyle health education or working with marginalised groups to increase their level of political analysis)

2. Create supportive environments (from the esteem-building support of small groups to ‘making healthy choices the easy choices’ in the numerous ‘settings’, such as schools and workplaces, in which people spend much of their time)
3. Strengthen community action (a defining ethos of health promotion, one already captured in our introductory garden stories)
4. Build healthy public policy (the locus of intersectoral or ‘whole of government’ work, the target of community and professional advocacy initiatives and the lever through which health equity among groups is achieved)
5. Reorient health services (to better balance the resources for health promotion work with that of curative medicine, and to improve health systems’ understanding of their roles to improve health)

These five foci, along with the Charter’s three strategies of ‘enable, mediate and advocate’, have an almost iconic stature in health promotion work in many parts of the world. Later chapters will review some simplified models that capture the panorama of practice the Charter portrays. While these five health promotion foci are usually interpreted as local or, at best, national responsibilities, we will also see how they apply at global levels of action.

Health, equity (social justice) and empowerment

Of the many concepts that inform this book, three are basic: health, equity (and its corollary, social justice) and empowerment. Below we offer some initial thoughts on how we approach their meaning.

There is no shortage of attempts to define health, from the World Health Organization’s classic, ‘a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity’ (World Health Organization 1946); to the Ottawa Charter’s emphasis on its being ‘a resource for everyday life’ (World Health Organization 1986); to the Bangkok Charter’s qualification of it as ‘a determinant of quality of life . . . encompassing mental and spiritual well-being’ (World Health Organization 2005). There are also the more traditional medical definitions which emphasise normal physical functions. Astute readers will notice circularity in all of these definitions: health is well-being, but what is well-being if not also health? As for health being normal functioning, who defines normal and how? These are troubling issues for the results-based approach to ‘investing in health’, the title of the globally influential 1993 World Bank report on health sector reform (World Bank 1993)

which championed a selective approach to health care based on narrowly prescribed cost-benefit analyses. This is also why so much of the accounting in health systems remains dominated by what can be counted: death and disease (mortality and morbidity).

The important elements of the concept of health that we might take from these definitions are (1) perception and meaning (health is as much what is experienced as what can be measured), (2) social relations (health is embedded in human networks and interactions), (3) capacities/capabilities (health is a product of many intrinsic and extrinsic resources) and (4) physical functioning (health is embodied and not simply imagined).

Equity, in turn and as applied to health, is a normative judgement of what is fair. It differs from equality, a measure of 'sameness', although the terms are often used interchangeably. This is particularly so in the UK, where health inequality has become synonymous with health inequity. In stricter terms, a health inequity is a difference (an inequality) in health (however measured) that is significant in size and number of people affected, preventable through policy or other intervention and not an effect of freely chosen risk. A major concern of health promoters is social inequities that reside in the structures of society, creating systematic differences in health outcomes between different population groups. Examples of these include gender differences that arise from patriarchal norms or discrimination; class differences that arise from inequalities in wealth, power and ownership/control of capital; and geographic differences that arise from higher exposures to risk or less access to remediable care or preventive resources.

Underpinning the concept of equity is that of social justice. There are several theories of social justice with different implications for equity. The two major theories differ in their emphasis on means or ends: equality of opportunity or equality of outcome. The first, and politically dominant, theory holds to the importance of ensuring that everyone 'plays by the same rules' – there is no discrimination. Fairness is judged by equality in process. The second, and politically challenging, theory holds to the importance of ensuring that rules work to minimise preventable differences in outcomes between the players. It discriminates positively in favour of those groups that start the 'game' of social and economic life with fewer resources, since equal rules for unequal players will always produce unequal results. While fairness in process is important, health promotion's concern with preventable differences in health outcomes aligns its ethics more closely to the second theory of justice (Labonté 2000; Laverack 2004).

Empowerment, in a related fashion, has two grammatical variants. The first variant is the term's use as a transitive verb, as in 'we shall empower

this or that group'. This common use may be well intended. It also recognises that there are real differences in certain forms of power that exist between groups and that may contribute to health inequities. But there are two limitations to this use of the word. The first limitation is that it renders people as objects of the health promoter's work, rather than as people capable of acting in their own right. It also masks from view the power that people might already possess. The second limitation is that it implies a purpose: empower to do what? The 'what' is often whatever the health promoter or her agency considers an important health problem. Despite decades of acknowledging such social determinants of health as poverty, unemployment or poor housing, health problems often end up being defined as a behavioural risk: smoking, obesity, substance abuse. This is not empowerment, but subtle coercion. The second variant of empowerment's use is as an intransitive verb. In this construction, people cannot 'be empowered' by others; they can only empower themselves by acquiring more of power's different forms. This requires a careful understanding of the different forms or practices of power, especially those that health promoters and their agencies might possess and that can be made available to be taken up and used by others (Labonté 1993a, 1998; Laverack 2003). The distinction in these two meanings is subtle yet important; we return to it, with examples, in Chapter 2.

Health promotion roles

Health promotion has struggled to define itself as a discipline or profession. It continues to do so, with arguments advanced in favour (e.g., providing quality assurance, legitimacy within health systems, practice standards) and against (e.g., limiting practice scope, professionalising for self-interest). There are, certainly, skills or competencies demanded of health promotion work, and useful efforts have been made to codify some of these. But in most countries health remains more a 'field of practice' than a distinct profession (O'Neill & Stirling 2007), the boundaries of which are not static. Neither are the issues, groups or institutions within the field and with whom practitioners might engage.

This does not mean that the roles health promoters assume in this field of practice are endless or complex. Their broad nomenclatures are fairly straightforward and can be characterised as follows:

1. Educator/watchdog: A combination of increasing public awareness of health determining behavioural, social and environmental conditions, and monitoring those conditions for their effects on health status.

2. Resource broker: Making internal resources (personnel, finances, material goods) more readily available to groups working on health determinants, whether or not these actions are undertaken in the name of health.
3. Community developer: Supporting community group organisation and action on health determinants, through dedicated community development/empowerment and competent health promotion staff and programmes.
4. Partnership development: Engaging in joint programming and policy development work, locally, regionally and provincially, with those in the public, private and civil society sectors with a 'stake' in health determinants.
5. Advocate/catalyst: Developing and advocating statements on policy options that influence health determinants, especially to more senior government levels (Labonté et al. 1998).

Health promotion tensions

Each of the above-mentioned roles is also riddled with tensions. This should not be surprising if we accept health promotion as an empowering practice aimed at reducing health inequities. The reason is simple: health promoters usually work for state or state-funded agencies, a social location of presumed neutrality in a far-from-neutral set of social power struggles.

Consider, first, the modern state. There are many competing theories: libertarian or neoliberal theories of the state as intruding on individual freedoms, critical theories of the state acting on behalf of elite-class interests, pluralist theories of the state as a neutral broker between competing interest groups, institutionalism theories of the state as creating its own organisational patterns of thought and behaviour and ossifying into them and feminist theories of the state as embodying patriarchal norms and practices. We are agnostic on which of these is most revelatory for health promotion practice. All contain analytical elements of usefulness.

What remains an essential feature of the state, however rendered, is that it bridges relationships that are shaped by economic markets (producer/consumer, owner/worker, creditor/debtor) with those that are formed in day-to-day living (our identities as parents, group members, hobbyists, neighbours, churchgoers). These latter relations are often short-handed as 'community' or, when more formally organised, as civil society, which the London School of Economics (2006) usefully defines as

the arena of un-coerced collective action around shared interests, purposes and values. In theory, its institutional forms are distinct from

those of the state, family and market, though in practice, the boundaries between state, civil society, family and market are often complex, blurred and negotiated. Civil society commonly embraces a diversity of spaces, actors and institutional forms, varying in their degree of formality, autonomy and power. Civil societies are often populated by organisations such as registered charities, development non-governmental organisations, community groups, women's organisations, faith-based organisations, professional associations, trade unions, self-help groups, social movements, business associations, coalitions and advocacy groups.

Markets, and the relationships they create, are inherently 'disequalising', in that they create inequalities between groups in income, power and health. States intervene in markets, in part, to reduce their level of inequalities, preserve social order and smooth economic functioning. Different countries, people and political parties hold differing beliefs over the depth of such intervention and the degree of inequalities that might still be considered 'fair', with implications for health equity, as we will see in Chapter 2. People in civil society, as citizens, in turn, often pressure states for different interventions into the market, either calling for less or more depending on their particular ideology or position of economic privilege. In sum, there are inherent tensions, or what social theorists call contradictions, in the relationships between all three of the principal domains – state, market, civil society – that condition our social lives and, in large measure, our health. The German sociologist Claus Offe (1984) usefully draws attention to the strained role these contradictions create for the state. On the one hand, the state requires the market to generate the wealth from which it derives the revenue for its functioning. On the other, the state requires the legitimacy of its citizenry in all their diverse voices and demands that cause it to grate constantly against the interests of those prospering most from the market. The citizenry itself is often contradictory: how often do we hear demands for more public services and demands for lower taxes, as if the two are unrelated? The crisis in governance that this contradiction creates has worsened in our modern era of globalisation.

For now, we explore how these inherent tensions in a more mundane fashion affect each of the five simply cast health promotion roles.

Educator/watchdog

There are two tensions in this role. First, what do we watch? We've already noted that despite years of acknowledging the importance of social determinants of health, most health promotion attention remains devoted to

behavioural risk factors. Rather than change social structures, a risky endeavour for those working in state organisations, we focus on changing individuals. This is not unimportant work, merely insufficient. The 'field of practice' has improved in this respect, with increasing attention given to the contexts that shape peoples' behaviours, for example, the tobacco or food industry and not just smokers or unhealthy food choices. Health systems now also give greater attention to monitoring and commenting upon the social determinants of health. But, as this chapter concludes, health promotion's actual efforts on these determinants remain marginal.

This leads us to the second tension: what do we do with what we watch? There remains a tendency in health promotion practice to default to what we characterise as the 'education and awareness paradigm': To improve health, create a pamphlet. To really improve health, create a poster and a mobile information unit. To be digitally astute, use all the resources of the Internet to tell people what they should do to keep healthy. Even as we embrace in our work the sweep of social and environmental determinants, we complain that the real reason there is so little action on them is that 'people just don't understand'. Our role is thus to teach the poor, the unemployed, the marginalised, the discriminated or the underserved that the conditions they experience are what are making them sick. We suggest that most people know this already, even if their concern is not expressed as an overwhelming desire to reduce their higher-than-population-average burden of disease. If there is education to be done about the social determinants of health, it is more likely to be with those who dominate economic markets or manage public finances, and for whom some studies show indifference, for example, towards using public policy levers to reduce economic causes of health inequities (Lavis et al. 2003).

Resource broker

There are two key tensions that play out in the role of resource broker. The first is having resources to broker, which requires that they be ring-fenced or clearly segmented from those dealing with health care. Otherwise, the seemingly ceaseless health care cost demands driven by technology, aging, media and, in the case of drug therapies, globalised patent rules could consume all of health systems' budgets. The second tension is the need to apply an equity stratifier to who gets the resources. Even staff time constitutes a resource, inasmuch as a programme or service made available at no private cost becomes an economic subsidy to whoever receives it. The 'inverse care law' is as alive and well in health promotion work as it is in utilisation of medical care. The inverse care law, first formulated by Julian Tudor Hart (1971) to describe the UK

National Health Service, describes how those with least medical need (the affluent) tend to use a disproportionately greater amount of public health services than those with greatest medical need (the poor). In health promotion, the inverse care law functions when wellness programmes attract the more affluent or maternal/child health programmes fail to attract the poorest, or when most of our investment goes into behaviour change programmes that past research finds is much more successful with the middle- and higher-income strata (Baum & Harris 2006). This does not mean these efforts should cease. State programmes that are universally accessible (open to everyone) gain longer-term and broader cross-class support than those that are targeted only to the most needy. Neither is there a simple algorithm to determine how health promotion resources should be allocated. But if we hold to the justice norm of greater equality in outcome, the first question posed in any new resource decision should be: How will this reduce the health gap between top and bottom, by raising the bottom nearer to the top?

Community developer

Tensions in community development as an empowering health promotion practice are among the best known and most discussed in the literature. We have already identified a key one in our Introduction's gardening stories: the localisation of political and economic determinants of health inequities at a level of social organisation that lacks the power and resources to tackle these effectively. Elsewhere we have called this a form of 'community-blaming' and have been critical of the simplistic idealisation of the community sometimes found in health promotion writings (Labonté 1993b).

Another basic tension exists between community development as community-based programming, where we regard the community as a setting in which to launch our education and awareness activities aimed at usually quantifiable programme outputs. And community development as empowerment, in which we act on issues of group interest, and an increase in their generic capacities is of greatest concern. There is a sense, though, in which this is a false-practice dichotomy. A community-based programme can be an entry into a community empowerment project, and community empowerment projects often incorporate community-based programmes. Extending from the Introduction's garden stories, health promoters might start with a nutrition education programme in a low-income community, because that is where greatest initial support lies, and then find themselves working with local coalitions to change social assistance rules to make it easier for welfare recipients

to afford healthier foods. They might even participate in networks dealing with inequitable aspects of the global food trade. But health promoters could as easily start with such a coalition, or with community gardens and food-buying clubs, if that is where organising momentum lies. At some point they will likely find themselves invited to offer nutrition education programmes. What remains of this practice tension is how well the health systems support health promoters in their abilities to move fluidly between these two working styles.

Partnership development

For some years health promotion has accepted the necessity of engaging with other sectors, particularly if it is to influence actions on the broader determinants of health. The legacy of Western rationalism and evolution of the modern state have left it with a bewildering, and at times multiplying, number of 'sectors'. If we add to this the divergent claims of civil society organisations and the influence of private business interest groups, the tensions in partnership development are self-apparent. A more specific complaint sometimes lodged against health promotion's efforts to engage in managing these partnership tensions has been one of 'public health imperialism': a recasting of all social and environmental concerns as health promotion issues in an effort to gather diverse partners under the umbrella of 'health'. Given the large size of the public health sector in most high-income countries, relative to education, welfare, housing, environment or justice, these colonising overtures have been viewed with distrust. The following story illustrates this point: A few years ago a lecturer of health promotion teaching in a school of social work complained that he had a hard time convincing his social work students that they were really doing health promotion. His students replied that they had an equally hard time convincing health promoters they were really doing social work. The point here is simply that health promotion is not the only practice, nor health the only sector, that has discovered the need to collaborate with others. But we all share a rather pre-Copernican view of the world in which we analyse and plan our activities by placing ourselves at the centre and then orbiting everyone else around us. The rich literature on effective partnerships identifies a simple preventive: always place the problem in the centre and circle the important sectors, disciplines and partners around it.

Advocate/catalyst

This brings us to the last and most problematic health promotion strategy: that of advocacy. It is something health promoters frequently advocate

for doing more of, but not much else. For in becoming advocates around policies for health and its determinants, we run straight into the jaws of politics. While not without risk, it is still relatively safe for health promoters and their state employers to challenge a single industry such as tobacco, but not the disequalising logic of global market capitalism itself. Why has the health-promoting cause of early childhood development captured governments' agendas in ways that poverty reduction has not? There are practical reasons: clarity of the policy message and convenient and market-ready slogans. But perhaps most importantly, early childhood development represents a health inequity whose remedy is not deeply structural or challenging in the same way as reducing income inequalities might be (Lavis 2002). Indeed, programmatic interventions often consist of an outpouring of small-scale pilot projects that fail to deal with the political and economic policies that lead to the family poverty that creates unhealthy development environments in the first place. It is ironic that Canada, a country that has played such a prominent role in the rhetoric of both health promotion and early childhood development, has failed singularly to use its tax/transfer programmes to reduce significantly child poverty rates, despite resolving in its parliament repeatedly to do so.

International evidence suggests that policies known to reduce health inequities are more likely to be supported by social democratic political parties than by conservative or libertarian ones (Navarro et al. 2004). This should not be surprising since such policies hinge more on a belief in the importance of a strong, regulatory and redistributive state than on the beneficence of the market's invisible hand. The tense discomfort this can create for health promoters is obvious. On the one hand, a health promotion policy platform will only survive if it is consistently lobbied on a non-partisan, all-party basis. On the other, health promotion that ignores where partisan political support exists for its work is unlikely to win any reforms in the policies that may matter most to greater equity in health outcomes.

Setting the historical context

Given health promoters' social position straddling state and civil society, these tensions are unlikely to be resolved; they are merely being grappled with. Their grappling is what provides much of the dynamism of health promotion practice, although not always comfortably. Neither are these tensions particularly new, including even the concern with empowerment.

The concept of local empowerment as a means to improve health dates back to at least the mid-nineteenth century in the UK. The political liberalism of the Victorian period led to the creation of many pressure groups, such as the Health of Towns Association, which shared concerns of the people about equity and social justice and acted as advocacy groups. These concerns arose, in part, from the dramatic dislocations, inequalities and appalling living and working conditions that accompanied rapid industrialisation. These pressure groups, with the assistance of key reformers within state institutions, mobilised broader middle-class support, which in turn, influenced the press and the political arm of government. The result was a series of new legislation aimed at curbing the worse of these conditions and enabling, for the first time, specialised local health boards to intervene to control the spread of disease. Often referred to as the 'sanitation phase', this period marked the birth of public health. Much has been written drawing similarities between this era of 'old' public health and that of the 'new' public health of the past three decades (Baggot 2000). These parallels include a concern with the social and environmental determinants of disease, political activism on the part of health reformers, the existence of social movements pressing for economic and social reform, notably unions and women's groups, and strategic linkages between health reformers and these progressive social movements.

There is also evidence of tension. Edwin Chadwick, the 'father' of public health whose 1848 Public Health Act ushered in local health boards, was a staunch advocate of the miasma theory of illness, which held that certain decaying matters in the air – created disease. The list seems strange to us today and included corpses in water along with coffee grinds and beached whales, though no reference was made to the sickly dense fog of coal-fired industrialisation. At the time evidence favouring the 'germ' theory was mounting, but this theory was opposed by the merchant class from which Chadwick required political support and among whom his own career had placed him (Ringen 1979). Had the germ theory prevailed it would have meant more regulation, including quarantine, on the global trade in goods upon which much of the wealth of the merchant class relied. There is also evidence that some of the local health boards were dominated by industrialists and merchants, who ensured that nothing was done in the name of health that might compromise their accumulation of wealth. This is a script now being played out at a much grander scale in the politics of trade treaties and the World Trade Organisation.

Other reformers took a more radical approach to grappling with the tensions of their social position. As Chadwick was manoeuvring his

Public Health Act through British parliament, Rudolf Virchow, a passionate germ theorist, famously prescribed the 'cure' for a typhoid epidemic among Silesian coal miners: improved working conditions, free education, food cooperatives, better pay, public works programmes for temporarily unemployed miners, strengthened local government and, to pay for these reforms, a tax on the nouveaux riche whose wealth relied upon the miners' labour. Unhealthy conditions, he argued, were the breeding grounds for epidemics; he also noted that all diseases had two causes: one pathological, the other political. Dissatisfied with his proposals, the government officials dismissed him. He immediately joined in street protests, ran successfully for local government and eventually became a powerful reformer within national government (Taylor & Reiger 1985). A few years earlier, in the same tumultuous era, John Snow undertook what today would be called a rudimentary cluster analysis of a cholera outbreak in a poor London neighbourhood, deducing that it centred on a shared water pump in Broad Street. Lacking certainty of proof, Snow nonetheless one night simply banged the handle off the pump, ending the cholera outbreak. Unlike Virchow he was richly rewarded with a monetary prize for his public health risk-taking.

Reform actions by British and other European governments during the mid-nineteenth century were not simply an effect of public health and civil society activism. They were also motivated by a need to improve the efficiency of their nation's workforce. Public health reform was as much due to the demands of economic production as it was due to a discourse of empowerment and good governance. This recurs today when health promotion or the costs of strategic medical or public health interventions are defended, in part, for the economic savings or growth returns they promise.

From biomedicine to health behaviourism

The germ theory eventually triumphed over competing explanatory discourses. This triumph heralded the twentieth-century dominance of biomedicine. Its close elision with industrial capitalism (body-as-machine, medicine-as-business), the promise of cure reducing the need to attend to economically meddlesome forms of prevention, helped (Brown 1979): although it was the antibiotic era that clinched its status.

The biomedical era continued to dominate until the 1960s and 1970s, when the growing costs of publicly funded health care collided with one of capitalism's cyclical crises of too much supply, too little demand and a declining rate of profit. This led to market pressures on the state

Box 1.1 Health education or health promotion?

The debate about the overlap between health promotion and health education began in the 1980s, when the range of activities involved in promoting better health widened to overcome the narrow focus on lifestyle and behaviour approaches. These activities involved more than just giving information and aimed for strategies that achieved political action and social mobilisation. Whereas health education aims at informing people to influence their future decision making, health promotion incorporates complementary social and political actions. These include lobbying and community development that facilitate political changes in peoples' social, workplace and community settings to enhance health (Green & Kreuter 1991). Health education around obesity issues might include school-based awareness programmes or exercise classes. Health promotion around obesity extends to legislation on food advertising and restricting access to unhealthy products in school shops. While in some countries, such as the USA, health education and health promotion still tend to be used interchangeably, health promotion is generally viewed as encompassing health education as one of its many roles.

to lessen taxation and liberalise the economy, which in turn fuelled government interest to find ways to reduce the fiscal pressure of rising medical care costs. At the same time, the 'epidemiological transition' in high-income countries was complete: few infectious diseases remained as threats, and chronic degenerative illnesses (heart disease, cancer, autoimmune disorders) had become the major causes of morbidity and mortality. These chronic diseases involve the interplay of different behavioural risk factors over time such as smoking, lack of exercise and a poor diet and have become synonymous with a 'healthy lifestyle'. The search for genetic explanation had yet to commence, and few were discussing the role poverty or hazardous environments played in creating disease. Health education to modify unhealthy behaviours became the principle public health intervention, slowly expanding to a broader policy focus to influence the economic and cultural forces that pattern unhealthy behaviours. As with the biomedical approach, however, there was little room for concerns with local empowerment and social equity. Many critics of this early phase in the transition from health education to health promotion in the 1970s to 1980s (see Box 1.1) cited the tendency of practice

to focus on individuals in ways that became victim-blaming (Brown & Margo 1978; Freudenberg 1978; Labonté & Penfold 1981). The confluence of state interests in medical cost containment, the rise of chronic disease with more scope for prevention and the emergence of powerful new social movements nonetheless created a fertile ground for a 'new' public health embrace of 'old' public health activism.

Health promotion on the ascendancy

The maturing of many of these progressive movements during the 1960s and 1970s played a marked role in the reconceptualisation of health promotion during the 1980s, at least in high-income countries. There are differing theories of social movements. Some emphasise their discursive role in changing how problems are framed and politics debated (Melucci 1989), while others emphasise their role in mobilising resources to become political competitors in policy change (Freeman 1983); without large organised civil society groups in these discursive fields, there would be little pressure to change state–market relations. Differences in these theories attest to new tensions: is empowerment a contest over meaning or a struggle over material resources? It is both, of course, and finding a balance between them is a central theme of this book. What is important here is recognition of the role social movements played, and continue to play, in challenging the medical and behavioural approaches to health by raising concerns for equity, justice and environmental sustainability. The most recent social movement reframing how we think about health, and one of the reasons for this book, is the one erroneously labelled 'anti-globalisation' and which might better be called the 'just globalisation' movement.

The knowledge challenges created by social movements entered public health and health promotion thinking through a process described by Ron Eyerman, a sociologist, and Andrew Jamison, an academic interested in social and political policy, as 'cognitive praxis' (Eyerman & Jamison 1991). Their argument is that the discursive reframing of societal images and identities that forms part of social movement activism shifts fields of practice via 'movement intellectuals'. These movement intellectuals, in the mode of activists like Virchow, drift from organisations to positions within the state, taking with them their new movement ideas. Others already in the state incorporate these new knowledge challenges in various policies, declarations and state documents. Some movement intellectuals shift into academia, influencing new generations of practitioners and creating new practice theories. An early reflection on how the Ottawa

Charter came to be, and why it had the impact it did, found the ideas of cognitive praxis and movement intellectuals compelling explanation (Pederson et al. 1994; Labonté 1994a). For a period of time, the mid-1980s to the mid-1990s, health promotion was on a discursive ascendancy. While practice lagged behind its preaching, there was a powerful and empowered sense of momentum and optimism.

This sense was not restricted to high-income countries alone, although these were the first to embrace the Ottawa Charter. Internationally, the World Health Assembly in 1977 set a target of 'health for all by the year 2000', a utopian quest that became operational in the following year's UNICEF/WHO conference in Alma Ata in the former USSR Kazak Republic. The much higher burden of infectious disease in many of the world's poorer nations, and the spartan condition of many of their public health systems, cast health activism at this conference under the rubric of primary health care. Like the Ottawa Charter, the 1978 Alma Ata Declaration on Primary Health Care arose in part as a response to the limitations of a biomedical and technological approach to improving health and as an affirmation of numerous experiences of community-based health care (Cueto 2004). It recognised that the gross inequalities in the health status between and within countries were ethically unacceptable and identified the practice of primary health care as key to attaining 'health for all by the year 2000'. The three essential features of Alma Ata-inspired primary health care resembled those of the Charter: a recognition that equity in health depends fundamentally on improving socio-economic conditions and alleviating poverty and underdevelopment; in this process, people in their community/citizen roles should be both major activists and the main beneficiaries; and health care systems should be restructured to support priority activities at the primary level because these respond to the most urgent health needs of the people (Werner et al. 1997; Magnussen et al. 2004). While not using the term 'empowerment' explicitly, the Declaration went on to underscore that 'people have the right and duty to participate individually and collectively in the planning and implementation of their health care' (World Health Organization 1978).

Health promotion in decline

The Ottawa Charter and the Alma Ata Declaration did not dominate global health discourse for long. Another movement was also afoot during the 1970s and 1980s, one with more powerful backers and greater political reach: neo-liberalism. This movement has its intellectual roots

in eighteenth- and nineteenth-century British liberal theorists such as Adam Smith and John Stuart Mill. Smith's influential economic theories maintained that when people acted in their own economic self-interest in a free market, all would benefit. The logic of the market's 'invisible hand' was simple: when people wanted goods, other people would make and sell them. If they became too greedy, no one would buy the goods or other manufacturers would compete with lower prices. If prices fell too low, the lack of profit would end production until people were prepared to pay more. When peoples' need changed, no one would buy, profits would drop and manufacturers would shift to producing goods people really wanted. Mill buttressed this argument with philosophical writings on liberty, which contain ideas few in health promotion or the progressive social movements that buoyed its 1980s activism would disagree with: guaranteeing individual choice as long as it did not harm another person and protecting free speech even if the opinions expressed may be factually erroneous. These ideas are consistent with justice as equality of opportunity. His economic writings, though, and like Smith's, weighed in against justice as equality of outcome. He argued against all but the lightest of taxation, which he considered a form of robbery of those who saved and benefited from their own efforts.

Classic liberalism, and the writings of these two influential theorists, is of course more complex. Even Smith's 'free markets' were deemed in need of state intervention when markets failed to provide beneficial public goods, infrastructures, services or other 'public works and . . . public institutions', as Smith referred to them. How the market's invisible hand is supposed to work in an era of monopolies and cartels, mass media, manufactured need and huge inequalities in economic wealth and power between nations that did not exist at the time of Smith's theorising remains the more contentious point. As for Mill, his defence of individual choice and free speech weaken when we consider that choices are conditioned and constrained by peoples' living environments with rippling effects on others that can be subtle yet substantial, and that the boundaries between erroneous speech and hate-mongering are blurry and politicised. Even so, the revival ('neo-') of their liberal theories in the 1970s and 1980s blunted the complexity of their sources' own writings, ignored the even greater complexities of social life two centuries on and, in populist discourse, reduced the sound bite to free markets and individual choice. Some argue that neoliberalism is a carefully managed attack by elites on what they perceived as a 'nanny state' costing too much money and encroaching too much on private wealth and privilege (Coburn 2000; Teeple 2000). We would add that, unintentionally, many

of the progressive social movements may have aided in this, since most of their activism was directed against the state and not the market. This helped to delegitimize state authority. What few dispute is that neo-liberalism became a direct assault on the interventionist welfare state that had characterised much of the post-World War Two period. Its story is basic to understanding how globalisation now affects health, and is discussed in later chapters.

For now, we consider how some of neo-liberalism's rolled-out ideas undermined the progressive activism of the Ottawa Charter and Alma Ata Declaration. Health systems became increasingly obsessed with new forms of private sector management theories which emphasised quantifiable results, short-term gains and 'value for money' (Baum & Sanders 1995; Barder & Birdsall 2006), rather than money for what is valued. In Canada there was a short turf war between health promotion and a reminted concept of population health. The issue was less about focus; like the Ottawa Charter, the population health approach emphasised the importance of the non-medical or social determinants of health. The issue concerned the rationale: much of the early population health literature promised reductions in public expenditures in health and welfare, characterised such spending as economically 'non-productive' and avoided the importance of socio-economic inequalities (Coburn & Poland 1996; Pindar 2007). Funding for health promotion, while not evaporating, became more confined to activities such as behaviour change and chronic disease prevention for which powerful cost-savings arguments could be made (Bernier 2007).

The Alma Ata's Declaration's comprehensive vision of primary health care similarly suffered. Policy makers, donor agencies and national leaders realised the potentially liberating nature of primary health care's emphasis on citizen participation and socio-economic determinants. Many, feeling threatened by this potential, became resistant to its implementation (Werner & Sanders 1997). Selective Primary Health Care (SPHC) arose as a competing concept, in which only interventions that contributed most to reducing child (<5 years) mortality were given priority. SPHC advocates argued that the comprehensive approach was too idealistic, expensive and unachievable in its goals; greater and more immediate gains would be made through a focus on growth monitoring, oral rehydration therapy, breastfeeding and immunisation, the so-called GOBI formula (Walsh & Warren 1979). This reasoning is true in the short term. There have also been notable successes in SPHC such as the low-cost Tanzanian Essential Health Interventions Project (TEHIP) (de Savigny et al. 2005). But decision-making power and control in most

instances of SPHC rested increasingly with foreign consultants with technical expertise, rather than flowing to community members (Magnussen et al. 2004). SPHC, like lifestyle health promotion, proved attractive to many political leaders: it promised easily quantifiable and achievable results within a short time; it dealt with high-prevalence health problems; and it was a simple and less resource-demanding alternative to establishing a network of permanent and equitably accessible health services (Gangolli et al. 2005). It also shifted focus from the awkward political issues of underlying health determinants rooted invariably in pervasive poverty or inequality.

The new millennium

Practice fields and their discursive constructions are dynamic; in popular argot, pendulums swing. In more recent years the activist language and social concerns of the 'old' public health and the 'new' health promotion have been reinvigorated for an array of reasons, a few of which we list below:

- The selective approach to primary health care has yet to show sustainable long-term results. Evidence suggests that only when it is supported by a more comprehensive system do selective interventions work effectively and efficiently (Knippenberg et al. 1997; Soucat et al. 1997).
- An outpouring and systematic gathering of research on the socio-economic determinants of health began to suffuse throughout health systems, notably, but not exclusively, in high-income countries. Conventional biomedical and behavioural explanations proved increasingly inadequate to account for differences in death and disease rates between different populations, drawing attention to causes in peoples' living and working conditions.
- Civil society opposition to the neo-liberal retrenchment of the state grew in many countries and coalesced globally in campaigns against what was regarded as the unhealthy and inequitable economic practices of modern globalisation. Neo-liberalism was increasingly shown to have failed on its promises of increased growth, trickle-down poverty reduction and improved health (Labonté et al. 2007).

The activism inherent in these critiques, though, has yet to trickle down to health promotion practice. In a provocative essay on health promotion in Canada, a group of young and old health promotion scholars

argue that health promotion remains a marginal practice in most health systems. Despite a decade of rhetoric on the social determinants of health, this practice continues to be dominated by health behaviour change programmes (Dupéré et al. 2007). Empowerment and social change as the 'defining elements' of health promotion remain marginal within its still marginalised field of practice.

But these defining elements still remain. They have also gained, if not practice traction, at least a rebounded legitimacy. One could even argue that health promotion as an empowering practice neither descended nor rebounded. If we dig beneath the term to what it represents, health through empowerment, justice through equity, social relations that are respectful, political mobilisations that are effective, we find in it the attempt to address the inequitable contradictions of capitalist modernity that have characterised many of the world's societies for at least two centuries.

Index

- accountability 74
- addiction
 - social determinant of health 45
- advocate
 - health promotion 10
 - role of 30
 - tensions in role of 14–15
- Africa
 - EPZs in 105
 - HIV/AIDS 110–11
- Age of Consent, The* 167
- Agreement on Agriculture (WTO) (1994) 145, 163
- Agreement on Government Procurement (WTO) (1996) 145
- Agreement on Technical Barriers to Trade (WTO) (1994) 145
- Agreement on the Application of Sanitary and Phytosanitary Measures (WTO) (1994) 145
- Agreement on Trade-Related Aspects of Intellectual Property Rights (WTO) (1994) 145, 151
 - health effects of 148
- Agreement on Trade-Related Investment Measures (WTO) (1994) 145
- aid 135–6
 - as redistributive obligations 139
 - Canadian approach to 182
 - inadequacies 136–8
 - linked to stance on ‘war on terror’ 133
 - Norwegian approach to 181–2
 - untying 138–9
- Alcohol and Substance Abuse Prevention (ASAP) Programme 35
- Alma Ata Declaration on Primary Health Care (1978) 20, 22–3, 128
- American Chamber of Commerce in Shanghai 126
- anti-globalisation movement 66
- antiretroviral (ARV) drugs
 - state obligations on 153–4
- Asia
 - EPZs in 105
- Asian Health Forum 35
- Asian women
 - depression and isolation among 35–6
- assessment 26–7
- Association for the Taxation of Financial Transaction for the Aid of Citizens (ATTAC) 180
- autonomy
 - characteristic of health promotion professionals 41
- avian flu 128
- Bangkok Charter for Health Promotion 7, 124, 126
- Bangladesh
 - export clothing factories in 103–4
- Bauman, Zygmunt 122
- behaviour modification 12
- Bello, Walden 165–7, 174
- beneficence
 - characteristic of health promotion professionals 41
- Bernstein, Ed 35
- bilateral investment agreements (BITs) 147
- Bill and Melinda Gates Foundation 135
- biofuel 164
- biology
 - health and 50–1
- biomedicine 17–19
- bioterrorism 129
- Birdsall, Nancy 122
- breastfeeding 68
- Buchanan, D. 56
- Buffett, Warren Edward 135

- Canada
 - approach to aid 182
 - child poverty 15
 - population health approach in 23
- capital flight 112
 - limiting 172
- 'carbon footprint' 176
 - food 162–3
- Caribbean
 - EPZs in 105
- cartels 177
- Casa Dona Juana 33
- Centre for Global Development 122
- Chadwick, Sir Edwin [1800–90] 16
- charitable donations 135
- Chiang Mai Initiative 177
- Chicago School of Economics 113
- child development
 - health and 49
- child labour 125
 - export clothing factories 104
- child mortality
 - MDG 131
- child poverty
 - Canada 15
- child-care facilities 84
- China
 - labour laws 125–6
 - pollution in 106
- civil society 11
- classic liberalism 21
- climate change 108
- colonisation
 - legacy of 163
- Commission on Macroeconomics and Health (WHO) (2001) 116, 133, 136
- Commission on Social Determinants of Health (WHO) (2005–8) 28, 123, 183
- commoditisation
 - health 141–2, 148–50
- communication
 - effective 74–6
 - norms of 75–6
- communication interventions 75
- communication strategies 40–1
- communicators
 - lack of skills 75
- community
 - concept of 37–8
- community capacity
 - building 82–4
- community capacity building skills 41
- community developer
 - health promotion 10
 - role of 29–30
 - tensions in role of 13–14
- community development 2, 101
 - health projects 58
- community events 84
- community health groups 58
- community nutritionists 27
- community organisations 59–61
- community participation
 - local empowerment 98
- community-based programming 77
- competencies
 - definition of 38
 - health promotion 38, 40–3
 - compulsory labour 125
- Confederation of British Industry 57
- conservative governments 113
- consultation 91–2
 - definition of 77
 - opportunities for 74
- continuum model
 - local empowerment 53–7
- cooperation
 - local empowerment 100
- coping skills
 - health and 48–9
- Cornea, Andrea Giovanni 123
- cost-benefit analysis 87
- cost-recovery programmes 110
- cotton farmers
 - suicide among in India 143
- culture
 - health and 49–50
- currency transactions
 - taxation of 180
- Daly, Sister Patricia 66, 68
- debt crises 112–13
- debt reduction 133
- debt servicing
 - developing nations 136–8

- debts
 - cancellation of 137
- decision-making
 - involvement in 74
 - political 85
 - stakeholders and 76
- decision-making powers 66
- decisions
 - implementing 93
 - moving towards 92
- Deglobalisation* 165–6
- demand
 - not matched by supply 75
- democracy
 - global governance 159
 - promotion of by interest groups 60
 - WTO and 171
- depression
 - among Asian women 35–6
- design
 - local empowerment 95
- developing nations
 - aid to 133, 135–8
 - debt servicing 136–8
 - untying aid to 138–9
- development
 - definition of 155
 - health as 130, 132–3, 135–9
- devolution 81
- Diamond, Jared Mason 43
- differential consequences
 - health and 51
- differential exposure
 - health and 51
- differential vulnerability
 - health and 51
- digital technologies 174
- direct action 93
 - towards empowerment 67
- direct democracy 85
- discussion papers
 - issue of 91
- discussions
 - local empowerment 99
- disease
 - prevention of 140–1
- disease-based programmes 133
- disempowerment 35
- displaced workers 143
- Doha Development Round 107, 146
- Durning, Alan Thein 56–7
- early life
 - social determinant of health 45
- Easter Island 43
- ecology
 - changing 43
- economic exploitation 26
- economic growth
 - health improvements and 121–2
 - income inequalities and 118, 120
 - liberalisation and 117–18
 - poverty reduction and 118
- economic insecurity 143
- economic policy
 - goals of 176
- economic theory 21
- economy
 - relocalising 159, 162, 164–5
- education
 - health status and 47
- educator
 - health promotion 9
 - role of 29
 - tensions in role of 11–12
- employment
 - health and 47
 - increase in informal nature of 160
 - nature of 160
- empowering assessment 27–8
- empowerment 7–9
 - domains of 30–2
 - health and 8–9
 - health promotion 182–4
 - local 16, 53–72
 - challenges to 73–102
 - design 95
 - evaluating 94–7, 101–2
 - implementation 95
 - measurable indicators of 95–6
 - measuring 96–7
 - outcomes 95–6
 - visual representation of 97, 101
- environment
 - globalisation and 174–6, 178–82
- environmental sustainability
 - MDG 131
- epidemiology 18

- epistemic communities 113
- equity 7–9
 - applied to health 8
- ‘ethical’ poverty line 132, 157
- ethics
 - health promotion 38, 40–3
- ethnic diversity 179
- ethnicity
 - health and 49–50
- evaluation
 - key characteristics of 94–5
 - local empowerment 94–7, 101–2
- Evans, Peter B. 116
- export clothing factories
 - Bangladesh 103–4
- export processing zones (EPZs)
 - 104–5
 - women favoured for employment in 105
- exports
 - food 162–3
- Eyerman, Ron 19
- fair trade
 - proposals to replace free trade with 167
- Farmer, Paul 178
- financial crises 107
- financial flows 107
- financial market liberalisation 105, 110
- fiscal monetarism 112
- Focus on the Global South 165
- food
 - ‘carbon footprint’ of 162–3
- food imports 162–3
- food production
 - local 3
- food shortages 164
- forced labour 125
- foreign exchange 173
- foreign investment
 - EPZs 105
- foreign reserves
 - accumulating 138
- Framework Convention on Tobacco Control (FCTC) 141–2, 170
- frameworks
 - policy process 86–7
- free trade
 - proposals to replace with fair trade 167
- Freire, Paulo [1921–97] 35, 61
- Friedman, Milton [1912–2006] 113
- G7 countries 113
- gender
 - health and 50
- gender equality
 - MDG 131
- General Agreement on Tariffs and Trade (GATT) (1994) 145
 - WTO successor to 144
- General Agreement on Trade in Services (WTO) (1994) 145
 - effects on health of 148, 150
- genetic endowment
 - health and 50–1
- geographic dimensions
 - community 37–8
- George, Susan 78
- germ theory 17
- Global Alliance for Improved Nutrition (GAIN) 134
- Global Alliance for Vaccine Initiative (GAVI) 134
- global debt crisis (1980s) 109
- Global economy
 - democratising 166–8
- Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) 134, 141
- global governance 170–2
 - democratising 159
 - limits of 173–4
- global health
 - international health distinguished 108
- global health ethic
 - need for 155
- global health interventions
 - security and 155
- global public goods 155
- global public-private partnerships (GPPPs) 134–5
- global taxation
 - proposals for 156

- globalisation 3, 174–9, 181–2
 - background to 111–12
 - explanation of 106–8
 - health and 116–18, 120–6
 - health equity and 181–2
 - HIV/AIDS and 110–11
 - human rights and 155–6
 - inequity in 122–3
 - relationship with health 127–58
- Globalisation Knowledge Network
 - 123, 168, 175–6
- ‘glocalisation’ 3, 159–84
- GOBI formula 22
- graphing
 - local empowerment 101
- groups
 - criteria for selecting to organise or support 39–40
- Habermas, Jürgen 75
- Haiti
 - HIV/AIDS 134
- Hart, Julian Tudor 12–13
- Hayek, Friedrich August [1899–1992]
 - 113
- hazards
 - exposure to 51
- health 7–9
 - as commodity 141–2
 - as development 130, 132–3, 135–9
 - as fundamental human right 128
 - as global public good 139–41
 - as human right 150–2, 154
 - as security 127–9
 - effect of General Agreement on Trade in Services on 148, 150
 - effect of trade treaties on 143–50
 - effect of TRIPS on 148
 - empowerment and 8–9
 - equity applied to 8
 - funding 133
 - global responsibility 151–2, 154
 - globalisation and 108, 116–18, 120–6, 174–9, 181–2
 - investment in 120–1
 - non-medical determinants of 23
 - perception of 8
 - relationship of power with 28–9
 - relationship with globalisation
 - 127–58
 - social determinants of 23, 25–52
 - social justice and 8
 - WHO definition of 7
- Health Action Zones 62–3
- health activism 68–72, 153–4
 - ‘glocalising’ 180–1
- health advocacy
 - role of media 90–1
- health behaviourism 17–19
- health care
 - based on narrowly prescribed cost-benefit analyses 8
 - costs of 12
 - privatisation of 148
- health coalitions 77
- health equity
 - globalisation and 181–2
- health improvements
 - economic growth and 121–2
- Health of Towns Association 16
- health policy
 - influencing 84–9
 - identifying issues 88–9
 - policy analysis 89, 91
- health promotion 3
 - approaches to 1–2
 - ascendancy of 19–20
 - competencies 38, 40–3
 - decline of 20–3
 - empowerment 182–4
 - ethics 38, 40–3
 - focus of 6–7
 - foundational theory of 42
 - funding 23
 - globalising work of 124–6
 - historical context 15–17
 - information provision on 81
 - link between global and local
 - 103–26
 - local empowerment 2
 - meaning of 6
 - political action and 65–8
 - practice of 25–52
 - programming 36–7, 75
 - recent developments 23–4
 - redistribution and 156–8
 - relocalising economy and 165

- social action and 65–8
- tensions in 10–11
- Victorian 16
- work of NGOs 108
- health promoters
 - role of 9–10, 178–82
- health sector reform
 - World Bank report on 7–8
- health status
 - education and 47
- healthy lifestyle 18
- health services 50
- Heavily Indebted Poor Countries (HIPC)s 138
- hegemony 26–7
- Herceptin
 - lack of access to 68–9
- Hines, Colin 164, 166–7
- HIV/AIDS 128, 133, 141, 153
 - globalisation and 110–11
 - MDG 131
 - pandemic in sub-Saharan Africa 109
 - treatment 70–2
- home-produced food
 - increased demand for 170
- honesty
 - characteristic of health promotion professionals 41
- Hong Kong
 - economic growth in 116
- human rights 129
 - globalisation and 155–6
 - health as 128, 150–2, 154
- human security 130
- Human Services Integration Forum (HSIF) 62
- Hunt, Paul 151
- hypothecation
 - public health services 173
- illiteracy 110
- implementation
 - decisions 93
 - local empowerment 95
- implicit conditionality 115
- imports
 - food 162–3
- income
 - social determinant of health 44
- income inequalities
 - economic growth and 118, 120
- indebted countries
 - sanctions against 112
- India
 - health promotion partnership in 61
 - medical tourism 149
 - Self-Employed Women's Association (SEWA) 161–2
 - suicide among cotton farmers 143
 - work of People's Health Movement in 152
- indirect action
 - towards empowerment 67
- inequality
 - creation of 11
- inequity
 - globalisation and 123–4
- Infant Baby Formula Action Network (IBFAN) 68
- infant formula manufacturers 68
- infection
 - fear of 129
- inflation 110, 112
- information
 - clarity of 74
 - meetings and 79
 - provision of 81
- interest groups
 - promotion of democracy by 60
- interest rates
 - rise in 112
- International Clearing Union (ICU)
 - proposals for establishing 167
- International Code of Marketing of Breast-milk Substitutes 68
- International Conference on Health Promotion (1992) 3
- International Covenant on Civil and Political Rights (1966) 30
- International Covenant on Economic, Social and Cultural Rights (UN) (1966) 150–1, 153
- International Finance Corporation 115
- international financial institutions 113
- international health
 - global health distinguished 108

- international health partnership
 - agreements 134
- International Health Regulations
 - revision of 141
- International Labour Organisation (ILO) 105, 122, 125
- International Monetary Fund (IMF)
 - 2, 109, 113–15, 136, 170–1, 177
 - pressure on to remove conditions on loans 138
- international trade 107
- intersectoral action on health determinants 63–5
- inverse care law 12–13
- involvement
 - health coalitions 77
- isolation
 - among Asian women 35–6
- Jamison, Andrew 19
- job losses
 - due to outsourcing 143
- judgemental assessment 26–7
- justice
 - characteristic of health promotion professionals 41
- knowledge
 - gap between practice and 74–5
- Labonté, R. 53–4, 56
- labour laws
 - China 125–6
- labour rights
 - violation of 160
- lamb
 - export from New Zealand 163
- Latin American
 - EPZs in 105
- Laverack, G. 41
- leadership
 - empowerment domain 31–3
- Leading Group on Solidarity Levies to Fund Development 173
- lending
 - indiscrete 112
- liberalisation
 - economic growth and 117–18
 - trade in goods and services 143–4
- life expectancy 122–3, 132
 - per capita income and 121
- Lindquist, E.A. 86
- links to others
 - local empowerment 99
- loans
 - pressure on World Bank and IMF to remove conditions on 138
- local authorities
 - improving service delivery 80
- local concerns
 - engaging with people to address 73–80
- local empowerment 53–72
 - challenges to 73–102
 - design 95
 - evaluating 94–7, 101–2
 - health promotion 2
 - implementation 95
 - measurable indicators of 95–6
 - measuring 96–7
 - outcomes 95–6
 - visual representation of 97, 101
- local health boards 16
- local involvement
 - road maintenance 82
- local leadership
 - local empowerment 98
- local partnerships
 - building 81
- local services
 - improving delivery of 80
- Localization: A Global Manifesto* 164
- McKnight, John 26
- McNamara, Robert Strange 112
- 'make poverty history' movement 136
- malaria 141
 - MDG 131
- Malaysia
 - economic growth in 116
- market
 - as wealth generator 11
- market integration 143–4
- Marmot, Sir Michael Gideon 28–9, 168
- maternal health
 - MDG 131

- measurable indicators
 - local empowerment 95–6
- measurement
 - local empowerment 96–7
- media
 - role in health advocacy 90, 92
- media stunts 93
- medical profession 84
- medical tourism 149
- medicine(s)
 - access to 148, 179
- meetings 78–9
- Mercosur 107, 177
- micrenewable technologies 176
- Milanovic, Branko 123
- Mill, John Stuart [1806–23] 21
- Millennium Development Goals (MDGs) 119, 130–3, 136, 169
- Monbiot, George Joshua Richard 166–7, 170
- monitoring 11–12
 - policy 93–4
- multilateral agreement on investment 180–1
 - collapse of talks to create 147
- multinational companies 108, 157, 177
- National Health Service (NHS) 13, 69
- National Institute of Health and Clinical Excellence (NICE) 69
- national security 128–30
- natural resources
 - taxes on consumption of 176
- needs assessment 79–80
- ‘neglected’ diseases 129, 179
- neoliberalism 21–2
- New Zealand
 - export of lamb 163
- Noël, Alain 173
- non-governmental organisations (NGOs) 61–2, 168–9
 - health promotion work of 108
- non-maleficence
 - characteristic of health promotion professionals 41
- non-spatial dimensions
 - characteristic of community 37
- North American Free Trade Agreement (NAFTA) 107, 147
- Norway
 - approach to aid 181–2
- Nussbaum, Martha 42
- nutrition 1–2
 - social determinant of health 45
- Offe, Claus 11
- Office of the High Commissioner for Human Rights 30
- offshore tax havens 157
- oil crises 111–12
- oil exports 138
- Oldham Health Authority 36
- Organisation for Economic Co-operation and Development (OECD) 113, 180
- Organisation of Oil Exporting Countries (OPEC) 177
- organisational structures
 - empowerment domain 31, 33–4
 - local empowerment 98
- Ottawa Charter for Health Promotion (1986) 6–7, 22–3, 43–4, 62, 151
 - impact of 19–20
- outcomes
 - local empowerment 95–6
- outside agents
 - role of 31
- outsourcing 160
 - job losses due to 143
- Pan-American Health Organisation 3
- participation
 - empowerment domain 31–2
 - opportunities for 76–9
 - passive 85–6
 - studies of 85
- partnership development
 - health promotion 10
 - role of 30
 - tensions in 14
- partnerships 61–5
- People’s Health Movement (PHM) 151–2, 180
- per capita income
 - life expectancy and 121

- personal action 57
- personal health practices
 - health and 48–9
- pharmaceutical companies
 - finance of research by 179
- pharmaceutical industry 84
- Philippines
 - medical tourism 149
- physical environment
 - health and 48
- Pogge, T. 155–6
- policy
 - influencing 41
- policy analysis 89, 91
- policy evaluation 93–4
- policy making
 - communities' influence on 85
- policy process
 - models of 86–7
- policy solutions
 - developing 85
- political action
 - health promotion and 65–8
- political paradigm
 - policy process 86–7
- pollution
 - China 106
- population health approach 23
- population health determinants 44
- poverty
 - globalisation and 174–9, 181–2
 - measuring 119
- poverty eradication 132
 - MDG 131
- poverty reduction
 - economic growth and 118
 - World Bank's measure of 132
- Poverty Reduction Strategy Papers (PRSPs) 115
- power
 - definition of 25–6
 - relationship of health with 28–9
- preventive medicine 140–1
- primary commodities
 - fall in prices of 112
- primary education
 - MDG 131
- private banks 113
- private health care 115
- private health insurance 141
- privatisation 110
- problem assessment
 - empowerment domain 31, 34
- problem assessment capacities
 - local empowerment 98
- programme design 40
- programme management 31
 - local empowerment 100
- protectionism 144
- protests 93
- public health 3, 13, 128, 133
 - historical context 16–17
- Public Health Act (1848) 16–17
- public health services
 - hypothecation for 173
- public sector wages
 - cuts in 110
- public services
 - improving delivery of 80
- public spending
 - decrease in 110
- publicity 93
- publicity campaigns 92
- purchasing power parities (PPP) 119
- purposive rationality 75
- Putnam, Robert David 179
- rationalist paradigm
 - policy process 86–7
- rationality
 - types of 75
- redistribution
 - health promotion and 156–8
- redistribution of power 81
- redistributive developmentalism 116
- redistributive obligations
 - aid as 139
- referenda 85
- Regional Intersectoral Committees (RICS) 62
- relationships
 - developing 35–6
- research
 - financed by pharmaceutical companies 179
- research skills 41

- resource broker
 - health promotion 10
 - role of 29
 - tensions in role of 12–13
- resource mobilisation
 - empowerment domain 31, 34–5
 - local empowerment 99
- restraining trade 168–70
- risks
 - exposure to 51
- road maintenance
 - local involvement in 82
- Rougham, John 101

- Sachs, Jeffrey David 116, 136
- Saskatchewan
 - health promotion partnership in 62
 - school drop-out rates 110
- Schumacher, Ernst Friedrich [1911–77] 57
- security
 - global health interventions and 155
 - health as 127–9
- Seedhouse, David 42
- Selective Primary Health Care (SPHC) 22–3
- Self-Employed Women's Association (SEWA) 161–2
- self-help groups 58
- self-interest 57
- Sen, Amartya Kumar 29, 42, 116
- severe acute respiratory syndrome (SARS) 128
- shared needs
 - characteristic of community 37
- shareholder activism 66–7
- Singapore
 - economic growth in 116
 - medical tourism 149
- skills
 - facilitating 41
- small groups 58–9
- Smith, Adam [1723–90] 21, 57
- Snow, John [1813–58] 17
- social action
 - health promotion and 65–8
- social capital 179
- social clauses
 - proposed for trade agreements 169
- social determinants of health (SDH) 23, 25–52
- social environment
 - health and 48
- social exclusion
 - social determinant of health 45
- social gradient
 - social determinant of health 45
- social insurance 114
- social interactions
 - characteristic of community 37
- social justice 7–9
 - health and 8
- social status
 - social determinant of health 44
- social stratification
 - health and 51–2
- social support
 - social determinant of health 45
- social support networks 46–7
- Solomon Islands
 - village development in 101
- South Africa
 - HIV in 70–2
 - Treatment Action Campaign (TAC) 68, 70–1
- South Korea
 - economic growth in 116
 - medical tourism 149
- Southern African Development Cone 177
- Soviet Union
 - collapse of 128
- Spahn, Paul-Bernd 173
- Spahn tax 173
- spatial dimension
 - characteristic of community 37
- spider web configuration 101
- stakeholders
 - definition of 76
- state
 - theories of 10–11
- Stiglitz, Joseph Eugene 114
- strategic rationality 75
- stress
 - social determinant of health 45

- sub-Saharan Africa
 - HIV/AIDS 109, 134
- suicide
 - among cotton farmers in India 143
- supply
 - demand not matched by 75
- Szreter, Simon 129
- Taiwan
 - economic growth in 116
- Tanzanian Essential Health Interventions Project (TEHIP) 22
- tax benefits
 - EPZs 105
- Tax Justice Network 157
- taxation 120
 - consumption of natural resources 176
 - consumption rather than income 114
 - currency transactions 180
- technical intervention 135–6
- Thailand
 - economic growth in 116
 - medical tourism 149
- tiger economies 116
- tobacco industry 84
- Tobin, James [1918–2002] 172
- Tobin tax 172–3
- tokenism
 - threat of 77
- toy factories
 - China 104–5
- tradable carbon emission permits 177
- trade agreements 107, 168
 - proposed social clauses in 169
- trade in goods and services
 - liberalisation 143–4
- trade liberalisation 105, 110
- trade restraint 168–70
- trade treaties
 - effect on health 142–50
- trade unions 126, 160
 - forbidden in EPZs 105
- training 41
- transnational companies *see* multinational companies
- transport
 - provision of 84
 - social determinant of health 45
- Treatment Action Campaign (TAC) 68, 70–1, 153, 179
- Tri-State Coalition for Responsible Investment 66–7
- Truman, David Bicknell [1913–2003] 60
- tuberculosis 141
- unemployment
 - social determinant of health 45
- UNITAID (International Drug Purchasing Facility) 157
- United Nations 169, 172
 - proposals for democratising 167
- United Nations Environmental Programme 163
- United Nations Millennium Project 136
- Universal Declaration on Human Rights (UN) (1948) 128
- universal tariffs 177
- Vancouver Agreement 64
- Virchow, Rudolf Ludwig Karl [1821–1902] 17
- visual representation
 - local empowerment 97, 101
- Voluntary Health Association of India (VHAI) 61
- volunteer time 79
- vulnerable peoples
 - needs of 130
- wages
 - in EPZs 105
- Wal-Mart Stores Inc 160
- Wallerstein, Nina 35
- ‘war on terror’
 - aid linked to stance on 133
- Watchworld Institute 57
- water 176
- wheel configuration 101
- women
 - employment of in EPZs 105
 - MDG 131
- Woodward, David 175–7

- work
 - social determinant of health 45
- working conditions 125
 - export clothing factories 103–4
 - health and 47
 - in EPZs 105
- workplace inequalities 143
- World Bank 2, 7–8, 109, 113–15, 136, 170
 - measures of poverty reduction 132
 - pressure on to remove conditions on loans 138
- World Commission on the Social Dimensions of Globalization (WCSDG) 122
- World Economic Forum 66
- World Health Assembly (1981) 68
- World Health Assembly (1997) 20
- World Health Organization (WHO) 6, 28, 68, 135, 172
 - constitution of 127–8
 - definition of health 7
- World Intellectual Property Organisation (WIPO) 168
- World Representative Parliament (WRP) 170
 - proposals for 167
- World Trade Organisation (WTO) 16, 66, 107, 143–6, 168
 - democracy and 171
 - role of 144–6
- Wright, Ronald 43
- Zambia
 - HIV in 109
 - manufacturing base 110