

Contents

| | |
|--|------|
| List of figures and tables | viii |
| Acknowledgements | x |
| General Introduction <i>Moyra Sidell, Linda Jones, Jeanne Katz, Alyson Peberdy and Jenny Douglas</i> | 1 |
| Section One: Key issues in health and health promotion: Introduction | |
| 1 The cycle of conflict: the history of the public health and health promotion movements <i>Charles Webster and Jeff French</i> | 9 |
| 2 The challenge of health inequalities <i>Hilary Graham</i> | 19 |
| 3 Older people's health: applying Antonovsky's salutogenic paradigm <i>Moyra Sidell</i> | 33 |
| 4 Social capital and health promotion <i>Penelope Hawe and Alan Shiell</i> | 40 |
| 5 The importance of social theory for health promotion: from description to reflexivity <i>Russell Caplan</i> | 51 |
| 6 Models of health: pervasive, persuasive and politically charged <i>Trudi Collins</i> | 62 |
| 7 Planning and delivering health promotion: integration challenges <i>Andrew Tannahill</i> | 72 |
| 8 The limits of lifestyle: re-assessing 'fatalism' in the popular culture of illness prevention <i>Charlie Davison, Stephen Frankel and George Davey Smith</i> | 85 |
| 9 An <i>empowerment model</i> for health promotion <i>Keith Tones and Sylvia Tilford</i> | 94 |
| 10 Counselling people living with HIV/AIDS <i>Pete Connor</i> | 101 |
| 11 More than words: dialogue across difference <i>Yasmin Gunaratnam</i> | 112 |

- 12 The social marketing imbroglio in health promotion
Ralph C. Lefebvre 122

Section Two: Questioning the evidence base of health promotion: Introduction

- 13 Epidemiology: to be taken with care
Joe H. Abramson 133
- 14 Explaining the French paradox
Michael L. Burr 146
- 15 Job-loss and family morbidity: a study of a factory closure
Norman Beale and Susan Nethercott 152
- 16 What counts as evidence: issues and debates
David V. McQueen and Laurie M. Anderson 165
- 17 Is prevention better than cure?
Christine Godfrey 175
- 18 The efficacy of health promotion, health economics and late modernism
Roger Burrows, Robin Bunton, Steven Muncer and Kate Gillen 184
- 19 Towards a critical approach to evaluation
Angela Everitt and Pauline Hardiker 194
- 20 A case study of ethical issues in health promotion – mammography screening: the nurse’s position
Alison Dines 201

Section Three: Promoting health in a wider context: Introduction

- 21 The changing global context of public health
A. J. McMichael and R. Beaglehole 211
- 22 Pedagogy of the oppressed: an extract
Paulo Freire (trans. Myra Bergman Ramos) 221
- 23 Addressing the contradictions: health promotion and community health action in the United Kingdom
Wendy Farrant 228
- 24 Dialogical evaluation and health projects: a discourse of change
Alan Beattie 239
- 25 User movements, community development and health promotion
Marian Barnes 257

| | | |
|---|---|-----|
| 26 | Promoting health with black and minority ethnic communities: developing strategies to address social inequalities and social exclusion <i>Jenny Douglas</i> | 264 |
| 27 | Econology: integrating health and sustainable development. Guiding principles for decision-making <i>Ronald Labonté</i> | 278 |
| 28 | Using sponsorship to create healthy environments for sport, racing and arts venues in Western Australia <i>Billie Corti, C. D'Arcy J. Holman, Robert J. Donovan, Shirley K. Frizzell and Addy M. Carroll</i> | 289 |
| 29 | Can the health sector influence transport planning for better health? <i>Adrian Davis</i> | 302 |
| 30 | Crime is a public health problem <i>John Middleton</i> | 313 |
| Section Four: Looking forward – dilemmas in health promotion: Introduction | | |
| 31 | Lifestyle, public health and paternalism <i>Dan Beauchamp</i> | 325 |
| 32 | Surveillance, health promotion and the formation of a risk identity <i>Sarah Nettleton</i> | 334 |
| 33 | Consumer health information-seeking on the Internet: the state of the art <i>R. J. W. Cline and K. M. Haynes</i> | 345 |
| 34 | Gendering health: men, women and wellbeing <i>Lesley Doyal</i> | 372 |
| 35 | The future of the health-promoting school <i>Susan Denman, Alysoun Moon, Carl Parsons and David Stears</i> | 383 |
| 36 | Think globally, act locally <i>Peter Townsend</i> | 392 |
| 37 | From healthy cities to locality based initiatives: margin to mainstream <i>Michael P. Kelly and Amanda Killoran</i> | 401 |
| 38 | Health promotion as an investment strategy: a perspective for the twenty-first century <i>Lowell S. Levin and Erio Ziglio</i> | 412 |
| | Index | 423 |

1 The cycle of conflict: the history of the public health and health promotion movements*

Charles Webster and Jeff French

Although the immediate sources of both health promotion and the 'New Public Health' are located in the 1970s, many of the ideas associated with these movements have much deeper roots. This short review sets the development of health promotion and the 'New Public Health' in a wider historical framework. Although we are concerned mainly with the UK, the key features are common to many other national contexts. Most histories of the development of public health, and more recently of health promotion, fail to acknowledge that, while methods and motivations may vary, co-ordinated community action to ensure a better life is as old as civilization and remains a feature of every community today. In histories of public health there has been a tendency to assume that concern for better health as a prerequisite for better life is a relatively new, medically-led and Eurocentric concept. This assumption is symptomatic of a historic interpretation that seeks to medicalize what has been, and remains, a complex and contested social phenomenon. What is required is a reassessment of the development of public health and health promotion that takes account of the social conflict inherent in these movements. In doing so, it should-not be taken as self-evident that we have necessarily built up a sophisticated and objective understanding of the contribution of public health and health promotion to better health. Finally, it is also necessary to bear in mind the fundamental purposes of health promotion and public health, and the extent to which they represent different conceptions of the aspiration to health.

The phrase 'public health' as currently used embodies many of the confusions, vested interests and singular interpretations that have resulted from a simplistic interpretation of its historical development. It could even be argued that the term public health is often used in a spirit of what might be described as conspiratorial confusion – a point made by Alan Milburn, as UK Secretary of State for Health:

'Public health' understood as the epidemiological analysis of the patterns and causes of population health and ill health gets con-

* From Adams, L., Amos, M. and Munro, J., (eds) 2002 *Promoting Health: politics and practice*, London: Sage.

fused with 'public health' understood as population-level health promotion, which in turn gets confused with 'public health' understood as public health professionals trained in medicine. So by series of definitional sleights of hand, the argument runs that the health of the population should be mainly improved by population level health promotion and prevention, which in turn is best delivered, or at least overseen and managed, by medical consultants in public health. The time has come to abandon this lazy thinking and occupational protectionism. (Milburn, 2000)

The minister's evident frustration testifies to the current confusion over definitions of purpose and territorial responsibility among health professionals. Implicit in the above quotation, and most other current discussions of public health, are elements of a definition that have, in fact, been in widespread use over the last seventy-five years. The goals of public health are usually stated to be 'preventing disease and promoting health', and the mechanism for realizing these objectives are to be organized interventions directed at particular groups or the community as a whole. Clearly, therefore, public health has always been associated in some way with health promotion. While this dual identity has been a source of strength, as noted below, it has also proved to be an effective source of friction. Even before the terms public health and health promotion came into use, dilemmas in defining the objectives of such interventions were apparent. In Britain, the first public health manifesto was issued on 25 January 1796, in response to the social upheavals associated with the Industrial Revolution. This remarkable 'Heads of Resolutions for the consideration of the Board of Health' in Manchester resisted the invitation to censure the labouring people for their moral delinquency; instead, it called for their protection through state intervention involving 'a system of laws for the wise, humane, and equal government' of working conditions (Maltby, 1918, pp. 121–2). Looking forward to the thinking of a much later date, the Manchester manifesto firmly located the root cause of ill health in the prevailing economic system. Although this episode demonstrates that general social activism and a strong liberation philosophy pre-date modern conceptions of public health, in the event such movements failed to bring about widespread improvements in health, owing to the absolute dominance of forces of economic production.

During the 1840s, the early public health movement predominantly focused on sanitary conditions, motivated by a desire to reduce Poor Law support and promote economic efficiency. However, at the same time, an alternative perspective which saw patterns of disease as a reflection of social conflict was being put forward by writers such as Friedrich Engels. In *The Condition of the Working Class in England*, in 1844, Engels (1973) cited the mode of economic production as the principal cause of ill

health. His justification for public health intervention was one based on notions of social justice rather than efficiency of production.

Most histories of public health label this supposed start of the modern public health movement in the 1840s as the *sanitation phase*, a period characterized by adoption of a medical perspective and concentration on environmental issues such as housing, working conditions, the supply of clean water and the safe disposal of waste. Under the supervision of the newly-invented Medical Officers of Health (MOH), the sanitarians focused on improving the health of working people by bringing about changes in their conditions of everyday living. The motivating forces of this early public health movement were economic advantage and, to a lesser extent, the maintenance of social cohesion between the working poor and the middle and upper classes.

A more critical perspective is provided by Turshen (1989), who suggests that attempts by some historians to portray public health doctors as the health champions of working people are misplaced. Turshen argues that what working people themselves wanted was radical social and economic change, not environmental engineering or minor social legislation designed to mitigate the worst effects of capital production.

The safe disposal of waste and the supply of uninfected water yielded real and measurable reductions in infectious disease, but the inadequacy of the sanitarian approach to health was exposed by the Interdepartmental Committee on Physical Deterioration, which reported in 1904. This committee revealed the enormous extent of ill health associated with poverty and economic exploitation, but rather than resulting in significant changes to the social and economic determinants of health, the committee's findings became the springboard for what is often termed the second, *personal hygiene*, era in public health intervention. Winslow (1952) characterizes this as focusing on education and hygiene, which relocated the responsibility for health improvement with individuals, as opposed to collective community action or state intervention. Newsholme's report of 1913 typifies the then prevailing medical public health attitude that poverty was not in itself a cause of infant deaths (Newsholme, 1936, pp. 179–82). Instead, this report maintained that it was the removable evils of 'motherhood ignorance' about infant care and 'poor personal hygiene' that were to blame.

The second stage of public health, occupying the first half of the twentieth century, generated a vast array of clinics and other institutional services to deal with the needs of such vulnerable groups as mothers, infants, schoolchildren, and those suffering from particular diseases such as tuberculosis. Inevitably, these services required the employment of a large workforce, with the result that this period became the heyday of the MOH and public health departments of local government. These services brought about greater contact with individuals and families, and 'health education' figured prominently in this work. Increasingly in the

UK, the conceptualization of health promotion was dominated by health education in schools. While this state-sponsored health education was underpinned by what we would now call a 'victim blaming' philosophy, an alternative 'liberation and empowerment approach' to health education was also being developed by lobbying groups such as the Children's Minimum Council, the Committee Against Malnutrition and the National Unemployed Workers Movement (Lewis, 1991).

The achievements of public health in the first part of the twentieth century were heavily publicized, not least by figures such as Sir Arthur Newsholme and Sir George Newman, Chief Medical Officers of the time. Both conducted their apologetics in the language of missionary zeal and in a paternalistic spirit, which invited uncritical admiration rather than objective understanding (Newsholme, 1936; Newman, 1939). As in the sanitarian phase, the personal hygiene era brought genuine health gains, but also disadvantages. On the eve of the Second World War, we might characterize public health professionals as bureaucratic, complacent, eugenic and preoccupied with national economic objectives. Worse, in the light of evidence relating to health during the interwar depression, was not only that public health professionals had made little impact on the problems identified by the Interdepartmental Committee on Physical Deterioration, but also that its elite had manipulated the official statistics to disguise the limitations of its competence (Webster, 1982).

In sum, although the public health establishment during its second phase made every effort to show that its health education services embodied a genuine attempt to empower and liberate the population, this was only true to the most limited extent, and the limitations were recognized by social activists on both the right and left. In the late 1930s, new thinking about public health emerged from such sources as the maverick Peckham Health Centre, from the eugenicist Richard Titmuss, and in the form of 'Social Medicine' as advocated by John Ryle (Ryle, 1948). The idea of Social Medicine was to apply a biomedical paradigm to populations. At least in the UK, this was largely an academic construct limited to an intellectual elite and not extending its influence beyond a few university public health departments, with the result that it was ignored by the dominant medical public health establishment.

For a short time, planners looked to Social Medicine as the means to revitalize public health. In fact, Social Medicine failed to consolidate its influence, with the result that, in the UK, epidemiology was its only long-term legacy. This approach is, in turn, being increasingly challenged as embodying a simplistic, biomedical and professionally dominated idea of health (Peterson and Lupton, 1996). None the less, the abortive Social Medicine movement underlined the limitations of the previous era and, in this respect, prepared the ground for health promotion and was one of the factors causing the medical profession to invent the 'new public health'.

Social Medicine accepted that 'health' implied a 'positive' condition, representing much more than freedom from communicable diseases. Achievement of positive health implied a changed attitude to the causes of ill health, involving reference to the 'whole economic, nutritional, occupational, educational, and psychological opportunity or experience of the individual or community' (Ryle, 1948, pp. 11–12). The success of Social Medicine depended on a new form of collaboration, in which all medical personnel, 'ordinary health workers and the general public', engaged in genuine teamwork (Leff, 1953, p. 15). Where necessary, this form of medical intervention also required commitment to social and political action (Crewe, 1945). Although Social Medicine was a British product, it was influenced by thinking elsewhere, particularly in America, and especially by Henry Sigerist, who is generally credited with having been the first to attach special importance to 'health promotion' and to the principles later embodied in the Ottawa Charter (WHO, 1986). Sigerist believed that the primary task of medicine was to 'promote health', and declared that medicine should be seen as a social science. It was 'merely one link in a chain of social welfare institutions', central to which was 'socialised medicine', for which he was also a leading advocate (Sigerist, 1941; Sigerist, 1943, p. 241). Although Social Medicine made little impact in the UK, it was more influential in North America and WHO circles, which ultimately became the main sources for igniting the health promotion movement in the 1970s.

The introduction of the National Health Service (NHS) in 1948 revolutionized health care in the UK. However, the benefits were distributed unevenly, and the activities most relevant to health promotion were located in the most neglected corners of the new service. As one of its most radical changes, the NHS reduced the functions of public health departments, thereby turning the once powerful MOH into a minor functionary in charge of only a small rump of preventive services. While health care was transformed, public health professionals were launched into a phase of disorientation.

In a move that seemed symbolic of this collapse of influence, the government abandoned its health centre programme. This had been the only important new function promised to the MOH, and many of the hopes for the realization of Social Medicine's potential had depended on the creation of health centres (Lewis, 1986; Webster 1988, pp. 381–8).

At the time of the NHS reorganization of 1974, which completely eliminated local government involvement in the health service, an attempt was made to rescue public health activity from extinction by repackaging it as community medicine, but this too was a failure (Lewis, 1986). In particular, the 1974 changes deprived community medicine specialists of their control of environmental health departments, and shifted them back into hospital administration and also abandoned the annual reports that were a key component of the watchdog role of the

MOH. Continuing erosion of confidence led to a further rescue effort in 1988, based on the recommendations of the Acheson Report (1988), which reintroduced public health medicine as the name of the specialty.

Alongside the decline in medically dominated conceptions of public health during the 1960s and 1970s, the empowerment conception of health education continued to grow in influence. It was not until 1976–7 that the UK government issued its first prevention policy documents, but these timid efforts made no permanent mark (Webster, 1996, pp. 660–86). They simply restated the contention that ill health was largely the responsibility of individuals whom, through ignorance, were not looking after themselves. It was implied that ill health, rather than being related to poverty, was attributable to affluent lifestyles. Reflecting the barrenness of thinking about promotion, the commentary on health education of the Royal Commission on the NHS was also entirely lacking in insight (Royal Commission on the NHS, 1979, pp. 44–7). With respect to prevention and promotion, perhaps the most important changes were incidental features of the 1974 NHS reorganization, which gave environmental health officers new professional autonomy under local government, and established health education as an embryonic specialism in the NHS.

Under the NHS, public health medicine limped along with its traditional routines, but it failed to respond to new challenges and avoided confronting the continuing problems of ill health associated with poverty. The mounting economic crisis of the 1970s prompted new concern about poverty and public health, and stimulated yet another rebirth of Social Medicine. The new social awakening centred around the problem of ‘inequality’ (Townsend and Bosanquet, 1972). In the field of health, this concern reached its classic expression in the Black Report (1980) (Townsend and Davidson, 1982). The findings of the Black Report drew together a great deal of evidence that highlighted appalling, inequalities in health, maldistribution of resources, and irrational disparities in the provision of seemingly every type of service, including, those relating to prevention and promotion (Hart, 1971; Culyer, 1976; Dowling, 1983).

In light of the above brief history, it is not surprising that the impetus for new thinking about public health and health promotion came from outside the UK. The context of this reappraisal was provided by a confluence of forces: first, the rising tide of radical critiques of the medical establishment and the health industry in the Western economies; second, a mood of self-criticism within health services concerning their shortcomings, especially with respect to the needs of the poor and the developing world; third, growing concern in Western governments over the escalating cost of health care; and finally, the dramatic impact of the oil price rises introduced by OPEC states at the end of 1973. This date marked the end of the golden age of the welfare state, introduced an era

of retrenchment, and provoked a rethinking of every aspect of health care. One of the early products of this rethinking was the development of empowerment models of health education and the concept of 'health promotion'.

The three seminal documents that launched the health promotion movement were the Lalonde Report *New Perspectives on the Health of Canadians* (1974), and the WHO's *Global Strategy for Health for All by the Year 2000* (1981) and the *Ottawa Charter for Health Promotion* (1986). Together, they set out a vision for health improvement that went beyond sanitation engineering, lifestyle health education and preventive and caring health services, and mark the advent of the *health promotion* phase of public health. Health promotion was concerned principally with empowering citizens so that they could take control of their health and in doing so attain the best possible chance of a full and enjoyable life. The principal methodologies included community development, empowerment, social marketing, advocacy, organizational development and the formulation of integrated health strategies. Bunton (1992) contended that health promotion represented a new form and conception of health intervention: it 'deliberately tried to address issues of power, political, economic and social structures and processes'. MacDonald (1997) suggested that, because health promotion is intrinsically revolutionary, governments have, since its conceptualization, been trying by elaborate means to accommodate it and have displayed great ingenuity in appearing to absorb its radical ideas without in reality disrupting the *status quo*. As governments seek to embed health promotion within the existing medical and health-care dominated agenda, attention is drawn away from the challenges that it presents for society – most radically to set health, rather than the creation of wealth, as the overarching goal of society. As we have seen, this is not a new idea, but rather a re-emergence of much earlier calls for health to take priority over wealth creation.

Kelly and Charlton (1995) have, however, pointed out that health promotion is characterized by a difficulty that arises from the failure by its advocates to address their unspoken assumptions about the relationship between social autonomy and social structure. They suggest that this is especially problematic when considering the effects of social inequality on oppressed groups: 'Here the emphasis is on social determinism among the oppressed while maintaining a place for the idea of free will among non-oppressed groups. Empirically, this may seem to be the way the world operates, and politically it may make sense to construct things in this way, but theoretically and epistemologically it does not work' (1995, p. 89).

Stevenson and Burke (1991) are even more critical of health promotion, arguing that it weakens struggles for social equity and political change to the extent that 'with its emphasis on organic harmony and consensus among diverse identities and its tendency to develop method-

ological 'resolutions' to political problems, health promotion mystifies rather than clarifies the nature of social barriers to meaningful change' (1991, p. 281).

Health promotion and the 'New Public Health' possess common characteristics. Both are closely associated with the WHO *Health for All* strategy, and both seem to consist of multiple and disparate stands. Draper believes that the new public health takes a 'comprehensive view of health hazards in the human environment, from the physical, chemical and biological to the socio-economic' (Draper, 1991, p. 10). Baum (1990) has argued that the 'new' public health carries the same flaws as many understandings of health promotion, in that it is underpinned by the assumption that change can be achieved through consensus building, while history teaches us that it is conflict and challenges to existing power structures that promote health.

If health promotion and the new public health have a major distinguishing feature, it would appear to be the conviction that health is a right – opposed to older ideas of health as a necessity for national efficiency, or as a moral duty of citizens. However, even this claim does not withstand critical examination. The 'health as a right' concept can be traced back for thousands of years and, like 'health as a means to efficient production', represents a recurrent theme. The health as a right concept has, however, continuously been subordinated to a more politically and capital sensitive paradigm that emphasizes individual and environment solutions to poor health over social and economic ones.

Yet it is possible to make an even more critical assessment of the new public health movement. It is arguable that the new public health – concept developed largely by medical practitioners working in the public health field – represents an assault by the medical profession, intent on recapturing the commanding heights which were lost to the globally developed and more inclusive notion of health promotion. Evidence of this reassertion of public health is evident in much of the UK government's recent health strategy. The term 'health promotion' is noticeable by its absence, despite the fact that, internationally, the phrase is used as an umbrella term that includes the subset of public health. As indicated in the quotation from Alan Milburn earlier in the chapter, it seems that the case for interdisciplinary and intersectoral partnerships to promote health is now accepted by the UK government. The Health Development Agency established in 2000 in England seems to be a concrete expression of this acceptance, although only time will tell whether the agency receives the governmental support it will need to be effective.

The public health and health promotion professions embody – and tolerate – conflicting ideas of why and how health should, and could, be improved. The meaning of public health and health promotion are themselves contested and open to a range of understandings. The origins of these conflicts lie in the contested nature of health itself, of the causes

of ill health, of the methods for reducing ill health and promoting well-being, and fundamentally, in the motivation for such interventions. The historical record suggests that one expression of these conflicts has been through the cyclical invention, abandonment and reinvention of the 'social model' of health and disease which, when advocated, quickly falls out of favour due to the fact that inevitably it brings its supporters into direct conflict with the state and existing economic interests. Alongside this, the history of public health has also been one of a long battle for occupational domination by the medical profession. Given a widespread acceptance of the complexity of improving health, and the UK government's moves to develop multidisciplinary public health leadership, the traditional hegemony of the medical profession is clearly no longer sustainable.

The promotion of health depends on the engagement of a wide number of sectors and professions. Public health promotion has always been, and remains, a collective activity. Only if we are prepared to recognize the historic conflict, and the contested nature of health promotion and public health, will it be possible to develop a deeper understanding of how the battle could be more effectively fought on behalf of those currently deprived of their rights to health. In the light of history, it is clear that the fundamental test of health promotion is yet to come as it struggles to exercise any influence at all in a world increasingly shaped by global economic forces.

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Index

- Abramson, J.H. 129, 133–42
accidental death 314
accidents 22, 27
accounts of health 33–5
Acheson, D. 14, 212, 405
Adams, L. 55
Adelhard, K. 353, 354, 355, 356, 357,
358–9, 361–2, 363
administering health 334–6
Africa 108, 350, 393
age 83, 113, 116, 178, 199, 415
of death 19–20, 22
agenda-setting 98–100, 178
Aggleton, P. 375
AIDS *see* HIV/AIDS
Akehurst, R. 182
Alao, A.O. 354
alcohol 147–9, 150, 331
see also alcohol abuse
alcohol abuse 85, 89, 175, 177, 297,
325–8, 406
conscientization 45
and crime 315, 320
disease-oriented approach 74–5
France 150
gendering health 375
individual interests, threatening of
332
paternalism 328–9
social theory 52
surveillance and risk identity 338
see also drink driving; safe alcohol
practices
Alessi, N.E. 361
Alexander, Z. 112, 114
Alma-Ata Declaration 232, 303
Ambre, J. 355, 356, 357, 358, 359
Amin, K. 267
Amtoft, M. 249
analysis levels 185
Anderson, L.M. 130, 165–73
Angell, M. 134
angina 20
anti-oxidants 150
Antonovsky, A. 6, 77, 404
Appleby, C. 347, 348, 351, 356, 358
area influences 29
area of residence 20
area-based initiatives 407–8
arena-centred programmes 78–9, 81–3
Argyris, C. 251
Armstrong, D. 336, 337, 340–1
Armstrong, M.A. 148
Arnoux, L. 67
arthritis 373
Aschenbrener, C.A. 347
Ashmore, M. 185, 187
Ashton, J. 46, 402, 417
Ashworth, P. 114
Atkin, C.K. 364
Atrens, D. 338
Audit Commission 242
Auerbach, J. 376
Austoker, J. 205
Australia *see* sponsorship to create
healthy environments
Austria 146
authoritativeness 356
auto-immune diseases 373
autonomy 42, 206, 207
Ayonrinde, O. 346, 347, 354

'Back-to-Sleep' campaigns 138
Bader, S.S. 347, 354
Bakhtin, M. 112, 113, 116, 117, 118,
120
Balkan crisis 214
Bangladesh 392
Barnes, C. 260
Barnes, M. 210, 257–62
Barrett, S. 360
Bartley, M. 413
Batt, S. 376
Baum, F. 16
Bazzoli, F. 361
Beaglehole, R. 209, 211–18
Beale, N. 130, 152–63
Beattie, A. 57, 210, 230, 239–53
Beauchamp, D. 323, 325–32
Beck, U. 337
behavioural factors 27, 28, 66, 69, 189,
339
Belgium 393
Bell, C.S. 361
Bell, N. 377
Bellizzi, M.C. 149
benefits 394–5
Bennet, G. 261
Bennis, W. 417
bereavement 152
Berer, M. 379
Beresford, P. 231
Berkelman, R.L. 135
Berland, G.K. 360
Bernardes, D. 374, 378
Bettcher, D. 213, 214
Beveridge Report 397
Bhabha, H. 250

- Bhopal, K. 115
 Bhopal, R. 265
 bias 135, 137
 biodiversity loss 216
 biological hazards 278
 biomedicine 34
 Birke, L. 372
 Black Country Access Federation 272
 Black Report 14, 89
 Blakemore, K. 267
 Blane, D. 413
 Blaxter, M. 33, 266
 Blennerhassett, S. 228
 blood pressure 146, 147, 150, 181
 see also hypertension
 Bloor, M. 339
 Boddington, N. 387
 body maintenance 86
 see also alcohol abuse; drug abuse; diet;
 physical activity; substance abuse
 Bond, M. 247
 Boneham, M. 267
 Bor, R. 102
 Boruch, R. 320
 Bosanquet, N. 14
 Bourdieu, P. 41, 42, 44, 47
 Bowl, R. 258, 259
 Boyer, C. 352, 356, 360
 Bradby, H. 113, 116
 Braude, R.M. 347, 354
 Brauer, M. 140
 Brenner, M.H. 160
 British Colonial Office 230
British Social Attitudes 396
 Brown, C. 267
 Brown, L. 287
 Bruera, E. 347, 348, 350, 351, 352, 353,
 354
 Bryson, L. 40
 BSE 134
 Buehler, J.W. 135
 Buhle, E.L. Jr 347
 Builder, C. 347
 Bullmer, M. 257
 Bunker, J. 408-9
 Bunton, G. 361
 Bunton, R. 15, 44, 184-92, 402
 Burchell, G. 335
 Burgner, M. 102, 109
 Burke, M. 15-16, 59
 Burr, M.L. 129-30, 146-50
 Burrell, G. 55
 Burrows, R. 130, 184-92, 402
 Busfield, J. 374
 Butcher, R.B. 165
 Butterfoss, F.D. 46

 Callinicos, A. 403
 Calnan, M. 67
 Cameron, C. 374, 378

 Campbell, J. 258
 Canaan, J. 375
 cancer 19, 74, 75, 76, 138, 405
 breast 140, 179, 376
 cervical 140
 and diet 286
 elderly people 35
 lung 22, 27, 179
 ozone depletion 216
 prostate 376
 Cantley, C. 194-5, 246
 capacity building 45
 Caplan, R. 6, 51-60
 Capra, F. 218
 cardiovascular disease 43, 148, 286
Care in Action 231
 Carroll, A.M. 289-300
 Carroll, S. 372
 Castel, R. 336
 Catch-22 138
 Central America 217
 Central Australian Aboriginal Congress
 235
 cerebrovascular disease 148
 Chalmers, A. F. 51
 Chalmers, I. 134, 135, 142
 Chapman, G. 349-50
 Charles, N. 373
 Charlton, B.G. 15, 138, 142, 401-9
 Charlton, J. 375
 Charsley, K. 266
 chemical hazards/pollution 217, 278
 Chi-Lum, B. 351
 child
 mortality rates 22
 protection 316
 support 396-7, 399
 Children's Minimum Council 12
 China 19, 230, 232
 cholesterol levels 146, 147, 150, 175,
 177, 181, 338
 Christie, N. 331
 chronic disease 85
 chronic obstructive airways disease 75
 Chu, C. 284
 circumcision 267, 271
 classification-and-framing scheme
 250-1
 climate change 215-16
 Cline, R.J.W. 323, 345-64
 Cobb, J. 279, 281
 Cochrane Collaboration 134, 142
 Cockburn, C. 230
 Cohen, D. 180, 184
 Cohen, I.L. 258
 Coiera, E. 347, 353
 Coleman, J. 41, 42, 168
 Collins, T. 6, 62-71
 Commission for Racial Equality 319
 Committee Against Malnutrition 12

- commonality 114–16
 Commonwealth of Independent States 393
 communication 123, 415–16
 communication and race/ethnicity 112–20
 dialogism and creative understanding 117–19
 ethnic matching: from commonality to connectivity 114–16
 community
 action 234, 272
 care 257
 control and cohesiveness 67, 68, 69
 definition 66
 development 57, 59, 315–16
 see also user movements and community development
 evidence 167–8
 health 68
 health action in United Kingdom 228–36
 development and ideology 230–2
 Health for All by the Year 2000 232–5
 participation/manipulation 229–30
 interaction 64–6
 model 67–8
 participation 303
 planning 80
 reflexivity and social theory 60
 regeneration 257
 safety 257
 comprehensibility 37, 39
 confounding variables 137
 connectivity 114–16
 Connell, R. 378
 Connor, P. 7, 101–10
 conscientization 45
 Conservative government 401
 control 85–7, 168, 230
 Cook, P.J. 326, 327
 Cormie, J. 261
 Cornia, G.A. 413
 coronary heart disease 52, 178, 338, 377, 405, 406
 disease- and risk factor-oriented approach 74, 75, 76
 health inequality 19, 20, 22, 27
 lifestyle 87, 88
 race/ethnicity: inequalities and exclusion 266, 267, 269, 275
 Corti, B. 210, 289–300
 cost 188–9, 350
 benefit analysis 242
 -effectiveness 178–81, 182, 186, 188, 190–1, 242
 indirect 180
 internalisation 284
 utility analysis 242
 cot death (sudden infant death syndrome) 138
 Cotter, P.R. 44
 counselling *see* HIV/AIDS counselling
 Court, C. 138
 Couto, R. 40
 Cox, K. 43, 97
 creative understanding 117–19
 Crewe, F.A.E. 13
 crime 313–21, 394
 causes 313–14
 and disorder partnerships 320–1
 domestic violence 318
 education 314
 health service, role of 316–17
 Healthy Cities 406
 prevention 315–16
 prisons and health 319
 racial harassment 318–19
 young, problems of 314–15
 Crime and Disorder Act (1998) 320
 Crime-GRIP project 320
 Criqui, M.H. 146, 149, 150
 critical
 consciousness-raising 96–8, 99
 discourse analysis 245
 evaluation 194–200
 interpretivist 194–5
 social science 196–7, 198
 Croft, S. 231
 Cuba 232
 cultural
 action 224–5
 devaluation 374
 features 113
 invasion 221–4, 225–6
 synthesis 224–6
 Culyer, A.J. 14
 Cumberledge report 231
 Cummings, S.R. 135, 181
 Curtis, S. 46, 47

 Daily, G. 215, 216
 Daly, H. 279, 281
 dangerous driving 375
 see also drink driving
 Daplan, R. 68
 DARE drugs education 320
 Darwin, C. 166
 Davey, B. 260
 Davey Smith, G. 6, 26, 85–93, 265, 266, 338
 Davidson, N. 14
 Davidson, W.B. 44
 Davies, C. 231
 Davies, J.K. 401–2
 Davies, P. 320
 Davis, A. 210, 302–11
 Davison, C. 6, 85–93
 De Kadt, E. 97–8

- de Leeuw, E. 310
 De Lorgeril, M. 146, 149
 de Semir, V. 134
 Dean, K. 167
 death
 accidental 314
 certificate diagnoses 146–7
 see also mortality; suicide
 decentralization 232
 decision making 279–80, 287
 Deering, M.J. 364
 DeGeorges, K.M. 351
 Dekker, E. 304
 Delanty, G. 403
 delivering health promotion *see*
 planning and delivering health
 promotion
 demography 266
 Denman, S. 323–4, 383–90
 Denmark 146, 148, 302, 303, 305, 310
 health-promoting school 386
 Ministry of Health 304–5
 see also transport planning
 Department of Health 112, 191, 231,
 266, 313, 338, 405, 406
 Department of Transport 407
 depression 214
 Detels, R. 133
 Dewi-Rees, W. 152
 diabetes 148, 267, 275
 dialogical evaluation 239–53
 alternative evaluation paradigms
 243–6
 as discourse of change 251–3
 ideational function 248–51
 mainstream approaches 239–43
 multiple stakeholders 246–8
 dialogism 112, 113, 116, 117–19, 120
 dialogue 169, 199
 diarrhoeal disease 216
 Dickinson, E. 101, 110
 diet 52, 177, 181, 272, 286, 297, 405
 disease-oriented approach 74
 France 147, 149
 global context of public health 211,
 213
 health-oriented approach 76
 health-promoting school 387
 HIV/AIDS 103, 104
 lifestyle 85, 86, 89, 91
 promoting Asian foods as healthy
 272–3
 surveillance and risk identity 338,
 339
 see also healthy food choices
 Dines, A. 131, 201–10
 disability 83, 113, 196, 199, 316, 394
 access 291
 adjusted life years (DALYs) 171
 support 396–7, 399
 user movements and community
 development 257, 258, 259, 260,
 262
 disadvantaged groups, access for 270,
 291, 292–6
 disclaimers 357
 discount rate 179, 190, 191
 disease 279
 -oriented approach 72–5, 76
 see also chronic; infectious
 Dixon, J.A. 215, 217
 Djukanovic, V. 232
 Doll, R. 138, 148
 domestic violence 317, 318, 320
 domination 221–2, 223, 224–5
 Donaldson, C. 243
 Donovan, R.J. 289–300
 Douglas, J. 210, 264–75
 Douglas, M. 337
 Dovey, K. 46
 Dow, M.G. 353, 354, 361
 Dowling, S. 14
 Downie, R.S. 72–3, 75, 76, 77, 78, 177,
 187
 Doyal, L. 323, 324, 372–9
 Doyle, D.J. 347, 361
 Draper, P. 16
 Drever, F. 22
 drink driving 314, 329–30, 331
 drug abuse 75, 214, 314–15, 393, 406
 and crime 320
 lifestyle 86, 89, 91
 in prisons 319
 Drummond, M.F. 175, 184
 Dubos, R. 35, 409
 Duden, B. 335, 341
 dummy-IQ association 137
 Dun, R. 232
 Dunbar, C. 115
 dynamism 172
 Dyson, S. 113

 Eade, D. 45
 East Africa 216
 Eastern Europe 393
 econology 278–300
 costs internalisation 284
 decision-making, principle-based
 279–80
 empowerment, equal 281–2
 global inequities, shrinking of 280–1
 information inclusiveness 280
 national inequities, shrinking of 281
 nurturing intangibles 284–5
 planning across generations 285
 replenishing and replacing 283–4
 sustainable development 282–3, 284
 economic
 aspects 67, 68, 69
 inequalities 379

- economic *continued*
 objectives 186–7
 Economic and Social Research Council 268
 economy, efficiency and effectiveness model 242–3
 Ecoworks 260
 Edinburgh Research Unit for Health and Behavioural Research 236
 Edley, N. 119
 education 19, 58, 190, 222–3, 314, 349
 action zones 406
 health-promoting school 384, 387, 388–9
 model 57, 94
 for radical action 96–8
 see also health education; literacy
 efficacy of health promotion, health economics and late modernism 184–92
 cost-effectiveness indicators 190–1
 costs 188–9
 economic objectives 186–7
 health promotion options 187–8
 outcomes 189–90
 study designs 188
 study problem, defining 185–6
 Egger, G. 290, 297
 Egypt 19
 elderly people 33–9, 180, 257, 261, 262, 406
 accounts of health 33–5
 salutogenic paradigm 35–9
 emancipatory reasoning 198
 embeddedness 42
 employment 24, 25
 Employment Action Zones 406
 empowerment 45, 234, 287–8
 critical evaluation 198
 elderly people 37
 equal 281–2
 evidence 168
 health-oriented approach 77
 health-promoting school 386
 model 94–100
 agenda setting 98–100
 education for radical action: critical consciousness-raising 96–8
 social capital 47
 surveillance and risk identity 342
 Eng, E. 44, 45
 Eng, T.R. 346, 347, 348, 349, 350–1, 360, 362
 Engels, F. 10–11
 environmental
 change 213, 214–15, 217
 factors 83, 91
 hazards 278
 health 14, 68
 scanning 124
 epidemiology 133–42
 accurate knowledge of results 134–6
 information relevance 139
 information sufficiency 139–41
 validity of inferences drawn from findings 136–9
 Epstein, P.R. 216
 equal pay 379
 equity 67, 68, 69, 191, 303, 310
 Erens, B. 266
 Escher, S. 259
 essentialism 114, 117
 Essex, D. 259–60, 358
 ethical issues: mammography screening 201–10
 background 201–2
 health education 205–7
 ‘nurse agin’ 203, 204, 205, 206
 ‘nurse committed’ 203, 204, 205, 206
 ‘nurse fence-sitter’ 204, 205, 206
 ‘nurse sidelines’ 204, 205, 206
 nurse’s position 202
 Etzioni, A. 257
 Eurocentrism 9, 53
 Europe 392, 393–4, 398
 crime 314
 diet 149
 health inequality 25
 health promotion as investment strategy 418
 health-promoting school 390
 lifestyle 91
 mortality 212
 ozone depletion 216
 pensions 396
 social insurance 395
 transport planning 303, 304, 311
 see also European
 European Network of Health Promoting Schools 383, 385, 387
 European Parliament 398
 European Union 108, 399
 Social Chapter 395, 398
 evaluation 355–60
 collaborative 246–7
 creative 249–50
 critical 249
 developmental 243, 245, 246
 dialectical 250–1
 economic 240, 242
 experimental 240, 241
 illuminative 249
 mainstream 243, 245, 248
 managerial 240, 242
 participatory 247
 pluralistic 246
 realistic 243, 244, 245, 246
 reflexive 247–8
 see also dialogical evaluation

- Everitt, A. 130–1, 194–200, 249
 evidence 165–73
 definition 166–7
 indicators 171
 problems 169–70
 rules 170–1
 theoretical basis 171–2
 Ewald, F. 339
 exercise *see* physical activity
 experimental procedures 188, 239

 Fabri, P.J. 347
 Fairclough, N. 245
 Faludi, S. 379
 family
 morbidity *see* job-loss and family
 morbidity
 spacing 211
 structure 24
 Family Health Services Authority 273
 Farish, S. 44
 Farrant, W. 209–10, 228–36
 Farrell, T. 359
 fatalism 85–7, 88
 Faulkner, A. 260
 Featherstone, M. 403
 Fee, E. 372
 Feinleib, M. 135
 Feldman, M.E. 137
 Feldman, W. 137
 feminism 375
 Fenton, S. 266
 Ferri, E. 24
 fertility rates 211
 Feuerstein, M.T. 247
 Figert, A. 376
 Finch, J. 232
 Fine, M. 116
 Fisher, A.L. 153
 Fisher, M. 182
 Fisher, S. 377
 Fitzpatrick, R. 69
 Flathman, R. 327
 Flora, J. 123
 Flory, J. 361
 fluoridation 100
 food-producing ecosystems impairment
 217
 forensic local intelligence system
 (FLINTS) 320
 Forrest, Sir P. 201, 205
 Fosger, S. 377
 Foucault, M. 334–5
 Fox, N.J. 239, 250
 France 25
 see also French paradox
 Frankel, E.N. 148
 Frankel, S. 6, 85–93, 339
 Freire, P. 6, 96–7, 98, 209, 221–7
 French, J. 5, 9–17, 55

 French paradox 146–50
 alcohol 148–9
 artefact 146–7
 diet 149
 wine 147–8
 Friedson, E. 402
 Fries, J.F. 180
 Frisse, M.E. 361
 Frizzell, S.K. 289–300
 Fromm, E. 222
 Fuhrman, B. 148
 functionalist approach 59
 Funnell, R. 46

 G7 countries 398
 Gagel, M.P. 361
 Gagliari, A. 351, 360
 Gahlinger, P.M. 139
 Gail, M.H. 138
 Galbraith, J.K. 99
 Gale, C.R. 137
 Gallagher, S.M. 346, 349, 352
 Gallie, W.B. 51
 Garbanino, J. 47
 Garrison, S. 355, 357
 gatekeepers 74, 78–9
 gender 83, 178, 257, 346, 415
 critical evaluation 196, 199
 health inequality 20, 22, 23, 24, 28
 models of health 66–7
 race/ethnicity 113, 116, 119, 266,
 270, 274
 see also gendering health
 gendering health 372–9
 bias in medical practice 376–8
 men 374–6
 sex differences in health and illness
 372–3
 women 373–4
 geo-political status 373
 geographical distribution 268
 geographically centred inputs 82
 Gepkins, A. 47
 Gerard, K. 243
 Germany 146
 Gershman, K. 136
 Gey, K.F. 149
 Gibbs, J. 375
 Giddens, A. 185, 337, 341, 403
 Gifford, S.M. 89
 Gillen, K. 184–92
 Gillies, P. 79
 global context of public health 211–18
 biodiversity loss and invasive species
 216
 climate change 215–16
 environmental change 214–15, 217
 food-producing ecosystems
 impairment 217
 health risks 213–14

- global context of public health *continued*
 stratospheric ozone depletion 216
 global inequities, shrinking of 280–1
 Godfrey, C. 130, 175–83, 189
 Goldstein, S.M. 46
 Gordon, D. 372, 374, 375
 Gorssman, R. 417
 Gottlieb, B.H. 44
 Government's Spending Review 407
 Grace, B.M. 58
 Grace, V. 67
 Graham, H. 5–6, 19–30, 377
 Grandinetti, D.A. 345, 347
 Gray, B. 46
 Gray, J. 214
 Greco, M. 342
 Greece 19, 25
 Green, C.W. 350
 Green, J. 101
 Green, L.W. 167
 Greenberg, R.S. 135
 greenhouse effect 278
 Greenland, S. 139
 Gregg, P. 24, 25
 Gregory-Head, B. 347, 348, 353
 Griffin, C. 375
 Griffiths Report 231
 Grønbaek, M. 148
 Grossman, M. 331
 Groves, D. 232
 Guard, R. 348
 Guay, T. 361
 Gunaratnam, Y. 7, 112–20
 Gunning-Schepers, I. 47, 175–6, 181, 189
 Gustafson, D.H. 347, 348, 349, 360, 362
 gynaecology 373
- HAART (Highly Active Anti-Retroviral Therapy) 103, 105, 106, 107, 108
 Haines, A. 215–16
 Hall, J.P. 181
 Hall, S. 113
 Hambleton, R. 232
 Hamilton, D. 249
 Hammond, E.C. 138
 Hancock, T. 62–3, 64, 69, 286
 Hanlon, P. 72
 Hanson, E. 114
 'hard-to-reach' audiences 125
 Hardiker, P. 130–1, 194–200, 249
 Harding, S. 24
 Hardy, B. 384
 Harkness, S. 23
 Harries, J. 251
 Harrison, J. 372, 374
 Harrison, R. 152
 Hart, E. 247
 Hart, J.T. 14
 Hart, N. 374, 375
- Hastings, G. 122, 124
 Hattersley, L. 20
 Hawe, P. 6, 40–7
 Hawkins, R. 354
 Haynes, K.M. 323, 345–64
 Haywood, A. 122, 124
 Health Action Zones 30, 262, 402, 406–7
 health agenda 267
Health for All by the Year 2000 1, 15, 16, 234–5
 community health action and health promotion 229–30, 231, 232–4, 235, 236
 Copenhagen 306
 first UK conference 235
 health promotion as investment strategy 412
 Healthy Cities 402, 403, 404
 race/ethnicity: inequalities and exclusion 271
 reflexivity and social theory 55
 transport planning 302, 305, 308, 310
 Health for All strategy (1985) 303–4
 Health Department of Western Australia 299
 Health Development Agency 16, 406
 health education 11, 14, 56, 85, 178, 180, 229
 efficacy, health economics and modernism 186, 187
 and lifestyle 90–2
 mammography screening 205–7
 progressive 187
 on smoking 177
 Health Education Authority 235, 236, 266, 269
 Health Education Council 229
 Health Education Department 229
 Health For All 317
 health improvement 80
 Health Improvement and Modernization Programmes 262, 408
Health of the Nation 175–6, 179, 182, 186, 191, 274, 340, 356, 360, 401
 Health on the Net Foundation 346
 health perceptions 269
 Health Profile 307, 308
 Health Promotion Development and Evaluation Program (HPDEP) 290
 health protection 177, 187
 Health Survey for England 266
 Health Variations Programme 268
 health-ease-dis-ease 36–7, 38
 health-promoting school 383–90
 Healthway 289, 291, 292, 293–5, 296, 297–8, 299
 Healthy Cities 45–6, 401–9
 from the margins 405–8

- Healthy Cities *continued*
 Liverpool 247
 Plan 304
 and postmodernism 402–5
 see also transport planning
 Healthy Communities Collaborative 406
 healthy food choices 290, 291, 292–6, 299
 Healthy Living Centres 406, 407
 healthy public policies 45–6, 69, 286
 Hearing Voices movement 259
 Hearn, J. 374, 375
 heart attacks (myocardial infarction) 20, 177
 heart disease 35, 90, 373
 see also coronary heart disease;
 ischaemic heart disease
Heart and Minds 318
 Hecht, F. 104
 Hedges, C. 114
 Heller, T. 35
 Hemenway, D. 136
 Henderson, J. 180, 184
 Hendriks, H.F.J. 149
 Henkel, M. 239, 242
 Higgs, R. 162
 Hill, A.B. 137, 138
 Hillier, S. 114
 hip fracture 136
 history of public health and health promotion 9–17
 HIV/AIDS 319, 339, 350, 352, 377–8, 405
 prevention 182
 surveillance and risk identity 337
 treatment versus prevention 180
 see also HIV/AIDS counselling
 HIV/AIDS counselling 101–10
 future prospects 108–9
 HAART 103
 initial diagnosis 102–3
 long-term adherence 103–5
 longer life, implications of 105–6
 partners and families 107
 personal reflections 109–10
 side-effects 103, 104, 105
 Hoggett, P. 232
 holism 34
 Holland, R. 52, 55, 56
 Holland, W.W. 180, 182
 Holman, C.D.J. 289–300
 Home Office 313, 319
 homophobic tendencies 339
 Honduras 97
 Hopkins, D. 387
 Houghton, J.T. 214
 House, E. 250
 housing 23–4, 35, 267–8, 270, 394
 Howard, P.A. 347, 353, 355, 356, 358
 Huang, M.P. 361
 Hudson, B. 384
 Huggins, A. 372
 Hull, T. 387
 Hulley, S.P. 135
 humanist approach 59
 Humphreys, B.L. 348
 Hunt, C.E. 138
 Hunter, D. 304
 Hurtado, E. 141
 hypertension 175, 177, 267

 Ibrahim, M.A. 135
 ideational function 245, 246, 251, 252
 Illich, I. 402, 409
 immunization 180, 211
 income 19, 25–6, 29–30, 213–14, 349, 374
 see also minimum wage
 India 115
 individual
 choices 94
 health 68
 interaction 64–6
 level factors 27–8
 industrial accidents and diseases 374
 inequalities in health 14, 19–30, 211, 212, 228
 area influences 29
 and crime 315
 individual level factors 27–8
 integration 82–3
 patterns and trends 19–26
 policy research 29–30
 understanding 26–7
 inequities 280–1
 Ineson, A. 233
 infectious diseases 19, 211, 214, 216
 information
 accuracy 357–8
 currency 357
 inclusiveness 280
 organization 358
 see also Internet and consumer health
 information-seeking
 informed consent 206, 207
 Ingelby, D. 59
 insider-outsider problem 112
 inter-sectoral collaboration 304–5
 Interdepartmental Committee on Physical Deterioration 11, 12
 international co-operation 303
 International Conference on Health Promotion 232–3, 234, 235
 International Fund for Agricultural Development 392
 International Monetary Fund 392, 393, 394, 398

- Internet and consumer health
 information-seeking 345–64
 evaluation 355–60
 hazardous conditions 352–5
 navigational difficulties 351–2
 potential benefits 348–9
 public health interest 345–7
 and research 360–4
 roadblocks to access 349–51
interpersonal function 245, 246, 251, 252
interpreting services 271–2
invasive species 216
investment strategy 412–20
 communication reframing 415–16
 future challenges 417–18
 health as human, social and economic investment 413–15
 Investment for Health 414, 416, 417, 418, 419, 420
 multi-sectoral action 416–17
 Ottawa Charter: action domains 412–13
Ireland 115
ischaemic heart disease 146, 147, 149–50
Israel, B.A. 44, 45
Italy 29
Iverson, L. 153
- Jackson, S.F. 45
Jacobsen, K. 153
Jacobson, R.L. 351
Jadad, A.R. 351, 360
Jahoda, M. 152
Japan 146
Jarvis, D. 140
Jelinek, M. 241
Jenkins, R. 160
Jensen, B.B. 386
job-loss and family morbidity 152–63
 aims 154
 consultations 156–7
 health care in Calne 154
 hospital referrals 159
 illness episodes 157–9
 observations 155–6
 occupation and/or redundancy notification 160
 redundancies in Calne 153
 results 156
 statistical testing 156
 study period 155
 subjects 154–5
Johnson, C. 198
Johnson, L. 377
Jones, J. 247
Jones, L. 236, 303
Jones, T. 267
Judkins, D.Z. 361
- Kadar, A. 376
Kahn, H.A. 138, 139
Kai, J. 114
Kandiyoti, D. 374
Kaplan, G.A. 46
Kark, S.L. 139
Karlsen, S. 265, 268
Kasl, S.V. 153
Kassirer, J.P. 134
Kattwinkel, J. 138
Kauffman, K. 114
Kaufman, D.M. 347
Kearns, R.A. 46
Keeley-Robinson, M. 57, 58, 59
Keen, C. 361
Kellner, D. 403
Kelly, M. 15, 77, 324, 401–9
Kennedy, S.M. 140
Kenner, C. 228
Kenya 392
Khonsari, L.S. 347
Kibbe, D.C. 356, 357
Kickbusch, I. 233
Kiernan, K. 24
Killoran, A. 324, 401–9
Kimmel, M. 375
Kinnon, C.M. 213
Kirkup, G. 247
Kitts, J. 372
Klatsky, A.L. 148
Klausen, H. 153
Knowles, J.H. 331
Koopman, J.S. 218
Korn, K. 361
Kraemer, S. 374
Krech, R. 412
Kreuter, M.M. 167
Krieger, N. 19, 44, 372
Kuhn, T.S. 51
Kurth, A. 377
- Labonté, R. 77, 210, 278–300
Labour government 401, 405
labour markets 25, 213, 375
 see also occupation
Lacroix, E.M. 353
Lalonde, M. 15, 303
Lamb, B. 372
Lamp, J.M. 347, 353, 355, 356, 358
Landolt, P. 41
language 266, 350
Lantz, P.M. 27
LaPerrière, B. 347, 348, 349, 351
LaRosa, J. 376
Last, J.M. 133, 215
Latin America 393
Lauritzen, S.O. 340
Layzell, S. 260
learning organisation strategy 251
Lee, K. 213

- Lees, S. 113, 114, 115, 118
 Lefebvre, R.C. 122–7
 Leff, S. 13
 Leininger, M. 114
 leisure activity 86, 273
see also physical activity
 Leon, D.A. 212
 Levane, L. 249
 Levi, L. 282
 Levin, L. 324
 Levin, S.L. 1, 412–20
 Levy, B.S. 214
 Lewis, G. 115
 Lewis, J. 13
 Lewis, L.K. 364
 Lichtenstein, M.J. 135
 life course perspective 28, 82
 life expectancy 141, 211, 213, 334, 409
 and crime 313–14
 gendering health 375
 health inequality 20, 25
 lifestyle 27, 28, 85–93
 conceptual place 88–9
 and coronary heart disease 87
 efficacy, health economics and
 modernism 189
 fatalism and control 85–7
 France 146
 gendering health 374, 375
 general principles and individual
 events 89–90
 health education and health
 promotion, implications for 90–2
 prevention 178, 179, 181–2
 race/ethnicity: inequalities and
 exclusion 266
 risk factor-oriented approach 75–6
 surveillance and risk identity 339,
 342
see also alcohol abuse; diet; drug abuse;
 lifestyle, public health and
 paternalism; physical activity;
 smoking
 lifestyle, public health and paternalism
 325–32
 alcohol abuse 325–8
 individual interests, threatening
 329–32
 paternalism 328–9
 Lincoln, T.L. 347
 Lind, J. 138
 Lindberg, D.A. 348
 Lindholm, I. 181
 lipoprotein 148–9
 Lister-Sharp, D. 242
 literacy 211, 271, 350
 Littleton, D. 354, 355, 356, 361
 Lloyd, T. 374
 Loader, B. 185
 Local Strategic Partnerships 408
 locality centred improvement initiatives
 81–3
 Lochner, K. 29
 Loh, J. 215
 ‘Look After Your Heart’ 178
 Loomis, D. 212
 Loury, G.C. 41
 Lown, B. 350
 Ludbrook, A. 242
 Lukes, S. 325
 Lunik, M.C. 347, 352–3, 355, 361
 Lupton, D. 12, 339, 341–2
 Lutkins, S.G. 152
 Lyndon, N. 374, 376
 Lyotard, J.-F. 403, 404
 Macdonald, J.J. 97
 MacDonald, T. 15
 Mach, E.P. 232
 Machles, D. 353, 361
 Macintyre, S. 29, 46, 268
 McCabe, A. 317–18
 McCarron, P.G. 314
 McCreaner, A. 101
 McFarlane, M. 355
 McGrath, I. 348, 351, 352, 353, 355, 359
 McGuire, A. 191
 McKenzie, N.J. 352
 McKeown, T. 303, 402, 409, 413
 McKinlay, J.P. 68
 McKinley, J. 348, 351, 353, 355, 359
 McKinney, W.P. 361
 McLellan, F. 351
 McLeod, S.D. 352, 353, 355
 McLeroy, K.R. 43
 McMichael, A.J. 209, 211–18
 McMillan, S.J. 348
 McNemar Test 291
 McQueen, D.V. 130, 165–73
 macro-physical environment 67, 69
 Maibach, E. 364
 Malik, A. 274
 Mallik, M. 377
 Mallory, C. 352
 Maltby, S.E. 10
 mammography screening *see* ethical
 issues: mammography screening
 manageability 37, 39
 Mann, C.C. 134
 Mann, C.E. 361
 Mann-Whitney U test 156
 Markela, K. 326, 331
 Marmot, M. 20, 28, 43, 76, 79, 413
 Marra, C.A. 353
 Martens, W.J.M. 216
 Marti-Costa, S. 44
 Martin, E.R. 350
 Martyn, C.N. 137
 Marx, K. 185
 Maslow, A. 34

- Mastroianni, A. 376
 material factors 27, 28, 29
 Maugans, T.A. 352
 Mayer, M. 347
 Maynard, A. 182
 Meade, T.W. 149
 meaningfulness 37, 38, 39
 medical model 58
 Medical Officers of Health 11, 13–14
 Melucci, A. 258
 mental health 214, 239, 267, 271, 317,
 319, 374–5, 406
 user movements and community
 development 258, 259, 260, 261,
 262
 Mercer, G. 260
 Messing, K. 374
 Messner, M. 375
 Mexico 392
 micro-physical environment 66, 67
 Middle East 217
 Middleton, J. 210, 313–21
 Milburn, A. 9–10, 16
 Mill, J.S. 327, 330
 Miller, D. 110
 Milton, M. 102
 Mincer, S. 184–92
 minimum wage 397–8, 399
 Ministerial Conference on Environment
 and Health (Third) 310
 Ministry of Health 419
 Minkler, M. 40, 43, 44, 97
 Mitchell, J.J. 355
 models of health 62–71
 community 66, 67–8
 established model 62–4
 healthy public policy implications 69
 implications for health promotion
 68–9
 individual 66–7
 model within a model 64–6, 69, 70
 recommendations 70–1
 theoretical underpinnings 68
 use of models 69–70
 Modood, T.I. 265, 266, 267
 Mondros, J.B. 44
 MONICA project 147
 Moon, A. 323–4, 383–90
 Mooney, G. 242
 Moos 47
 moral debate 198
 morbidity 175–6, 180–2, 186–7, 189,
 334, 419
 elderly people 33
 France 147
 health inequality 20, 27, 29
 lifestyle 85, 89
 race/ethnicity: inequalities and
 exclusion 264, 265, 266
 see also job-loss and family morbidity
 Morgan, G. 55
 Morris, K. 351
 Morris, T.A. 348
 Morrow, R.H. 135, 139
 mortality 187, 189, 190, 191, 334, 394,
 419
 and bereavement 152
 breast cancer 201–2
 France 147, 148
 gendering health 377
 health inequality 19, 23, 27, 29
 infant and child 405
 ischaemic heart disease 146, 149–50
 lifestyle 85, 89
 premature 375
 prevention 175–6, 181, 182, 186
 race/ethnicity: inequalities and
 exclusion 265
 standardized mortality ratios 20–1
 Mothers Against Drunk Driving 330
 Mowbray, M. 40
 Moynihan, C. 375
 Mulholland, J. 113
 multi-agencies 186, 188
 multi-risk factor strategy 187
 multi-sectoral action 303, 416–17
 multiple stakeholders 246–8
 Murray Parkes, C. 152
 Myers, N. 216

 National Community Health Resource
 see Community Health UK
 National Electronic Library for Public
 Health 406
 National Health Promotion Conference
 (Australia) 43
 National Health Service 162–3, 184,
 228–9, 231–2, 235, 239, 242, 304
 abolition of regional offices 275
 gendering health 372, 377
 Health Technology Assessment
 Programme 241
 introduction (1948) 13
 Royal Commission 14
 standards in prisons 319
 National Healthy School Standard 383,
 384, 385
 national inequities, shrinking of 281
 National Service Framework for mental
 health 239
 National Survey of Ethnic Minorities in
 Britain (Fourth) 266, 267
 National Unemployed Workers Union
 12
 Navarro, V. 68, 214
 Nazroo, J. 265, 268
 Neff, J. 347
 Neighbourhood Renewal Fund 408
 nested levels 69
 Nethercott, S. 130, 152–63

- Netherlands 138, 146, 393
see also transport planning
- Nettleton, S. 44, 323, 334–43
- Neuburger, H. 179
- neutrality 206
- New Deal for Communities 30, 406, 408
- New Labour 29
- New Opportunities Fund 407
- new public health 16, 186, 230, 288, 402–3
- new social movements 258
- New York Online Access to Health 350
- New Zealand 138
- Newell, D.J. 241
- Newman, Sir G. 12
- Newsholme, Sir A. 11, 12
- NHS Plan* 405, 408
- Nielsen, J. 359
- non-experimental designs 188
- non-insulin-dependent diabetes 148
- Norman, D.A. 359
- North Africa 217
- Norum, D. 153
- Nottingham Advocacy Group 259–60
- Novak, H. 171
- Novelli, W.D. 126
- Novello, A.C. 387
- Nutbeam, D. 166, 402
- Oakley, A. 241, 372, 377
- obesity 177, 213, 406
- objectivist approach 54, 57, 58
- Obst, O. 353, 354, 355, 356, 357, 358–9, 361–2, 363
- obstetrics 373
- occupation 19, 20, 22–3, 113, 374
- O'Donnell, C.R. 46
- Ogden, J. 342
- Oil and Petroleum Exporting Countries 14
- O'Keefe, D.J. 356, 357
- Oliver, M. 258, 338
- O'Mahoney, B. 352, 358
- Oppenheim, C. 267
- oppressed, pedagogy of 221–7
 cultural invasion 221–4
 cultural synthesis 224–6
- oppression 265
- Oravec, J.A. 347
- O'Sullivan, S. 377
- Ottawa Charter 1–2, 13, 15
 action domains 412–13
 community health action and health promotion 234
 evidence 167
 health promotion as investment strategy 415, 417
 health-promoting school 385, 386
 Healthy Cities 404
- integrating health and sustainable development 285
- integration 79–80
 reflexivity and social theory 55, 57, 58
 social capital 45
- Our Healthier Nation* White Paper 274, 405
- Øvretveit, J. 239, 240, 243, 245
- Pandolfini, C. 353
- Papadopoulos, I. 113, 114, 115, 118
- Papenek, H. 373
- Pardue, M.-L. 373
- parent–child relationship 222
- Parker, E. 45
- Parlett, M. 249
- Parrott, R.L. 364
- Parry, M. 217
- Parsonage, M. 179
- Parsons, C. 323–4, 383–90
- partnerships 385
- paternalism 206, 207
see also lifestyle, public health and paternalism
- paternity leave 379
- pathogenic paradigm 35, 36
- patriarchy 53
- Patton, C. 339
- Pawson, R. 243–5
- Pearce, N. 212
- Peckham Health Centre 12
- Pedler, M. 251
- Pennbridge, J. 346, 352
- pensions 393, 394, 395–6, 399
- Pereira, J. 347, 348, 350, 351, 352, 353, 354
- Perkins, D.A. 242
- Perry, I.J. 148
- personal hygiene 11, 12
- personal skills development 286
- Personal, Social and Health Education 384, 386
- Peter, T. 126
- Petersen, C. 359
- Peterson, A. 12
- Petitti, D.B. 142
- Petticrew, M. 377
- Pharaoh, P. 142
- Phillipines 392
- philosophical arguments 350
- philosophical assumptions 52–5
- physical activity 74–5, 177–8, 273, 291, 297, 338–9
 Healthy Cities 406
 HIV/AIDS 103, 104
 lifestyle 85, 89, 91
- physiological effects 148
- Pilgrim, S. 266, 270
- Pimentel, D. 217

- Pini, P. 134
 Pinn, V. 376
 Piotrow, P.T. 349
 Plamping, D. 251
 planning and delivering health
 promotion 72–83
 arena-centred programmes 78–9
 disease-oriented approach 72–5, 76
 health-oriented approach 76–7
 risk factor-oriented approach 75–6
 Pleck, J. 375
 polarization 393, 394, 397
 policy research 29–30
 Policy Studies Institute 266
 political
 economy model 57
 factors 67, 68, 69, 214
 individualism 330–1, 332
 Poor Law 10
 Popay, J. 46
 Popham, R. 326
 population-based strategies 187
 Portes, A. 41, 42, 47
 Post, J.A. 355, 358, 359
 postmodernism 402–5
 poverty 213, 279, 350, 392, 393
 child 405, 407
 and crime 313, 314, 315
 elderly people 35
 gendering health 375
 health inequality 25, 26, 30
 race/ethnicity: inequalities and
 exclusion 264, 267, 269
 social insurance 394
 power 43–4, 47, 119–20, 195–6, 198–9,
 230, 334–5
 Power, C. 20, 22, 23, 27, 28
 powerlessness 198
 Powles, J.W. 211, 215
 Pratt, J. 251
 PREVENT simulation model 175, 176,
 179, 181, 189–90
 prevention 58, 94, 95, 175–83
 cost-effectiveness 178–81
 efficacy, health economics and
 modernism 187
 future mortality and morbidity
 175–6
 options identification 177–8
 primary 181
 Primary Care Trusts 275
 primary health care 234, 303
 primary-level health promotion 177
 Prior, D. 262
 Prior, L. 339–40
 prisons and health 319
 process indicators 189
 programme management 385
 Prout, A. 249
 psychological distress 257, 258
 psycho-social
 costs 27–8, 29
 environment 66, 67, 69
 stressors 76
 public health *see* global context;
 lifestyle, public health and
 paternalism
 Public Health Alliance 313, 317
 Pure Water League 100
 Purnell, C. 102, 109
 Puska, P. 135
 Putnam, R.D. 29, 41, 42, 44, 47

 Quackwatch.com 360
 qualitative methodology 165, 167,
 300
 quality 384
 adjusted life years 171, 178, 189–90
 of life 176, 180, 186, 190, 310, 317,
 409
 quantitative methodology 165, 167,
 239, 300
 quantity of life 176, 180
 quasi-experimental designs 188

 race/ethnicity 66, 178, 346, 415
 crime prevention 316
 critical evaluation 196, 197–8, 199
 gendering health 373, 375, 378
 integration 83
 racial discrimination/harassment
 267–8, 270–1, 317, 318–19, 320,
 339
 radical change 53
 user movements and community
 development 257
 see also communication and
 race/ethnicity; race/ethnicity:
 social inequalities and social
 exclusion
 race/ethnicity: social inequalities and
 social exclusion 264–75
 African Asians 267
 African Caribbeans 270, 272, 273
 Africans 266
 Asians 316
 Bangladeshis 266, 267, 268, 269, 270,
 271, 273
 Caribbeans 266, 267, 268, 316
 Chinese people 267
 health agenda 267
 health promotion role 265
 incidence of ill health 265–6
 Indians 266, 267, 268, 270, 271, 273
 Pakistanis 266, 267, 268, 269, 270,
 271, 273
 Smethwick Heart Action Research
 Project 269–74
 socio-economic conditions and health
 267–8

- Rachman, S. 114
 radical change 53–4, 59, 60, 68
 Raine, J. 317–18
 randomized control trials 239, 241–2, 389
 Rappaport, J. 47
 rational-technical modes of practice 198
 Ravnskov, U. 338
 Razay, G. 149
 reciprocity 41
 Redberg, R.F. 377
 redundancies 393
 Reed, D.S. 330
 Rees, G. 205
 Rees Jones, I. 46, 47
 reflexivity 51–2, 55–60, 341
 rehabilitation 177
 Reid, E. 243
 relational ties 44–5
 religion 113, 266
 Renaud, S. 146, 149
 Renshaw, J. 242
 reorientation of health services 286
 replacing 283–4
 replenishing 283–4
 research 360–4
 Rice, R.E. 364
 Richards, B. 348, 353
 Rickson, R. 284
 Rimm, E.B. 148, 149
 Ringel, B.L. 146, 149, 150
 Rippen, H.L. 355, 356, 357, 358, 359
 risk factors 75–6, 187, 190
 risk identity *see* surveillance, health promotion and risk identity
 risky sports 375
 Roberts, H. 377
 Roberts, I. 22
 Roberts, J. 372
 Robertson, A. 44
 Robinson, T.N. 345, 346, 347, 348, 349, 355
 Rodgers, A. 205
 Rogers, C. 34
 Romme, M. 259
 Rose, N. 335
 Rosen, M. 181
 Rosenthal, H. 229
 Ross, H.L. 330
 Rothenberg, R.B. 355
 Rothman, K.J. 139
 Rudat, K. 266, 267
 Rudin, J.L. 354, 355, 356
 Russell, J. 229
 Russell, L.B. 179, 182
 Rutter, M. 387
 Ryan, W. 44, 331
 Ryen, A. 112
 Ryle, J.A. 12, 13
 Sabo, D. 372, 374, 375
 Sacchetti, R. 354
 Sachs, L. 340
 safe alcohol practices 291, 292–6
Safer Sandwell 313
 St Leger, A.S. 147
 Saltonstall, R. 67
 salutogenic paradigm 35–9, 404
 Samdal, O. 387
 Sanchez-Merki, V. 45
 Sandwell 313–21
 Health Promotion Unit 269
 sanitary reforms 11, 12, 96, 211
 Sarason, S.B. 44, 47
 Saudi Arabia 393
Saving Lives: Our Healthier Nation White Paper 401
 Scala, K. 417
 Scandinavia 337
 Scared straight deterrence programme 320
 schistosomiasis 216
 Schlesselman, J.J. 135
 Schmidt, J.G. 202
 Schmidt, W. 326
 Schofield, T. 372, 375
 Schon, D. 251
 Schulz, A.J. 44
 Schweinhart, L.J. 314
 Scott, S. 250
 Scott, T. 182
 Scottish Office 236
 Scragg, R.K.R. 138
 screening 140, 177, 180, 181, 405
 Scrimshaw, S.C.M. 141
 Scriven, A. 46
 seat-belt legislation 325, 328, 329
 secondary level prevention 177, 180
 sectoral barriers 304–5
 Seedhouse, D. 44
 Seidman, S. 403
 self-empowerment model 57, 58
 Selvin, S. 139
 Sempos, C.T. 139
 Senge, P. 252, 417
Sense of Coherence 37–8
 Serrano-Garcia, I. 44
 SES (socioeconomic status) 23, 26, 27, 30
 sex discrimination 267, 339, 379
 sexual identity 378
 sexual risk-taking 354
 sexuality 113, 196, 199, 257
 sexually transmitted diseases 355
 see also HIV/AIDS
 Seymour, H. 402
 Shakespeare, T. 258
 Shardlow, P. 260

- Sharp, I. 377
 Shaw, G.B. 127
 Shaw, M. 23
 Shaw, S. 261
 Sherr, L. 101
 Shields, R. 116, 117
 Shiell, A. 6, 40–7
 Sianne, G. 375
 sickle cell anaemia 267, 271
 Sidel, R. 44
 Sidel, V.W. 44, 214
 Sidell, M. 6, 33–9
 Sigerist, H. 13
 Silberg, W.M. 348, 353, 355, 356, 357
 Simpson, R.L. 347
 single agency 186, 188
 single-parent families 375
 Single Regeneration Budget 406
 Skolbekken, J. 337–8
 Skrabanek, P. 138, 205
 Slaper, H. 216
 Slater, P. 332
 Slovenia 416
 Smaje, C. 113, 265
 Smethwick Heart Action Research Project (SHARP) 264, 269–74, 275
 Smith, G. 141, 194–5, 246
 Smith, K. 24
 Smith, N.L. 250
 Smith, R. 319
 smoke-free areas 290, 291, 292–6, 297, 299
 smoking 52, 138, 141, 189, 213, 297, 338–9
 community development 315
 disease-oriented approach 74–5
 France 146, 147, 150
 gendering health 375
 health education 177
 health inequality 28
 Healthy Cities 405, 406, 407
 individual interests, threatening of 332
 lifestyle 85, 87, 89, 325
 paternalism 328–9
 prevention 175, 176, 178, 179, 181
 in prisons 319
 sponsorship 290
 Tobacco Control Act (1990) 289
 victim blaming 331
 workplace bans 287
 Snow, J. 138
 social capital 29, 40–7
 definition and background 41–2
 and health promotion 43–6
 social class 20, 373, 375, 378
 critical evaluation 196, 199
 health inequality 22, 24, 28
 models of health 66–7
 race/ethnicity 113, 116, 119, 266, 274
 Social and Community Planning Research 266
 social development 394
 social exclusion 407
 see also race/ethnicity: social inequalities and social exclusion
 social inequalities 379
 see also race/ethnicity: social inequalities and social exclusion
 social insurance 394–5, 399
 social justice/equity 67, 68, 69
 social marketing 122–7
 audiences 124
 channel 124–5
 environmental scanning 124
 equals health promotion 122
 equals mass communication 123
 exchanges 125
 institutionalisation 126
 is a theory for health promotion 122–3
 management 126–7
 process tracking 125
 targets people 123
 ‘Social Medicine’ movement 12–13, 14
 social regulation 54–5
 social theory 51–60
 reflexivity 55–60
 theoretical and philosophical assumptions 52–5
 society 186, 188
 socio-economic factors 76, 83, 178, 214, 218
 health inequality 19, 26, 27, 28
 inequalities 23–6
 race/ethnicity 267–8
 Soja, E.W. 250
 Sonnenstein, F. 375
 Sonnenberg, F.A. 346, 354, 363
 Sooman, A. 46
 South Africa 108
 South Asia 217
 Spain 393
 Sparkes, J. 23
 sponsorship to create healthy environments 289–300
 Health Promotion Development and Evaluation Program (HPDEP) 290
 Healthway 289
 methods 291–2
 results 292–7
 Springett, J. 247, 253
 Stacey, M. 188, 233
 Stampfer, M.J. 149
 Standing Medical Advice Committee 181
 Staples, R. 375
 Statistical Package for the Social Sciences 291
 Stears, D. 323–4, 383–90

- Stein, J. 372
 Steiner, B.D. 361
 Stemmer-Frumento, K. 361
 Stephens, C. 213
 Stevens, B. 44
 Stevens, L. 361
 Stevens, R. 34
 Stevenson, H. 15–16, 59
 Stewart, M. 406
 Stewart, S. 180, 182
 Stolley, P.D. 135
Strategy for Neighbourhood Renewal 407
 stratospheric ozone depletion 216
 see also sun protection measures
 stroke 22, 74, 269
 structural adjustment/reforms 292–9,
 392–3, 417
 Sub-Saharan Africa 214
 subjectivity 54, 194–5, 196, 198
 substance abuse 45
 suicide 314, 319, 354, 375
 sun protection measures 290, 291,
 292–6, 299
 Sundsvall Conference 1–2
 supportive environments 286–7
Surestart 30, 402, 405, 406, 407
 surveillance, health promotion and risk
 identity 334–43
 administering health 334–6
 from ‘dangerousness’ to ‘risk’ 336
 individualization of risk 339–41
 ‘risk epidemic’ 337–8
 risk factors, social construction of
 339
 ‘risky self’, formation of 341–3
 Susser, M. 137, 138, 139, 141
 sustaining communities 282–3
 sustaining diversities 284
 Sutherland, I. 96
 Sweden 340, 393
 SWOT analysis 124
 Szaz, T. 402

Tackling Drugs Together White Paper 313
 Taft, A. 229, 235
 Tannahill, A. 6, 72–83, 177, 187, 201
 Tanzania 232
 Taubes, G. 134, 138
 tax policy 326–7
 Terence Higgins Trust 107, 109
 Terris, M. 138, 326
 tertiary-level prevention 177
 Tesh, S. 44, 63
 textual function 245
 thalassaemia 265, 267, 271
 Thatcher, M. 231
 theoretical assumptions 52–5
 think globally, act locally 392–400
 child and disability support 396–7,
 399
 Europe 393–4, 398
 international social insurance 394–5
 key strategy 394
 minimum wage 397–8, 399
 pensions 395–6
 social insurance 399
 structural trends 392–3
 worker rights 399–400
 Thomas, L. 347
 Thompson, H. 266, 269
 Thornley, P. 235
 Thornton, P. 261
 Tilford, S. 6, 94–100
 Till, J.E. 347
 Tilley, N. 243–5
 Timyan, I. 377
 Titmuss, R. 12
 Tobacco Control Act (1990) 289
 Tobin, J. 377
 Tolley, K. 181, 185, 187, 191
 Tomaiuolo, N.G. 361
 Tomlin, A.C. 361
 Tones, B.K. 6, 37, 57, 94–100, 166
 Toomey, K.E. 355
 topic-centred health promotion 79, 82
 Torkington, P. 269
 Touraine, A. 258
 Townsend, P. 14, 313, 324, 392–400
 Tozer, R. 261
 traditional approach 59
 traditional family disintegration 383
 training 272
 translation and interpreting services
 271–2
 Transport, Environment and Health
 Charter 310–11
 transport planning 302–11
 Copenhagen (Denmark) 302, 303,
 305, 306–8, 310
 Groningen (Netherlands) 302, 303,
 304, 305–6, 310
 Health for All strategy (1985) 303–4
 policy background 302–3
 sectoral barriers and inter-sectoral
 collaboration 304–5
 Sheffield (England) 302, 303, 305,
 308–9, 310
 Travin, M. 377
 Treacher, A. 339
 treatment 179–80
 trustworthiness 41, 356, 357
 tuberculosis 265
 Tunstall-Pedoe, H. 147
 Turshen, M. 11

 underload/overload balance 38
 unemployment 23, 267–9, 314, 375,
 394
 United Kingdom 9, 14, 136–7, 177,
 336, 337, 392

- United Kingdom *continued*
 Advocacy Network 259
 alcohol abuse 148, 149
 'Back-to-Sleep' campaigns 138
 drink driving 330
 gendering health 377
 health education in schools 12
 health inequality 19, 20, 23, 25, 26, 29
 health-promoting school 384, 385, 388
 Healthy Cities 401
 HIV/AIDS 101, 108
 hospital referrals 159
 inequalities 47
 interdisciplinary and inter-sectoral partnerships 16–17
 ischaemic heart disease 146
 job-loss and family morbidity 163
 lifestyle 90, 91
 mass media campaigns 99
 pensions 396
 public health manifesto 10
 social insurance 394, 395
 'Social Medicine' movement 13
 standardized mortality ratios 21
see also community health action in United Kingdom; National Health Service; transport planning
- United Nations 392
 Intergovernmental Panel on Climate Change 215
- United States 136, 337, 341, 349, 350
 alcohol issues 148, 326, 329–30, 331
 Constitution 335
 DARE drugs education 320
 Department of Health and Human Services 351
 gendering health 375, 376, 377
 health inequality 25
 Highscope Perry project 314
 individual interests, threatening of 332
 job-loss and family morbidity 153
 ozone depletion 216
 paternalism 329
 San Francisco 97
 'Social Medicine' 13
 urban unrest 230
- user movements and community development 257–62
 change, achievement of 259–61
 contested communities 257–8
 new policy directions 261–2
 user movements 258–9
- value for money framework 242–3
 Vaughan, J.P. 135, 139
 vector control 211
 victim blaming 331
- Victorian Health Promotion Foundation 290
 Vincent, N. 166
 violence 375
see also domestic violence
 Voge, S. 350
- Waddell, M. 119
 Wadsworth, J. 24, 25
 Wagner, D.G. 403
 Waldfoegel, J. 23
 Waldron, J. 374, 375
 Walker, A. 33
 Wall, E. 40, 41
 Wall, S. 140–1
 Wallerstein, N. 45
 Walt, G. 212
 warning signs 357
 Warren, W.H. 97
 Watkins, S.J. 152–3
 Watson, K. 242
 Watson, R.T. 212, 215, 217
 Webster, C. 5, 9–17
 Weick, K.L. 298
 Weil, S. 249
 Weiler, R.M. 361
 Weiner, J. 166–7
 Weintraub, T.A. 377
 Weisbord, S.D. 354
 welfare pluralism 231
 Werbner, P. 114
 West, J. 236
 West Midlands Institute for Public and Environmental Health 319
 Westin, S. 153
 Wetherell, M. 119
 White, E. 377
 Whitehead, A.N. 403
 Whitehead, M. 19, 20, 47
 Whittaker, J.K. 47
 Whittington, C. 55, 56
 Wigfield, R. 138
 Wiggins, R.D. 19
 Wilcoxon rank sum test 156, 159
 Wilkins, A.S. 347, 350
 Wilkinson, H. 375
 Wilkinson, M. 249
 Wilkinson, R. 25, 29, 76, 79, 191, 413
 Williams, A. 181
 Williams, D. 268
 Williams, S. 67, 138
 Williamson, B. 257
 Willinger, M. 138
 Willmott, P. 257
 Willott, G. 375
 Wilmot, W.W. 363
 Wilson, E.O. 218
 Wilson, M. 267
 Wilson, S.M. 44
 Wing, S. 212

- Winslow, C.E.A. 11, 168
Wistow, G. 259
Wizemann, S. 373
Woods, M. 205
Woolcock, M. 41–2, 44
Wootton, J.C. 349, 351, 355, 357, 359
work environment 66
worker rights 399–400
working conditions 267, 268, 379
Working Together 316
World Bank 392, 393, 394, 398, 417
World Health Assembly 165
World Health Organization 1, 13, 233
 community health action and health
 promotion 234
 Disability Adjusted Life Years (DALYs)
 171
 health promotion as investment
 strategy 416, 420
 Healthy Cities 401, 402
 MONICA project 147
 Regional Office for Europe 230, 233,
 310, 385, 412
 ‘Target for Health for All’ 233
 ‘Theory in Health Promotion’ 38
 transport planning 311
 see also Health for All by the Year 2000;
 Healthy Cities
Wright, P. 339
Wyatt, J.C. 356, 357, 358, 359, 362,
 363
Xenophanes 142
Yach, D. 213, 214
Young, I. 387
Young, M. 257
young, problems of 314–15
Ziglio, E. 1, 324, 383, 412–20
Zimbabwe 115
Zimmerman, M.A. 47