1-1-2008

Politics and Health

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Politics

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"Medicine is a social science, and politics is nothing else but medicine on a large scale. Medicine, as a social science, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution: the politician, the practical anthropologist, must find the means for their actual solution." Rudolf Virchow (German Doctor, 1821-1902)

Learning outcomes

This chapter will enable readers to:

- Compare competing definitions of politics and variants of political science
- Understand the political nature of health
- Examine the influence of politics and political ideology on health
- Assess the emerging contribution of politics to health studies

OVERVIEW

The discipline of politics examines the debates, ideas and institutions that surround community organisation and collective decision making about resources. In this chapter, the contribution of politics to health studies is examined. The first part of the chapter considers how politics is defined and how this underpins the various strands of political science. It also examines some of the key concepts of political study: power, ideology, democracy, government and the state. It also explores what contribution politics has and can make to health studies. The second part considers some of the theoretical and methodological approaches within politics. It looks at political ideologies, how they offer competing definitions of politics, varied views of the social and political world, and divergent views on health and health improvement. Examples are used throughout to highlight the relevance of such approaches to health studies. The third section is a case study of the politics of obesity which places the issues raised earlier in the chapter within the context of a high profile issue in health studies.

INTRODUCTION

In broad terms, politics is about community organisation and collective decision making about resources - or as Laswell has claimed 'who gets what, when, how' (Laswell, 1936). However, as there are a variety of competing definitions utilised both over time and by different political ideologies, it has been suggested that the definition of politics is in itself a political act (Leftwich, 1984). Following Heywood (2000), a broad four-fold classification is possible:

- *Politics as government* - Politics is primarily associated with the art of government and the activities of the state.

- *Politics as public life* – Politics is primarily concerned with the conduct and management of community affairs.

- *Politics as conflict resolution* – Politics is concerned with the expression and resolution of conflicts through compromise, conciliation, negotiation and other strategies.

- *Politics as power* – Politics is the process through which the production, distribution and use of scarce resources is determined in all areas of social existence.

This classification shows a large variation in the conceptualisation of politics; for example, the first concept is very narrow and the last is very broad. The first concept, which is the most prevalent definition within mainstream political discourse in the UK, places very restrictive boundaries around what politics is – the activities of governments, elites and state agencies - and therefore also restricts who is political and who can engage in politics (i.e. the members of governments, state agencies and other elite organisations). It is a 'top-down' approach that essentially separates politics from the community. This should be contrasted with the last definition, which offers a much more encompassing view of politics: politics, effectively, is everything. Politics is a term that can be used to describe any 'power-structured relationship or arrangement whereby one group of persons is controlled by another' (Millett, 1969). This is

a ‘bottom-up’ approach which suggests any and every issue is political and, likewise, anyone and everyone can engage in a political act.

These competing definitions of politics have also permeated into the contemporary discipline of political science (the study of politics) where the different academic approaches similarly operate divergent conceptualisations (Stoker, 2002):

- *Behavouralism* - Politics is the processes associated with mainstream politics and government
- *Rational choice theory* - Politics is the conditions for collective action in the mainstream political world
- *Institutionalism* - Politics is the institutional arrangements within the mainstream political world
- *Feminism* - Politics is a process and the personal can be political
- *Anti-foundationalism* - Politics is a narrative contest that can take place in a variety of settings
- *Marxism* - Politics is the struggle between social groups, in particular social classes

The definition of politics utilised by the various different strands of political science underpins their entire approach to the study of political life. Some of these are explored further in the next section. Underlying each approach to political science is a concern with answering questions about power, ideology, democracy, government and the state (Box 1).

BOX 1 HERE PLEASE

1. THE CONTRIBUTION OF POLITICAL SCIENCE TO HEALTH STUDIES

The concepts and methods of political science have a clear potential to contribute to the study of health. However, to date (aside from specific discussions about health care), health has not been widely considered as a political entity within academic debates or, more importantly, broader societal ones. In this section, we examine some of the reasons behind this, and then discuss more recent arguments which suggest that health is political and, therefore, that political science has much to offer our understanding of health.

Health as apolitical

The marginalisation of the politics of health is unlikely to have a simple solution as the treatment of health as apolitical (i.e. not political) is almost certainly the result of a complex interaction of a number of different factors. Drawing on Bambra et al (2004, 2005) we suggest some reasons for this below.

Health = health care

Health is often reduced and misrepresented as health care (or in the UK, as the National Health Service). Consequently, the *politics of health* becomes significantly misconstructed as the *politics of health care* (see, for example, Freeman, 2000), and more specifically as the politics of the NHS. For example, the majority of popular political discussions about health concern issues such as NHS funding and organisation, NHS service delivery and efficiency, or the demographic pressures on the future provision of healthcare. The same applies in most other 'developed' countries.

The limited, one-dimensional (Carpenter, 1980) nature of this political discourse surrounding health can be traced back to two ideological issues: the definition of health and the definition of politics. The definition of health that has conventionally been operationalised under Western capitalism has two interrelated aspects to it: health is both considered as the absence of disease (a biomedical definition) and as a commodity (an economic definition). Both of these definitions focus on individuals, as opposed to society: health is seen as a product of individual factors such as genetic heritage or lifestyle choices, and as a commodity

which individuals can access either via the market or, in the UK's case, the health system (Scott-Samuel, 1979).

Health in this sense is an individualised commodity that is produced and delivered by the market or the health service. Inequalities in the distribution of health are therefore either a result of the failings of individuals through, for example, their lifestyle choices; or of the way in which healthcare products are produced, distributed and delivered.

It is important to note that this limiting, one-dimensional view of health is common across the political spectrum, with left-wing versus right-wing health debates usually focusing on the role of the NHS. This 'NHS illusion' has resulted in the naive perspective amongst health activists that societal ill-health can be cured by better NHS services (Carpenter, 1980) when in fact, as Hunter (2003: 111) claims: 'All available evidence suggests that the NHS, essentially a 'sickness' service, will never take the wider public health seriously.'

Health and concepts of politics

Earlier in this chapter, we outlined 4 broad definitions of politics and suggested that the first one, politics as the art of government and the activities of the state, was the most prevalent within current political discourse. The hegemony of this conceptualisation of politics influences which aspects of health are considered to be political. Health care, especially in countries like the UK where the state's role is significant, is an immediate subject for political discussion. This is not, of course, to imply that health care is unimportant; rather, that it should be seen as one of several important health determinants.

Health and political science

To date, health has not been seriously studied within political science - nor for that matter has politics within health. This has compounded its exclusion from the political realm. Health, to a political scientist (in common with more widely held views) most often means only one thing: health care and, usually, the NHS. Some political scientists will argue that they do study health as a political entity but what is usually under analysis is the politics of health *care*.

Understanding why this has happened requires us to consider the various schools of thought within political science and their corresponding definitions of the political, as discussed in the introduction. These schools of thought have not been equally successful in political science and the discipline is dominated, especially in the USA, by the behavouralist, institutionalist, and rational choice strands. To adherents of these schools, politics - and therefore political science - is concerned with the processes, conditions and institutions of mainstream politics and government. As the politics of health care revolves around the politics of institutions, systems, funding, and elite interactions, it fits the priorities of these mainstream schools of political science. Health, in its broader sense, therefore tends to be thought of as apolitical and of academic concern only to disciplines such as sociology, public health or medicine.

The political nature of health

The hopes, aspirations and expectations of the advances in scientific and medical knowledge in improving human health and wellbeing, forecast at the beginning of the 20th century, have failed to be realised (Townsend and Davidson, 1992; Whitehead, 1992; Acheson, 1998). As one of the reasons for establishing the NHS in 1948 had been to reduce inequalities in health, it came as a surprise to many in the 1970s when a growing body of evidence began to emerge which suggested the provision of access to free health care had done little to reduce the contrasting health experiences of different groups in Britain. In 1977, when the then Secretary of State for Health and Social Security, David Ennals, established a working group to investigate the reasons behind these increasing health inequalities. This resulted in the now famous Black Report (Black et al, 1980), which emphasises the importance of material and structural factors in explaining variations in health status by social class. To many, this was a chance to put health, not just health care, on the political agenda. However, as the newly-elected Conservative government dismissed the recommendations of this report virtually wholeheartedly (see Berridge and Blume, 2003), the 1980s saw a continued policy focus on *health care* rather than health. Where public health was discussed at all, the focus was on improving overall population health (rather than reducing health inequalities), largely through attempts to get individuals to change their lifestyle-behaviours (e.g. Department of

Health, 1992). By the mid-1990s, however, a backlash against individualistic, lifestyle-behavioural approaches to health was clearly evident. Not only did a growing body of post-Black Report research provide further evidence of the importance of social and economic factors in the distribution of health experiences (e.g. Fox et al, 1985; Dahlgren and Whitehead, 1991), but Crawford's (1977) claim that the heavy policy emphasis on lifestyle-behaviours constituted nothing less than 'victim-blaming', had become widespread in academic discussions (e.g. Labonte, 1986). By this stage, there was a consensus amongst many of the people involved in public health research and activity that health was very much a political issue.

However, this consensus did not automatically result in political scientists taking an interest in health and it is not until relatively recently that a body of work has emerged which overtly argues that health is itself a political issue (see for example, Navarro 2004), and should therefore be examined using political science perspectives (Bambra et al, 2004, 2005, in press). For example, by examining why and how policy decisions about health are made, and identifying the role in which political ideologies play in these decisions (Smith, in press).

Bambra et al (2004, 2005) have argued that 'health, like almost all other aspects of human life, *is* political in numerous ways'. They identify four key aspects of the political nature of health: unequal distribution, health determinants, organisation, and citizenship. Ultimately, health is political because power is exercised over it. The health of a population is not entirely under the control of an individual citizen but is under the control of the wider political relations of society. Changing society is only achievable through politics and political struggle.

Unequal distribution

Evidence that 'the most powerful determinants of health in modern populations are to be found in social, economic, and cultural circumstances' (Blane et al, 1996) comes from a wide range of sources and is also, to some extent, acknowledged by Government (Townsend and Davidson, 1992; Social Exclusion Unit, 1998; Department of Health, 1998; Acheson, 1998; Wanless, 2004). Yet differences in health experiences between areas and social groups

(socio-economic, ethnic and gender) remain, as discussed above. How these inequalities in health are approached by society is highly political and ideological: are health inequalities to be accepted as 'natural' and inevitable results of individual differences both in respect of genetics and the silent hand of the economic market; or are they abhorrences that need to be tackled by a modern state and a humane society? Underpinning these different approaches to health inequalities are not only divergent views of what is scientifically or economically possible, but also differing political and ideological opinions of what is desirable. The extent to which political ideologies have governed policy perceptions of health inequalities is discussed more under 'conservatism' in the following section.

Health determinants

Whilst genetic research is helping us to better understand why some people are predisposed to experience certain diseases, and other causes of ill health are becoming better understood, it is evident that environmental triggers are, in most cases, even more important and that the major determinants of health or ill health are inextricably linked to the social environment (see Figure 1) (Dahlgren and Whitehead, 1991; Acheson, 1998; Marmot and Wilkinson, 2001). In this way, factors such as housing, income, employment - indeed many of the issues that dominate political life - are all important determinants of health and wellbeing. The importance of these factors, which are beyond the realm of the health sector, also help demonstrate why non-healthcare policies are of such importance to health (Townsend and Davidson, 1992; Acheson, 1998; Whitehead et al, 2000; Wanless, 2004).

Organisation

Health is political because any purposeful activity to enhance health needs *'the organised efforts of society'* (Secretary of State for Social Services, 1988) or the engagement of *'the social machinery'* (Winslow, 1920): both of these require political involvement and political actions. Population health can only be improved through the *organised* activities of communities and societies. In most countries, the organisation of society is the role of the state and its agencies. The state, under any of the four definitions of politics outlined on page 1, is a (and more usually, *the*) subject of politics. Furthermore, it is not only who or what has

the power to organise society, but also how that organisational power is processed and operated that makes it political.

Health and Citizenship

Health is political because, the right to 'a standard of living adequate for health and well-being' (UN, 1948) is, or should be, an aspect of citizenship and of human rights (Box 2). Citizenship is 'a status bestowed on those who are full members of a community. All who possess the status are equal with respect to the rights and duties with which the status is endowed' (Marshall, 1963). Following Marshall, it is possible to identify three types of citizenship rights: civil, political and social. Health, or the right to a standard of living adequate for health and well-being (UN, 1948), is an important aspect of social citizenship. The welfare state (see Social Policy chapter), ensured that certain health services and a certain standard of living became a right of citizenship. However, the extent to which health is a right of citizenship is a continued and constant source of political struggle. For example, 45 million US citizens currently lack access to health care and even in the United Kingdom's National Health Service, access to health care is rationed through high charges for drug prescriptions, dentistry and optometry services (Bambra et al, in press).

2. THEORETICAL AND METHODOLOGICAL APPROACHES

In the preceding sections we examined what politics is, we have defined some of the key concepts in political science and we have shown how health has only recently begun to be analysed from a more political perspective. In this next section, we outline some of the key approaches to politics – political ideologies.

Conservatism

The literal interpretation of conservatism is to 'conserve', i.e. to maintain what has been tried and tested, rather than to seek radical change. As Eccleshall (1994: 63) puts it: 'Whereas other ideologies stand *for* something – a more even distribution of resources, for example, or an extension of civil liberties – conservatism warns *against* dismantling established institutions.' Part of maintaining the traditional order of things includes a belief that human talent varies naturally and, consequently, that attempts to 'level' things out (in the way many socialists advocate) are artificial and destined to fail. The existence of a social hierarchy is not only viewed as inevitable but also desirable as it is thought to promote innovation and success, and allows the majority to benefit from the leadership of particularly talented individuals. Rich people tend to be thought of as creators of prosperity rather than plunderers of the poor (a view which contrasts with socialist and communist ideas about wealth). Hence, conservatism differs from many other political ideologies in its vindication of inequality (Eccleshall, 1994).

Conservative preferences for maintaining tradition are associated with preserving the dominance of particular groups (e.g. wealthy, white men) or of a religion (e.g. Christianity) or culture (e.g. 'Britishness'). Taken to an extreme, these preferences may be linked to xenophobia, nationalism and racism. More often, these preferences are associated with a morality emphasising the importance of self-discipline, decency, the 'nuclear family unit' and a respect for the rule of law.

As well as a tendency towards tradition, other features of conservatism include a view of society as a collection of self-interested individuals, a belief which underlies Margaret

Thatcher's infamous claim that 'there's no such thing as society'. Of particular importance to health, conservatives tend to see role of the state as minimal, with a preference for limited (if any) welfare provision. Whilst some conservatives favour a society in which the privileged classes provide basic welfare (e.g. housing) to the 'deserving poor', there is agreement that too much provision by the state removes incentives from the poor to improve themselves, creating a dependency culture and a permanent underclass of what Thatcher called 'moral cripples'. The only exception to conservative preferences for minimal government intervention in society tends to be around law and order, where significant state intervention is often viewed as essential to maintain the smooth running of society.

Despite the association between conservatism and tradition, some strands of conservatism have involved advocating for radical change. For example, although the 'New Right' movement of the 1980s (strongly associated with Thatcherism in the UK, and Reaganism in the USA) employed a traditionally conservative moral rhetoric, the drive towards the free market and competitive individualism (see Friedman and Friedman, 1980) took its inspiration from liberal thinking (Dearlove and Saunders, 1991). This resulted in widespread restructuring and privatisation of the welfare state in the 1980s (See Social Policy Chapter). From the early 1990s onwards, the popularity of New Right ideas amongst conservatives began to decline and currently there is much uncertainty about the direction of the British Conservative party.

EXAMPLE 1 HERE PLEASE

Liberalism (and 'neo-liberalism')

At its heart, liberalism is essentially an economic approach but, like all economic doctrines, it has far reaching political and social repercussions. With its focus on freedom and choice, liberalism emphasises the importance of individual rights over those of social groups. Classical liberals believe a free market guarantees social justice, allowing all those with talent and a willingness to work to succeed. The flip-side of this presumption is that poor social circumstances are explained by liberals in rather Social Darwinian terms, as a result of individual weakness and/or laziness (Heywood, 1992). This genre of liberalism was popular

in the 18th and 19th centuries, when its proponents advocated minimal state intervention in the economy and the importance of the 'invisible hand of the market' and free trade. Popular discontent with the social consequences of this approach (including extensive material deprivation such as that of the Great Depression in the 1930s) resulted in the emergence of strong political opposition (from Communism, Socialism and Social Democracy) and put pressure on liberals to adapt. Out of this situation, 'modern liberalism' emerged, which conceded that state intervention to reduce the excesses of market economics and mitigate its negative effects was desirable. In post-war Britain, this resulted in the emergence of Keynesian welfare capitalism.

The crisis of the welfare state in the late 1970s led to the re-emergence of classical liberal ideas, especially in relation to economics, exemplified by the approaches of the Thatcher and Reagan governments. This form of liberal thinking, which resurrected market economics, is known as 'neo-liberalism' (neo meaning new). Under the 'neo-liberal' governance of Thatcher in Britain, state intervention was scaled back and public expenditure cut, the economy was deregulated and state-owned companies were privatised. Once again, the primacy of the individual came to the fore (with a corresponding rise in the emphasis placed on traditional morality and responsibility). Politically, neo-liberalism is associated with the USA in particular but economic globalisation means it has increasingly become perceived as hegemonic (i.e. globally dominant) to the extent that some commentators argue there is now no alternative (Fukuyama, 1989).

EXAMPLE 2 HERE PLEASE

Socialism and Social Democracy

According to Heywood (1992), socialism is the broadest of political ideologies containing a variety of perspectives from revolutionary communists to reformist social democrats. The meaning of *socialism* is therefore not fixed and it differs by place and time. Originally socialism was associated with the Marxist/Communist tradition, and used to describe material equality (common ownership of the productive wealth and a classless society) in contrast to

the purely political equality (right to vote and be represented) of capitalism (Heywood, 1992). The Social Democratic Parties (SDP) of Western Europe were originally based within the Marxist tradition but by the early 20th century a split occurred: the Communist Parties continued to advocate revolution and the overhaul of capitalism, whilst the SDP supported the reform of capitalism and proposed a parliamentary road to socialism. The SDP were therefore no longer committed to the abolition of capitalism but to reforming it on moral grounds (in the UK particularly, *social democratic* ideology was strongly influenced by the utopian socialism of Morris and Owen). In the immediate post-war period this entailed using increased state intervention (such as the public ownership of key parts of the economy and the establishment of the welfare state) to mitigate the effects of capitalism and thereby achieve needs based social justice (Heywood, 1992). However, there is little agreement amongst social democrats about how much state intervention is required in the economy and this has been notable in policy differences between countries (compare for example the UK and Sweden). The most recent evolution of *social democracy* – the Third Way (associated with Blairism in the UK) (Giddens, 2002) – has seen the abandonment of previous commitments to public ownership and a dilution in views of the extent to which capitalism is seen to require reform. (Giddens, 1998) This, alongside the collapse of actually existing socialism in the Eastern bloc, has lead to speculation as to whether socialism is dead.

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Nationalism (and fascism)

Unlike other political ideologies discussed in this section, nationalism does not describe an interrelated set of values and is probably better thought of as a belief, rather than an ideology (Heywood, 1992). This belief, that all nations should-be self-governing, spread from the French Revolution of 1789, so that countries previously thought of as 'realms' or 'kingdoms' began to be thought of as 'nation-states', and their inhabitants as 'citizens' rather than 'subjects'. As an idea, nationalism straddles the political spectrum; at various times and places, nationalism has been associated with both democratic and authoritarian governments, and with Left-wing and Right-wing political movements. For example, ideas about nationalism

have been employed to promote the importance of social cohesion, order and stability by right-wing parties in Britain and France, whilst they have also been adopted by left-wing (Marxist) movements advocating 'national liberation' in countries like China and Vietnam. This is partly because the concept of a 'nation' is difficult to pin-down, sometimes being used interchangeably with 'state', 'country' and even 'race' (Heywood, 1992).

Nationalism is an embedded feature of most modern societies (Billig, 1995) as demonstrated in the pervasiveness of flags, national anthems, public ceremonies, and national currencies and languages. However, important debates about nationalism remain. On the one hand, some commentators suggest that the growing importance of regional and global institutions (such as the European Union and United Nations) mean that nationalism is becoming irrelevant. On the other, the recent devolution of power to countries such as Wales and Scotland, and the persistence of some separatist movements (e.g. the pressure for Basque independence in Spain), suggest nationalism is alive and well.

An extreme interpretation of some of the ideas involved in nationalism form the basis of fascism, which focuses on establishing the dominance of a particular community or social group (often referred to as the 'dominant race'). Under fascism, subservience to the glory of a particular 'nation' or 'race' is demanded and, consequently, individual liberties are eliminated. Fascism is therefore both extremely elitist and patriarchal – the dominance of one group over others is seen as and desirable and inequality between this group and others is actively promoted. Aside from this central belief, many of the ideas involved in fascism are vague and inconsistent; it is more identifiable with particular movements and individuals, such as the fascist dictatorships of Hitler (Germany, 1933-1940), Mussolini (Italy, 1922–1943) and Franco (Spain, 1938-1975), than with any systematic ideology.

EXAMPLE 4 HERE PLEASE

Feminism

There are a number of different feminisms, such as liberal, socialist or radical, and each has a different approach to politics. This reflects the fact that feminism is an evolving social movement. However, what unifies each approach though is the idea that 'the personal is political'. Previously the private domestic and family sphere and relations between men and women were considered as 'non-political'. Feminism brought these issues into the public sphere, therefore politicising them and getting them on the political agenda (Chapman, 1995).

The origins of feminism date back to the French Revolution in the late 18th century and Mary Wollstonecraft's tract on the rights of woman. In the context of the19th century and early 20th Century, women (particularly those in wealthier countries with emerging democracies) argued for the same legal, political and economic rights that men had begun to obtain. In the UK, women gained the same voting rights as men in 1928, the Equal Pay Act was passed in 1970 and the Sex Discrimination Act in 1975.

This equal rights approach of liberal feminists - to gain access to the public sphere on the same terms as men by overcoming discrimination - was challenged in the 1960s and 1970s by both socialist and radical feminists. Socialist feminists argued that women would only gain full equality with men under socialism and that the oppression of women was a vital element of the capitalist system – in this context, the legal equal rights gained during the 20th century could only have a limited impact on the systemic power inequality between the sexes. Only the removal of the private sphere altogether (by the collectivisation of domestic work and child care) would ensure equality (Chapman, 1995).

Radical feminists shifted attention further, to the nature of domestic relations between men and women, and other more cultural aspects of male domination and oppression. They highlighted the 'oppressive dualism of gender' and argued that we live in a patriarchal society in which women are systematically dominated by men in all areas of life (Randall, 1987). The goal was no longer to be 'just like men', but to challenge societal assumptions about masculinity and femininity, arguing that they were social constructs rather than fixed natural

phenomena. They also drew attention to the limits which unequal and restricting traditional gender roles placed on women (and also men). This meant that women's individual experiences of oppression were collectivised and considered as consequence of their political relationship of subordination and oppression by men and therefore something that could be changed – primarily by women's political empowerment and liberation from gender socialisation.

EXAMPLE 5 HERE PLEASE

Environmentalism:

Many, if not all, of the political ideologies discussed so far have tended to perceive nature as nothing more than a resource for human beings to exploit. However, since the 1960s, when Rachel Carson published *The Silent Spring* (1962), there has been an ever-increasing awareness of a growing ecological crisis. As both the number of human beings, and the demand for higher standards of living increase, an increasing number of people are predicting a global catastrophe (e.g. through climate change) will soon challenge the way we live. As with all of the other ideologies discussed, the term environmentalism is often applied to a broad range of ideas and theories, from those which fundamentally question conventional assumptions about nature to far less radical responses to specific environmental issues. Generally, environmentalists claim that, by conceiving of nature as an ever-plentiful resource, humans have placed not only their own future in jeopardy, but that of the whole global eco-system. To avoid disaster, environmentalists advocate that all policies should be judged by their sustainability (i.e. the extent to which a particular policy can be maintained without damaging the fragile the ecosystem).

This ideological perspective criticises a basic assumption of the other ideas discussed in this section, namely the central position of human beings. This sets environmentalists apart from the usual Left-Right political spectrum. Since the 1980s, 'Green' parties have emerged in most industrialised countries, including the UK, with the aim of moving environmental concerns up the political agenda. Pressure groups such as Greenpeace and Friends of the

Earth have also helped increase awareness of environmental concerns such as acid rain and nuclear waste. Currently, most major political parties in Britain claim to be concerned with the environment, but their various responses tend to suggest environmental concerns can be accommodated without the need for radical change. In contrast, an increasing number of scientists and environmentalists believe that the damage to the ecosystem caused by humans is now so great that significant climate and environmental change is inevitable. If this is the case, all humans can hope to achieve, even through radical change, is damage-limitation (e.g. Lovelock, 2006). Despite increasingly pessimistic predictions by these groups, the more radical branches of environmentalism are unlikely to be taken seriously by mainstream politics as they suggest there are limits on human, material ambitions; a suggestion which challenges the core of many influential ideologies.

EXAMPLE 6 HERE PLEASE

3. CASE STUDY: THE POLITICS OF 'FAT' IN A HEALTHIST SOCIETY

This case study will demonstrate how a fairly straight forward public health issue like obesity is socially and politically constructed. In keeping with the theme of the present chapter we will draw upon the questions relating to power, ideology, democracy, government and the state (Box 1) to illustrate the interaction between health and politics. In particular we consider the aforementioned theme: *Politics as power* – whereby politics is the process through which the production, distribution and use of scarce resources is determined in all areas of social existence. The *power* of A to define the values and beliefs B ought to hold. B's perceptions and preferences are moulded by A in such a way that B accepts that these are the norm. This dimension of power is played out, for example, in processes of socialisation, ideological hegemony, the control of information, and the control of the mass media.

In 2002, the World Health Organisation (WHO) designated obesity as a global pandemic (WHO, 2000; 2006) – even though it only effects the developed world. Obesity is defined by health professionals using Body Mass Index [BMI]: Height / (Weight), whereby BMI of > 30 is obese and BMI 25-30 is overweight. Since the 1970s trends for obesity have been increasing worldwide. In England, obesity levels amongst adults have tripled since 1980, with over half the adult population defined as overweight (BMI >25 – 30) or obese (BMI >30) (NAO, 2003). The sharp rise in the prevalence of obesity amongst children seen in recent years is continuing at an unprecedented rate. By 2010 it is predicted that one in three children in the UK will be obese. The public health and social consequences of obesity in adults is well documented (Royal College of Physicians, 2004). An obese person loses on average 7 years of life compared with someone whose weight is healthy (DoH, 2003), an estimated 30,000 people die each year in the UK as a result of obesity, mainly from complications of heart disease, diabetes and blood pressure, the annual cost to the NHS is estimated in the region of £500 million (*ibid*) although others say this estimate is conservative. In addition to the individual suffering, obesity represents a significant social and economic burden to society. Industry estimates claim that millions of pounds are lost annually due to obesity related ill health. People who are overweight are significantly at risk of becoming obese. Evidence, however, of the health risks associated with being overweight (BMI 25-30), as opposed to obesity, are equivocal. To date the efficacy of

treating obesity in adults and children has shown limited effectiveness (HDA, 2002) and critiques of the current model for obesity treatment and prevention have highlighted concerns of possible negative impacts on mental health (Evans *et al.*, 2003). It is against this background that public health pursues the primary prevention of obesity –targeting people whose BMI is in the upper range of normal (BMI 20-25) or already overweight (BMI > 25)- as a priority to minimise costs to individuals and society of the health risks associated with obesity (BMI >30).

Not surprisingly, obesity has become one of the most discussed issues of our time. The exponential increase in media coverage, and the inherently individual blaming tone it adopts - seems to have the elements of what social scientists call a 'moral panic'. Moral panics are typical during times of rapid social change and involve projecting increased anxiety onto vulnerable or marginalises groups. As Guthman and Dupais (2005) note such unprecedented media attention on obesity and health has resulted in a situation whereby obesity is more than simply a threat to individual and public health. Obesity reportedly raises airline costs (through increased fuel-costs), affects worker productivity through ill health and disability, and is even a security threat, as fitness levels amongst armed and civilian or public security personnel fall due to overweight. Thus obesity per se is far bigger than fat. *It is a moral, social and political issue.*

A fundamental oversight in the public health community is the equivocal nature of the association between fatness and public health. The health risks associated with obesity, particularly with respect to overweight (BMI <30), have been overstated (Gard and Wright, 2005).

Considerable debate also exists around current methods of defining obesity. This relates both to the methods used for measurement - for example callipers, BMI, and waist to hip ratio – but also to the various parameters used to determine whether someone is classified as obese. These debates refer to both adults and children; however, the definition of *childhood* obesity is even more contested due to differing growth rates. These definitions, currently used to determine the prevalence of obesity, are representative of the dominant paradigm for the prevention and treatment of obesity. Hence, the 'problem' of obesity originates from and is

embodied in, the traditional scientific or biomedical model whereby obesity is defined in pathological terms, as a major risk factor in the causality of non-communicable diseases, in relation to a function of body dimensions. For example, the use of BMI is widely contested due to the potential social and emotional impacts of *medicalizing* someone's body size and composition (for people within the upper normal or the lower overweight categories), thereby legitimizing the stigma associated with being 'fat'.

Likewise, public health policy and practice has persisted in pursuing its crusade to identify a single or set of causal factors responsible for obesity. Diet and physical activity have long been recognised as primary factors in the aetiology of overweight and obesity (Swinburn et al,2003; Prentice and Jebb, 1995; 2002). Obesity is therefore viewed as the individual's failure to balance the equation between energy inputs (food consumed) and energy outputs (exercise). This emphasis on individual culpability is not new – nor is it exclusively limited to the health arena, with increasing emphasis on individual responsibility across all areas of policy (e.g. the shift from occupational to individual pensions). We only have to look back in history to observe the relationship societies have had with food and body size. First, consider the religious references to 'gluttony' and 'sloth' and we can begin to appreciate the moral undertones – and normative values and political interests – inherent to the language associated with obesity and health today. The images and connotations conveyed by the terms gluttony and sloth are indeed powerful in neo-liberal societies where discipline and self-control are seen as virtuous, whilst bodies that are 'out of control' must be vilified. If prevalence is higher in certain population groups then this can perpetuate negative attitudes and labelling of groups, e.g. lower socio-economic and ethnic minority groups, as lazy or feckless. Indeed some social scientists argue that the current emphasis on human agency, individual responsibility and culpability, is unhelpful to the prevention or treatment of overweight and obesity and may well be counterproductive.

Interestingly, less attention has been shown towards the vested interests of the various political, commercial and public bodies involved in the obesity issue. According to Guthman and Dupais (2005) many of the world's leading authorities on obesity, who operationalise criteria and definition of obesity, happen to be funded by the pharmaceutical and weight-loss industries; as

have certain members of the International Obesity Task Force (responsible for WHO reports). Indeed, the pharmaceutical, weight-loss and food industries all have a vested interest in maintaining what is currently a narrow public health focus on the obesity issue and amounting to moral panic.

SUMMARY

- There are a number of different definitions of politics. These underpin different approaches to political science and competing political ideologies. Politics focuses on the debates, ideas and institutions that surround community organisation and collective decision making about resources.
- Politics has not traditionally focused on health. There are various reasons for this including the prominence of debates about health care. Political analysis has much to offer our understanding of population health and health inequalities and how they can be improved. The political analysis of health that exists suggests that politics could be an important contributory discipline to health studies in the future.
- Political ideologies offer competing definitions of politics, and have differing perspectives on population health and whether/how it should be improved. The role of political ideology on health and on public health policy is beginning to be examined by researchers. Examples in this chapter suggest that ideology underpins both how health is viewed and the extent to which it is considered to be a political issue.
- Political ideology is also important when it comes to every day debates about issues such as obesity.

Questions for further discussion

1. Over the next few days examine media reports about health:
    a) What issues are up for discussion?
    b) Do they relate to health or health care?
    c) What ideological values underpin the issue, how it is presented and the solutions that are proposed?
    d) Which political interests are being promoted?
2. 'As anyone who has lived among villagers or slum-dwellers knows only too well, the health of the people is influenced far more by politics and power groups and by the distribution of land and wealth than it is by the prevention and treatment of disease' **(**Werner, 1981). Discuss this proposition with particular reference to obesity.

3. Visit the Department of Health website at: http://www.dh.gov.uk/Home/fs/en

   Search the site to examine which health issues are highlighted, how they are presented and how they intend to tackle them.

Further reading

There are several introductory books on politics and political ideologies. These will enable you to follow up general points related to the discipline.

- Heywood, A. (2000). *Key concepts in politics*. London: Macmillan.
- Heywood A. (2003) *Political Ideologies: An introduction*. London: Palgrave.
- Jones, B., Kavanagh, D., Moran, M. and Norton, P. (2006) *Politics UK.* London: Longman.
- Marsh, D. and Stoker, G. (eds). (2002). *Theory and Methods in Political Science*. London: Macmillan.

In addition, these accessible journal papers discuss the role of politics in the study of health:

- Bambra, C., Fox, D. and Scott-Samuel, A. (2005) Towards a politics of health, *Health Promotion International* 20: 187-193.
- Bambra, C., Fox, D. and Scott-Samuel, A. (in press) A politics of health glossary, *Journal of Epidemiology and Community Health*

Acknowledgements

This paper draws on Bambra et al (2004, 2005, in press). We would therefore like to acknowledge the co-authors of these publications Debbie Fox and Alex Scott-Samuel as well as other members of the Politics of Health Group http://www.pohg.org.uk/

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Box 1: Key concepts in political science as related to health (extract from Bambra et al, in press)

Power
At the general level, *power* is about the ability to achieve a desired outcome – *power* to do something, but more narrowly, it is used to mean *power* over something or someone and to make decisions (Heywood, 1992). Influence is the external ability to have some effect on the content of these decisions. According to Lukes (1974) there are three forms of *power*:

- The *power* of A to influence the behaviour of B. This exercise of *power* is observable and is tied to public conflicts over interests (such as access to resources- education, decent housing, health care etc). It is performed in the public arena as part of decision-making processes.
- The *power* of A to define the agenda, preventing B from voicing their interests in pubic (policy) decision-making processes. Potential issues and conflicts are kept off the agenda to the advantage of A and to the detriment of B. The use of this type of *power* can be obvious or concealed.
- The *power* of A to define the values and beliefs B ought to hold (for example what counts as fair / who gets what). B's perceptions and preferences are moulded by A in such a way that B accepts that these are the norm. This dimension of power is played out for example in processes of socialisation, ideological hegemony, the control of information, and the control of the mass media.

There is also disagreement about whether *power* only exists when it is attributable to a specific agent (intentionalist) or whether power is a feature of systems (structuralist), such as capitalism (Heywood, 1994).

Research has linked a lack of power and control with premature mortality and the social gradient of health (Marmot and Wilkinson, 1999).

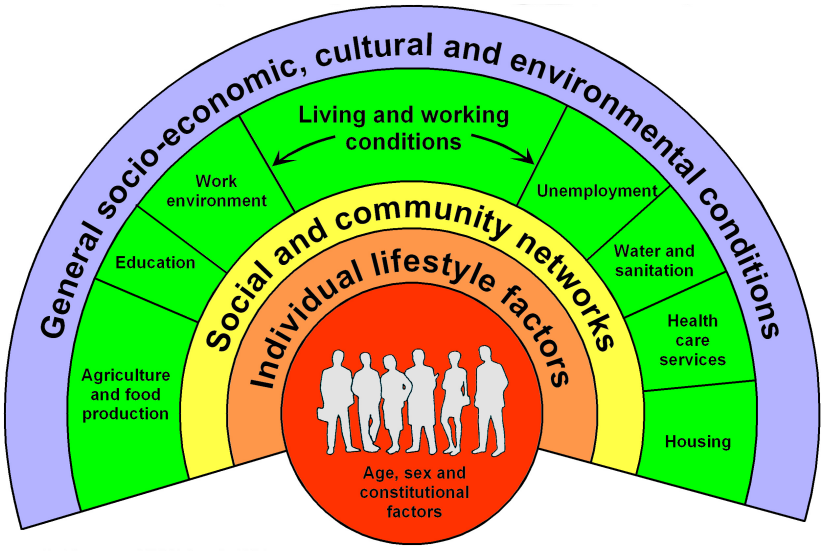
Ideology
Ideology is a system of inter-related ideas and concepts that reflect and promote the political, economic and cultural values and interests of a particular societal group (Bambra et al, 2003). Ideologies, like societal groups, are therefore often conflicting and the dominance of one particular *ideology* within a society to a large extent reflects the power of the group it represents. *Ideology* can be used to manipulate the interests of the many in favour of the power and privileges of the few (Ledwith, 2001). So, for example, liberal democratic *ideology* with its emphasis on the individual, the market and the neutral state, can be seen as a reflection of the power of business interests within capitalist society (Bambra et al, 2003) A hegemonic (i.e. universally prevailing) *ideology* is usually one that has successfully incorporated and cemented a number of different elements from other competing ideologies and thereby fuses the interests of diverse societal groups and classes (Gramsci, 1971). There is emerging evidence that ideology plays a key role in determining mortality and population health (Navorro, 2004) - see examples in the 'Theoretical and Methodological Approaches' section.

Democracy
In a literal sense, democracy means rule of the people (from the Greek terms demos and kratos). Democracy takes two forms: direct or indirect. It is direct democracy which is most closely derived from the Greek model as all citizens participate in decision taking and policy making. Modern models of direct democracy include: participatory democracy in which there is widespread use of advisory referendums and public consultations; and industrial or economic democracy in which workers own companies and/or are involved in decision making (Wilkinson, 2005) It is, however, indirect democracy, in which representatives are elected, which has been the more common model. This is especially the case under Western capitalism where liberal democracy combines representative democracy with the liberal citizenship rights of private property, economic freedom, political equality and limited government (Locke, 1978). It has been suggested that economic democracy is beneficial for health (Wilkinson, 2005).

Government
To govern is to rule or exercise control over others. More narrowly, government relates to a set of institutions which together make (legislative), implement (executive) and interpret (judicial system) policies and laws (Heywood, 1994). There are different types of government including democratic, authoritarian and totalitarian with correspondingly different health outcomes as we shall see in the following section (Navarro and Shi, 2001).

State
The state is an 'essentially contested concept' (Gallie, 1956). There is therefore no agreed definition of the state although perhaps the most widely used is the narrow theory of the state as simply the institutions of central and local government, the police, the army, and the civil service. The state is considered to be neutral and independent – above party political disputes or the conflicts of economic interests. Political power is dispersed amongst a wide variety of social groups which compete with one another for dominance and control of the independent institutions of the state. The state can also be seen as the embodiment of the collective will. An alternative perspective, however, has been put forward by, Marxists (notably Althusser), which broadens the parameters of the state to include many aspects of civil society including schools, the health care system, the professions (such as medicine) and the media (Althusser, 1971). Disputes about the role of the state underpin many discussions about health care, e.g. how much should be publicly provided (by the state), and health status, e.g. the extent to which individuals are responsible for their own health compared to collective (state) responsibility for health.

Figure 1: 'Rainbow' model of the determinants of health



Source: Dahlgren and Whitehead, 1991

Box 2: United Nations Universal Declaration of Human Rights 1948.

> *Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.*

Example 1 – The UK Conservative Party and health inequalities

As discussed in the section on the 'Political Nature of Health', Thatcher's Conservative government decided to reject the main recommendations of the Black Report (Black et al, 1980), which suggested health inequalities were largely a result of material inequalities in Britain and recommended policy changes aimed at tackling material differences in wealth, such as increasing the level of state benefits (especially for children) and improving social housing and transport. Understanding conservative and New Right ideologies can help us understand why Thatcher's government made this decision: As discussed above, the New Right conservatism of 1980s British governments involved a commitment to reducing tax (and therefore public expenditure) so it was unlikely that a party elected on this basis would agree to policy recommendations which depended on increased public expenditure. Furthermore, traditional conservative acceptance of societal inequalities also played a role; quite simply, Thatcher's Conservatives did not view health inequalities as a policy problem, but rather as a 'natural' feature of society (see Berridge, 2002). As the New Right ideological hold over the Conservative party lessened under John Major in the early 1990s, it became more legitimate to discuss the issue of variations in health in policy circles but only by employing the less emotive term, 'health variations'. In 1997, the new Labour government (traditionally associated with more egalitarian values) made it clear that they considered health inequalities to be a significant policy problem and, for the first time in over a decade, explicit political commitments were made to reducing 'health inequalities' (e.g. Department of Health, 1997). However, in keeping with the 'Third Way' these commitments were accompanied by a promise not to increase public spending for at least two years.

Example 2 – Neo-liberalism and the individualisation of health:

Neo-liberalism has been criticised for its negative impact on health by a range of commentators. David Coburn (2000), for example, claims that neo-liberal policies damage health in the following three ways: Firstly, neo-liberal economic policies result in increased inequalities in wealth, which many health researchers believe are directly related to health inequalities (e.g. Wilkinson, 2005); Secondly, the liberal emphasis on individuals corrodes social cohesion, which is also thought to be important for health (again, see Wilkinson, 2005); Thirdly, neo-liberal attacks on the welfare state reduce the 'safety-net' available to people living on low incomes, exacerbating poverty in some groups and making access to health-related services (such as dentistry) more difficult.

Other critiques of neo-liberal policy in relation to health focus on the individualistic nature of the ideology. Authors such as Rose Galvin (2002) claim that neo-liberal governments have deliberately emphasised the importance of avoiding 'risky behaviours' in such a way that individuals are positioned as responsible for their own health status. This, Galvin (2002: 119) argues, leads to assertions about individual culpability for those living with chronic diseases, 'for if we can *choose* to be healthy by acting in accordance with the lessons given us by epidemiology and behavioural research, then surely we are culpable if we do become ill'. In achieving public consensus that risky-behaviours (such as excessive consumption of alcohol, lack of exercise and poor diet) cause chronic disease, governments are able to shift responsibility for health improvement away from themselves and onto individuals, thereby allowing the kind of minimal state intervention advocated by liberalism.

Example 3 - Socialist approaches to improving the health of populations:

A recent comparison of the level of population health amongst 29 developed countries over the period 1945-1980 (Navarro and Shi, 2001) demonstrates that population health fared best in countries that had social democratic governments in rule for most of this period. In this period, these countries (Sweden, Finland, Norway, Denmark and Austria) all had extensive welfare states, funded by relatively high taxation which allowed higher expenditure on social security (e.g. health, education and family support services) than in countries under other types of governance. This suggests that socialist values of equality, redistribution of wealth and a strong welfare state are beneficial for health, which makes sense in light of recent and growing consensus around the importance of social determinants of health (see page X). Evidence from regions of India (Kerala) and north-east Italy, where significant improvements in population health outcomes (reduced health inequalities and associated population health improvement) have also occurred under socialist governance (Navarro and Shi, 2001) add support to those who argue socialist programmes are most compatible with healthy populations. Even Cuba, which is governed by a non-elected socialist government, demonstrates impressive health outcomes, with life expectancy rates that are on a par with developed countries that spend twenty times as much on health (Veeken, 1995). Whether the key to these health improvements lies in a more egalitarian society, as Wilkinson (2005) would suggest, or in better government responses to material deprivation, as Lynch and colleagues (Lynch et al, 2000) might argue, is debatable. Whatever the cause of reduced health inequalities and improved population health in these countries might be, the dominance of governments of a socialist persuasion demonstrates the importance of political ideology for health.

Example 4 – The negative health consequences of fascist regimes:

It could be argued that some level of shared national identity is likely to be beneficial for health, on the basis that it is seen to promote social cohesion - a feature which authors such as Richard Wilkinson (2005) argue is closely linked to health. However, as nationalist ideas have been employed by such a wide variety of political movements, it is difficult to draw any clear conclusions about nationalism's implications for health. Navarro and Shi's (2001) comparison of 29 countries (also referred to on page X) found that the poorest health outcomes of all the countries they looked at were in Spain, Greece and Portugal, all of which had undergone significant periods of fascist rule in the period of study. This suggests, at the very least, that extreme incarnations of nationalism are likely to be health-damaging. The authors claim the causes of poor health outcomes in these ex-fascist countries are likely to result from a combination of regressive fiscal policies (i.e. policies which tend to favour the wealthy, without benefiting the poor), under-developed welfare states, and the general repressive nature of such regimes.

Example 5 – Is Patriarchy the Source of Men's Higher Mortality?

Whilst it is quite widely accepted that patriarchy has negative health consequences for women (e.g. Doyal, 1995), more recent research suggests male dominance in society also has important negative health effects for men (Stanistreet et al, 2005). By comparing data from 51 countries, Stanistreet and colleagues demonstrate that societies which have higher rates of female homicide (female murder victims) also have higher rates of male mortality. The researchers claim that female homicide rates can be viewed as an indicator of the extent to which a society is patriarchal, on the basis that most female homicides are carried out by men, and the researchers therefore suggest that patriarchy reduces male life expectancy. Patriarchy is a complex phenomenon and is consequently difficult to measure but research which takes a different approach supports claims that patriarchy is damaging to male health. For example, data from societies where relationships between men and women are more equal (e.g. Israeli Kibbutz) demonstrate increased male life expectancy, resulting in smaller differences in life expectancy between men and women (Leviatan and Cohen, 1985). These findings challenge assumptions that patriarchy, by allowing the dominance of males, is likely to be beneficial to men, and instead indicate that oppression may be harmful to the oppressors as well as the oppressed.

Example 6 – Environmentalism and public health: a shared agenda?

An awareness of links between the environment and human health are not new; for example, many of the 19th century achievements in improving public health were a result of changes to the environmental conditions in which people lived (e.g. around sanitation and air pollution). Following the success of environmental activists in promoting the political nature of their cause, from the 1960s onwards, clear links between the public health and environmental movements began to develop. In 1990, Maurice King wrote a now-famous commentary in the medical journal, *The Lancet*, in which he argued that an ecological approach to public health was essential in order to avoid the likelihood of humans being caught in a 'demographic trap'. Increasingly it became clear that public health could not afford to focus solely on human health, for without a sustainable, healthy environment in which to live, human health would inevitably decline. By the mid-nineties, the term 'ecological public health' was being used as a means of highlighting the dependence of public health on the survival of the ecosystem (Nutbeam, 1998). Since then, it has become increasingly accepted by mainstream public health activists that the two issues ought to be viewed as a shared agenda. In 2006, the UK Public Health Association and the Faculty of Public Health published a joint manifesto entitled, '*The Convergence of Health and Sustainable Development*', which aimed to establish a network incorporating both environmental and public health activists. The manifesto, signed by a wide range of public health practitioners and advocates, makes links between environmental degradation and health inequalities and commits signatories to, for example, 'undertaking carbon audits and ecological footprint analyses' and bringing together social, environmental and economic policies 'to achieve synergy.'