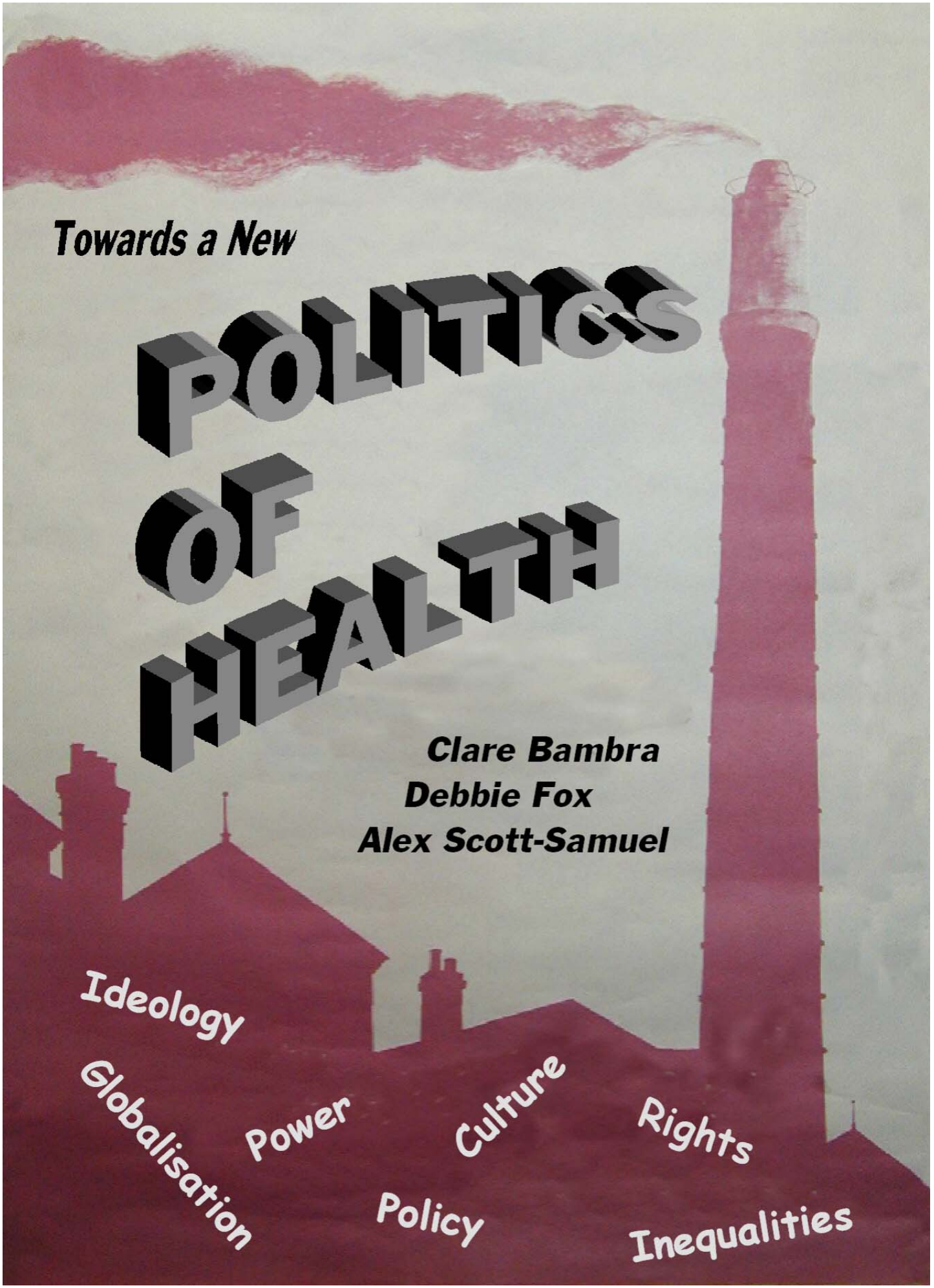
Towards a New
POLITICS OF HEALTH
Clare Bambra
Debbie Fox
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Ideology
Globalisation
Power
Culture
Rights
Policy
Inequalities

Towards a New Politics of Health

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Politics of Health Group
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Front Cover

Designed by Paul Blackburn
Based on an original poster 'A Public Health Warning' by Islington Community Health Council, 1981.

Towards a New Politics of Health

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... and at least I know this, that if a man is overworked in any degree he cannot enjoy the sort of health I am speaking of; nor can he if he is continually chained to one dull round of mechanical work, with no hope at the other end of it; nor if he lives in continual sordid anxiety for his livelihood, nor if he is ill housed, nor if he is deprived of all enjoyment of the natural beauty of the world, nor if he has no amusement to quicken the flow of his spirits from time to time: all these things, which touch more or less directly on his bodily condition, are born of the claim I make to live in good health...

William Morris, 1884

1: Background

> *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)

> *It is ultimately profit, rather than a concern to improve overall living standards, which is the most important determinant of economic and social decision-making in capitalist society, this will be reflected in various ways in patterns of health and illness* (Doyal and Pennell, 1979)

It is profoundly paradoxical that, in a period when the importance of politics and public policy as determinants of health is routinely acknowledged at the highest political levels in the UK, there remains a continuing absence of serious debate about the ways in which political power, relations and ideology influence people's health (Navarro and Shi, 2001). While to some extent the unhealthy policies of the Thatcher government acted as a stimulus to such debate, as early as the mid-1980s the introduction of the World Health Organisation's Health For All strategy (and, more recently, the election of the New Labour government) created the illusion that these issues had finally – and adequately – been acknowledged. Such views can and very clearly should be challenged.

Arguably, existing groups with an interest in health and politics such as the Political Studies Association's Health Politics group, the Socialist Health Association, the UK Health Equity Network and the UK Public Health Association meet some of the need – but to a very limited extent. There is an evident need for a dynamic, inclusive left-of-centre group committed to discussion and development of the theoretical issues relating to the impact of power and ideology on the public health, and to advocacy and campaigning around these issues. This has echoes of the Politics of Health Group (POHG) that flourished in

the late 1970s and early 1980s, under the umbrella of the British Society for Social Responsibility in Science (BSSRS). POHG held regular meetings on diverse political and health-relevant themes, undertook advocacy and campaigning, and published pamphlets (eg Cuts and the NHS – What are we fighting for?; Food and Profit – It makes you sick), journal papers (eg Left orthodoxy and the politics of health – Mick Carpenter, 1980), and books (eg It makes you sick: the politics of the NHS – Colin Thunhurst, 1982; What is to be done about illness and health? – Jeannette Mitchell, 1984).

Freire (1989) suggests that:

> *Action to translate the vision into reality is set in motion by relating the pattern of society it envisages to the historical circumstances of the context, in which objective and subjective conditions stand in a dialectical and not mechanical relationship to one another…the vision should be capable of being translated into reality and the steps to bring this about should be possible in the concrete conditions in which they find themselves (cited in Ledwith, 2001)*

This paper is a first step in 'action to translate the vision' for the development of a new Politics of Health Group into reality. It is aimed at anyone who wishes to be part of a new social movement to promote a vision of health rooted in shared values of equity, sustainability and the common good. Given the diverse backgrounds of current and potential new members of the Group, it would seem useful to define key terms so as to develop shared knowledge and understanding. In Section 2, we review terms such as health, politics, power, ideology and hegemony and highlight problems in their meaning and application. We then explain our rationale as to why health is political and explore possible reasons why it has been depoliticised in Sections 3 and 4. Section 5 discusses reasons why health should be repoliticised now, and in Section 6 we make suggestions as to what the Politics of Health Group should do next.

2: Health, politics and power

Health

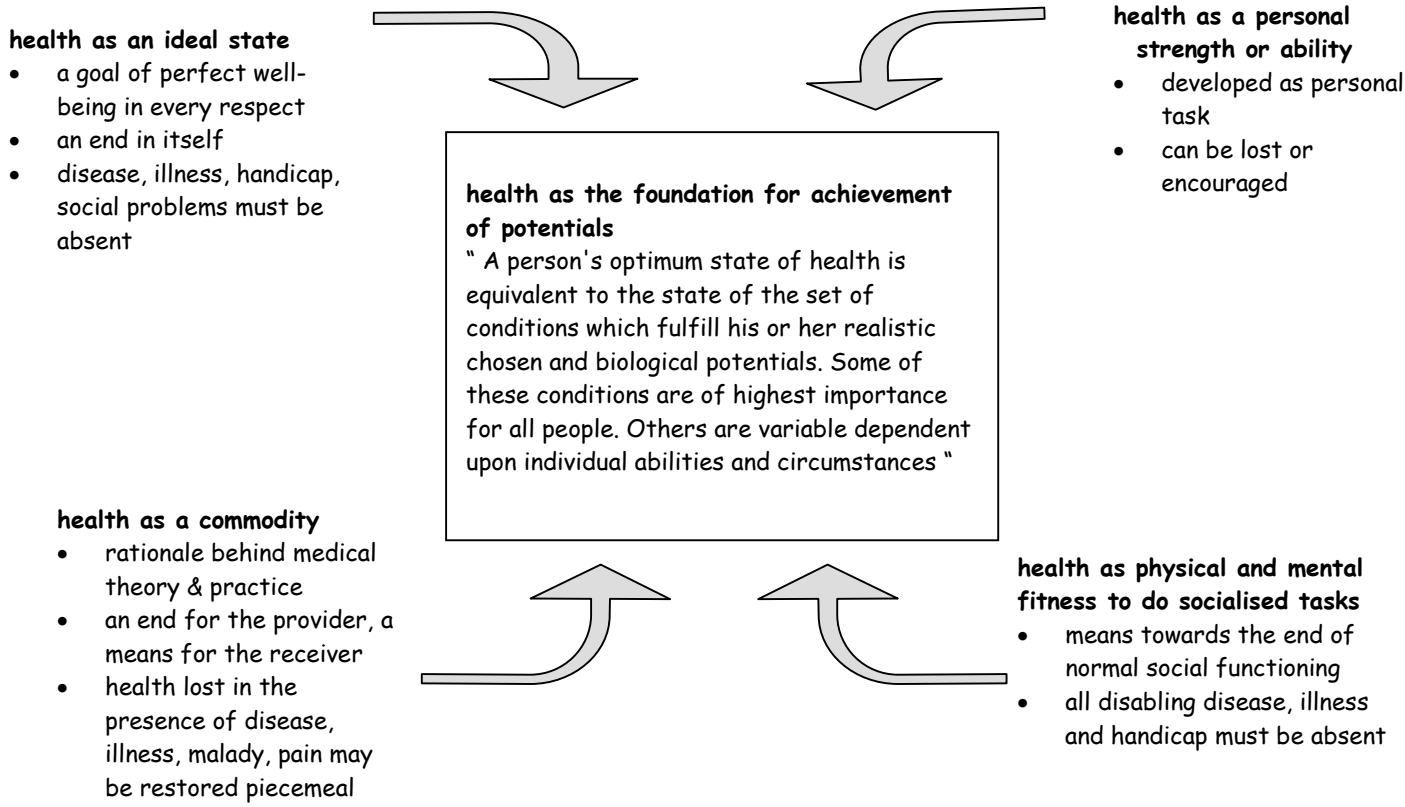
Definitions of health have changed over time: its etymological roots lie in the Old English for 'whole':

> *Old English: haelth; related to Hal, derived from Old English hael, meaning whole* (Collins Concise Dictionary, 1995)

The Old English implies that a person who was healthy was 'whole'. The World Health Organisation attempts to encompass this in its 1946 definition of health as 'a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity'. This definition is itself a political statement, as Navarro (1998) notes in his discussion of the origins of Brotherston, Evang and Stampar's influential forrmulation, which lie in the anti-fascist struggles of World War 2. In contemporary Western societies, several competing theories of health co-exist (Seedhouse, 1986):

- Health as an ideal state;
- Health as a personal strength or ability;
- Health as physical and mental fitness to do socialised tasks;
- Health as a commodity;
- Health as the foundation for achievement of potentials

Figure 1: Theories of health



After Seedhouse, 1986 and Naidoo & Wills, 2000)

Health has also been defined as the ability to adapt positively to challenges (Antonovsky, 1979); as a narrative and as a metaphor (Armstrong, 1973; Lakoff and Johnson, 1980; Sontag, 1991; Burr, 1995) that is expressed in the everyday language we use and the mental maps we construct to guide us on our journey through life (Blaxter, 1990; Bandura, 1997), and as spiritual strength (Zohar and Marshall, 1999). In Western societies the notion of spirituality has been the province of organised religion and viewed separately from physical and psychological well-being; however, in this context it is used to refer to a sense of the sacred and a search for wholeness.

The understanding of health and its determinants also varies by culture. For example, in several central African languages the word for health is the same as the word for life (in the sense of 'all that is necessary to live a fulfilling life') (Povall, 2000). Whilst similar in

meaning to the old English 'hael' the underlying concept of contemporary Western notions of health is quite different to non-Western traditional thought. Herrick (1978), drawing on the work of Maruyama (1974), categorises these differences as follows:

Table 1: Western and Non-western thought

Western thought (***Cartesian reductionism)***	**Non-Western, traditional thought** (***Holistic, whole systems thinking)***
Unidirectional causal paradigm	Mutual causal paradigm
Cause-effect	Interactional relationships
Predetermined universe	Self-generating and self-organising universe
Hierarchies	De-emphasis on hierarchies
Competitiveness	Symbiosis and co-operation
Unity by similarity and repetition	Harmony in diversity
Categories	Contextual factors

Source: After Maruyama, 1974 and Herrick, 1978 (our italics)

Health is therefore what Gallie (1956) calls a contested concept, as *'there is no one clearly definable general use of any (concept)…which can be set up as the correct standard use.'* Gallie argues that to be 'essentially contested', the concept under scrutiny must fit a number of criteria:

Table 2: 'Essentially contested concept' criteria

Criteria	Health
Appraisive: The concept must signal, appraise or accredit with some value an achievement or particular state	Health has value, something to be achieved that can be described, measured or appraised
Complex in character: It should possess a range of sometimes variable, yet complex qualities	Health can mean one or several different things to an individual
Ambiguous: A particular view of the concept may be accepted or rejected by others particularly if their understanding or its use or outcome differs	Health can mean anything from 'free from disease' to 'you have a great sun tan'
Persistently vague: The same individual's use of the concept in one context may differ when used in another with no clues as to the change in meaning intended by the user	The use of the term health can lack consistency of meaning depending on context (social, cultural, geographic and historical)
May be used aggressively or defensively: To use an essentially contested concept implies that it is used in conflict with others	There are various parties with different interests in health, eg medicine v complementary therapy
Has a degree of authority: Some common derivation of the concept is recognised by the different parties	Assumption that some sort of intervention can lead to making 'whole' again
Credibility: The meaning suggested must be likely and plausible	Contests exist between different interest groups adding legitimacy to the notion that health has a number of different meanings

(Adapted from Gallie, 1956, and di Viggiani, 1997)

Nadoo & Wills (2000) suggest that in the West a gradual shift in the meaning of health occurred during the 18th century as the increasing dominance of medicine encouraged a mechanistic view of the body. In this mechanical / medical conceptualisation, health is the absence of disease, and ill health is the presence of disease. The causation of disease presence or non-presence, and hence of a state of ill health or health, is examined at the level of the individual.

More recently, conceptualisations of human health and wellbeing have become more of a ‘pick'n'mix’ of Western and non-Western thought, with research and other aspects of the quest for knowledge shifting toward an ecological (holistic) model or framework. This framework focuses on the interconnections as well as the parts, giving individual and context, process and outcome equal importance. Personal health is seen as the product of connections between mind, body, spirit, emotions, and society; population health as an emergent property arising from the interactions of individual, environmental, material and social relations; and global health as the outcome of all these interactions worldwide (Bateson, 1980; Hancock, 1985; Dahlgreen and Whitehead, 1991; Capra, 1997). In short, the level of health experienced or attainable by an individual, community or population is a direct result of the interaction and quality of the relationship between the various determinants of health.

There are many different models of health, its determinants and how it may be achieved (eg, Lalonde, 1974; Dahlgren and Whitehead, 1991; Evans et al, 1994), but that presented by Doyal and Gough (1991) is the only one to date that explicitly includes a ‘political’ dimension as a human ‘need’ for human flourishing (health) (Figure 2).

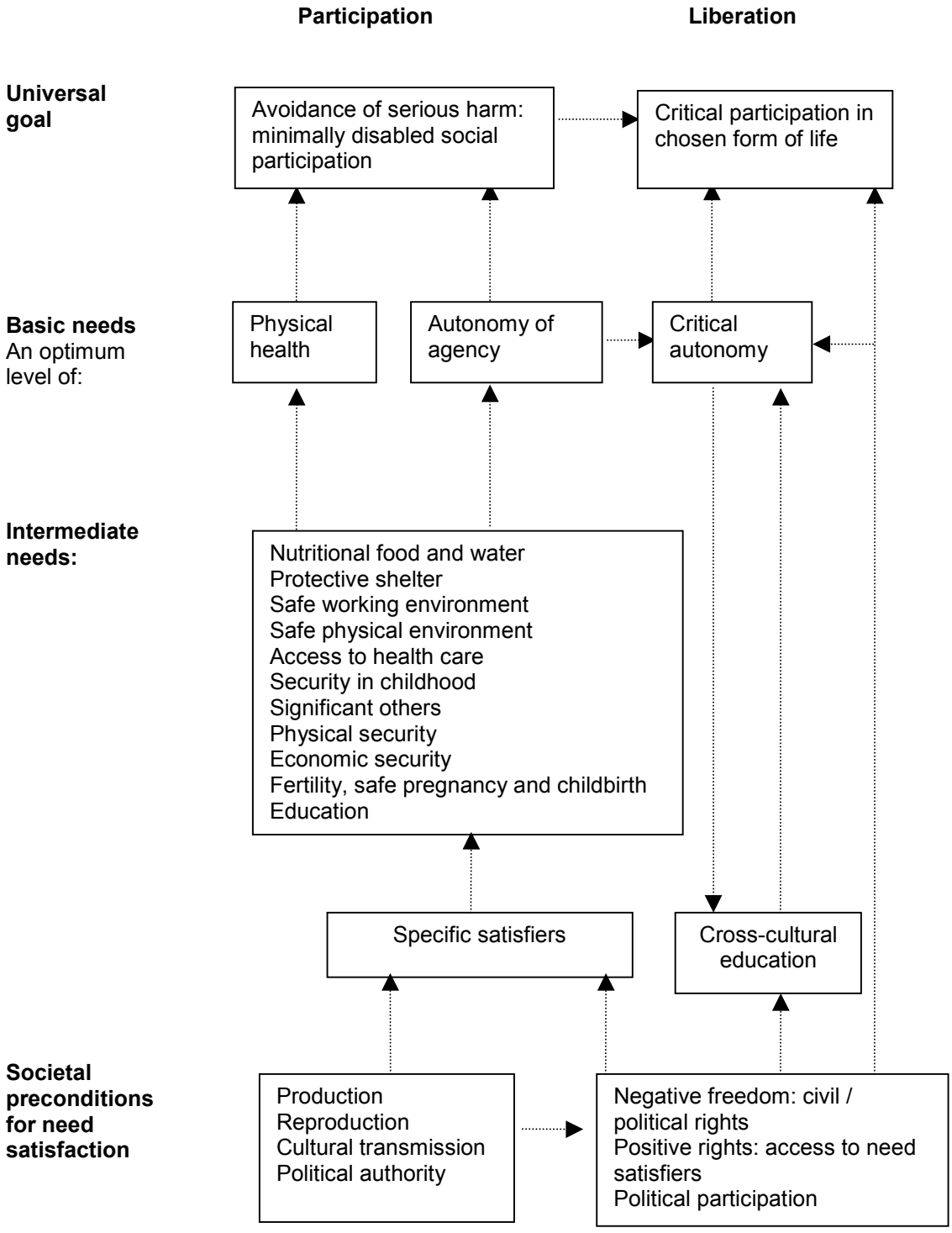


Figure 2: Theory of human need. Adapted from Doyal & Gough, 1991

Doyal and Gough propose that how society defines health and the dominance of a particular perspective can have significant impact on what action is done to promote health and wellbeing. So in order to

understand 'health', we need to explore the political, social, cultural, temporal and spatial context within which the meaning of health is created and the processes that promote or stifle particular courses of action.

Given what we already know about the diversity of health and its determinants, it would be easy to accept, as adequate, contemporary discourse on action for heath gain (for example, what actions are considered effective measures to promote and protect health; the legitimacy of different 'types' of evidence, and levels of 'measurability') that follow from debates on soft science vs hard science, objectivity vs subjectivity, and reductionism vs holism. However, such simplistic polarisations render invisible the underlying values and processes that propagate one idea over another: hence the need to explore the relevance of politics, ideology, power and hegemony in relation to health.

Politics

The definition of politics is in itself a political act (Leftwich, 1984). The nature and scope of the political is, like health, a contested concept, as the naming of the key elements itself constitutes a political choice. This is evident in the divergent conceptualisations of the political that have been utilised both over time and by different political ideologies. 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 (ie, 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 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, as any and every issue is political and likewise anyone and everyone can engage in a political act.

These competing definitions have also permeated the contemporary academic discipline of political science where the different schools of thought similarly operate divergent conceptualisations:

Table 3: Definitions of politics within political science

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

(Adapted from Stoker, 2002)

The definition of politics utilised by the various different schools of political science underpins their entire approach to the study of political life. The definition of politics that is employed by an individual, a group, an organisation or a society is of vital importance as it sets the parameters that determine which issues are considered as political. Political issues enter into the political discourse and are the subject of public discussion and debate; issues that are regarded as non-political or apolitical are marginalised or ignored.

Ideology

> *…sooner or later, it is ideas, not vested interests, which are dangerous for good or evil.*
> (Keynes, cited in Marquand, 1996)

Ideology, like health, politics or power, is an amorphous and difficult concept that encompasses many different meanings such as false ideas (Marx and Engels), class struggle (Lenin), or societal 'cement' (Gramsci, Althusser).

Table 4: Definitions of ideology

Marx & Engels	The German Ideology 1846	Ideology is a false set of ideas that arises from material conditions and represents the interests of the ruling class: 'if in all ideology men and their circumstances appear upside-down as in a camera-obscura, this phenomenon arises just as much from their historical life-process as the inversion of objects on the retina does from their physical life-process'. The ruling class develops ideologies to present that part of the truth that best serves their interests.
Lenin	What Is To Be Done? 1902	Ideology is a useful weapon in the class struggle that can be used by either side to promote their interests regardless of truth or falsity of their concepts.
Gramsci	Selections from the Prison Notebooks 1929-35	Ideologies are organic and necessary to a social formation. They have a material existence, as they are present in the practical activities of individuals, groups

		and institutions and as they 'provide a unity of faith between a conception of the world and a corresponding norm of conduct'. Ideology acts as societal cement in the sense that it binds together different groups and ideas. A hegemonic ideology is usually one that has successfully incorporated a number of different elements from other competing ideologies and thereby fuses the interests of diverse societal groups.
Althusser	Lenin and Philosophy and other essays 1971	'Human societies secrete ideology as the very element and atmosphere indispensable to their historical respiration and life'. Ideology is omnipresent in all social forms and it is used to cement society together. Capitalist ideology is promoted throughout the economic, political and civil institutions of capitalist society.

However, perhaps a more generic and workable – if a little simple – definition for this paper would be that 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. 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. So, for example, the dominance of 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 organised capital within our society.

Indeed, recent claims, in the wake of the fall of the USSR, that ideology is dead (eg Fukuyama, 1992) reinforce the dominance of the ideology of liberalism, as there is now 'no alternative' to the hegemony of the Western capitalist-democratic model. The Blair governments have also walked this path, as with 'no alternative' comes 'no ideology' – and so decisions are falsely presented as being based on rationalism and

pragmatism rather than on values and on compromise with ideological concerns:

People ask me if I think ideology is dead. My answer is: in the sense of rigid forms of economic and social theory, yes. The 20th century killed those ideologies and their passing causes little regret…

(Tony Blair, Labour Party conference 2001)

Understanding ideology and how it functions is crucial in understanding how it can be used to manipulate the interests of the many in favour of the power and privileges of the few (Ledwith, 2001).

Power

Power is a key political concept which underlies public decision-making and the allocation of goods and services. It is crucial to the understanding of relations within health and health services and to the content and form of healthy public policies.

In his influential book, Lukes (1975) outlines three dimensions of power:

- The first dimension is 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 second dimension is 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 third dimension is the power of A to define the values and beliefs B ought to hold (for example what counts as fair, or 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, the control of information, and the control of the

mass media. The latter dimension is akin to Gramsci's notion of 'hegemony' – discussed below.

Lukes' conceptual analysis allows for power in the form of 'want manipulation'. If someone's wants are being manipulated, then their actions may either be indicative of a genuine want in the real interests of that individual, or the result of some form of want manipulation. The recent expose of the 'newly constructed' female sexual dysfunction condition, whereby drug companies have developed a pharmacological 'cure' for a condition grounded in social (gendered) relations, appears to be a good example of hegemonic manipulation by biomedical elites (Moynihan, 2003).

It seems self-evident that the power to shape people's thoughts and desires is the most effective kind of power since it anticipates areas of potential conflict and even pre-empts an *awareness* of possible conflicts. Those that don't conform to the norm may be blatantly portrayed (and therefore perceived) as deviants and rightfully (read morally) excluded socially, legitimising Victorian notions of 'the feckless habits of the poor'.

What is needed then is a framework or concept that would help us understand the processes by which power is exercised and that can be used to identify contradictions that are 'sold as real, natural, logical, common sense' (Ledwith, 2001). As Ledwith points out, without such a framework we remain 'trapped within a dominant ideological discourse' – in other words, devoid of a truly 'scientific eye' (Patton, 1990). Hegemony is such a concept.

Hegemony

…an order in which a certain way of life and thought is dominant, in which one concept of reality is diffused throughout society in all its institutional and private manifestations, informing with its spirit all taste, morality, customs, religious and political principle, and all social relations, particularly in their intellectual and moral connotations. (Gramsci, 1971)

Hegemony is a difficult and complex conceptual framework made up of different concepts. The table below gives a brief and simple overview of Gramsci's concept of hegemony.

Table 5: Concepts within hegemony (after Simon, 1991)

Concept	What it means
The relations of forces: economic-corporate/hegemonic	The building up of systems of alliances. To become a hegemonic class, the group has to find ways to combine its own interests with that of others and be prepared to make compromises in order to become representative of a broader block of social forces eg working class / middle class voters and single issue groups such as women's rights, green movement, animal rights. "Each strives to strengthen its own position and disorganise the alliances of the other to shift the balance of force in its favour"
National popular	"A class or group must take into account the popular and democratic demands and struggles of people which do not have a purely class character" if they are to achieve national leadership or positions of power. For example the civil rights movement and women's movements cannot be reduced to 'class' struggle. So hegemony has a national popular dimension, as well as a class dimension, that is expressed as a "collective will" bringing together different types of social groups that share a particular view of the world, aligning to create a "war of position". But each force (group) maintains its own autonomy and identity
Passive revolution	Capitalist and working classes (forces) have different strategies by which to maintain or advance their position. Passive revolution is the response of the bourgeoisie consisting of a "process of reorganisation of the social and economic structures without relying on the active participation of the people" to re-establish its hegemony. For example the emergence of Thatcherism and Reaganomics resulted in far reaching modifications to the social and economic structures of the UK and USA through the agency of the State (top down), with no democratic debate. "Social reforms demanded by the opposition may be carried out but in such a way as to disorganise these forces (classes/groups) and damp down popular struggles" - for example, abolition of the Poll Tax.
Anti-passive revolution	The continual extension of a class (working class) and popular democratic struggles, as only after the "capture of

	power" can the construction of socialism begin. This means that for socialism to succeed the class must win State power and the hearts and minds of the people.
Intellectual and moral reform	Creating a new hegemony by transformation of the popular consciousness – of people's way of thinking as to how the world is and should be. For example, ideas as to the morality of particular lifestyles evident in the 1980s, which allowed victim-blaming to be perceived as the norm – individualisation of ill health because of the 'feckless habits of the poor' and welfare scroungers who should 'get on their bike' to find work.
Common sense	"The uncritical and partly unconscious way in which people perceive the world". This has negative and positive connotations. The belief that all people are philosophers with some conception of the world that enables them to make sense of their lives. But that this can be contradictory, containing ideas from a variety of sources. Particularly from the past – "which make them accept inequality and oppression as natural and unchangeable". On the more positive side, incongruence in lived experience and conscious ideas can lead to resistance to oppression and the prevailing ideology.
Civil society	Civil society consists of organisations and institutions including schools, hospitals, churches, political parties, trade unions, mass media, cultural and voluntary associations. It does not include the "institutions and apparatus which make up the State" as these have a monopoly of coercion. Civil society is the sphere in which popular and class struggles occur, where dominant groups organise consent and hegemony and less powerful groups organise opposition and alternative ideologies – a counter hegemony. For example Margaret Thatcher transformed conservatism into a different politics
The State	The State is "the entire complex of practical and theoretical activities with which the ruling class not only maintains its dominance but manages to win the consent of those over whom it rules".
Historic block	"The way in which a hegemonic class combines the leadership of a block of social forces in civil society with its leadership in the sphere of production". In other words it is misleading to separate economics from politics in the acquisition of hegemonic legitimacy, as both are needed to obtain it.

Ledwith (2001), working as a community development worker in the 1980s, views the profound changes she observed in the values within a working class community in the North of England, as a "hegemonic consequence" of New Right ideology. Their (the community's) new language echoed that of the State (eg 'welfare scroungers') and broke down working class notions of 'solidarity' and communitarianism. In reality the 'rolling back of the State' resulted in transfer of wealth from poor to rich and new patterns of poverty and ill health (Whitehead, 1992), with a shameful increase in the number of children in poverty – the most vulnerable.

In relation to health, the concept of hegemony can therefore act as a tool to ask the right questions and to challenge actions to promote health that smack of ideological dominance asserted as moral persuasion of how we ought to live.

3: Why is health political?

Like the man in the bar who prefaces every political statement with "I'm not political but …", the inherently political nature of health has for too long been hidden from view. It is high time that the implicit, and sometimes explicit but unstated politics within and surrounding health were more widely acknowledged. Health, like almost all other aspects of human life, *is* political, in numerous ways. In this section we examine five aspects of the political nature of health:

- **Unequal distribution:** health is political because, like all other life chances under a capitalist economic system, some social groups gain more of it than others.

- **Health determinants**: health is political because its social determinants, such as housing and income, are amenable to political interventions and are thereby dependent on political action (or more usually, inaction).

- **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).

- **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.

- **Globalisation**: health is political because we now face a complexity of worldwide crises – social, economic, ecological and ethical – that impact upon us all and contribute to ill health and avoidable deaths.

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, nor of a doctor (especially not of a doctor, except in some instances of individual disease), but is substantially under the control of the social relations of the capitalist system. Changing this system and these relations are only achievable through politics and political struggle.

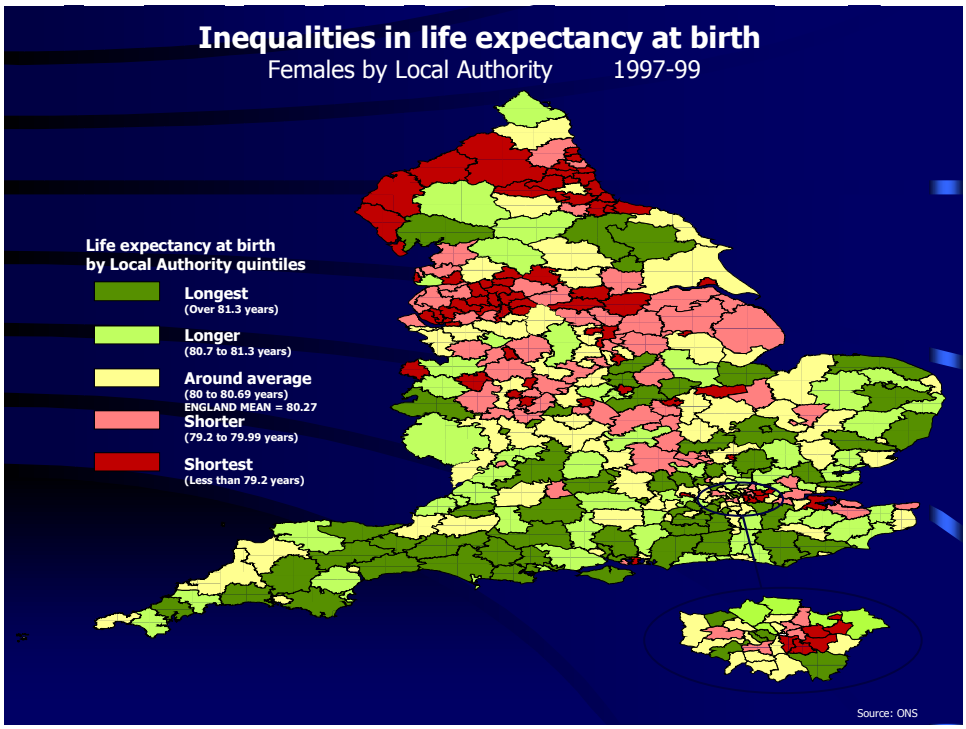
Unequal distribution

> *Capitalism does not just extract surplus labour and value from working class people, in so doing it also shortens their lives, and often cruelly incapacitates them during their available span* (Carpenter, 1980).

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). 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; Acheson, 1998;

Secretary of State for Health, 1999). Yet inequalities of health continue:

Figure 3: An example of the social distribution of health in the UK



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.

Health determinants

Whilst genetic predispositions to, and causes of ill health are becoming increasingly better understood, it is evident that environmental triggers are in most cases even more important, and that the major determinants of health and ill-health lie in the social

and physical environments (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 important determinants of health and wellbeing. Similarly, many of the major determinants of health inequalities lie outside the health sector and therefore require non-health care policies to tackle them (Townsend and Davidson, 1992; Acheson, 1998; Whitehead et al, 2000). Recent wider acknowledgements on both sides of the Atlantic of the importance of the social determinants of health (Evans et al, 1994; Marmott and Wilkinson, 1999) are welcome – but they fail to seriously address political determinants of health and health inequity.

Organisation

> *The science and art of preventing disease and prolonging life, and promoting physical and mental health and efficiency, through organized community efforts. …And the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health* (Winslow, 1920).

> *The science and art of preventing disease, prolonging life and promoting health through the organised efforts of society* (Secretary of State for Social Services, 1988).

The above definitions of public health highlight the social and political aspects of improving health. 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. Health can only be improved through the *organised* activities of communities and societies. The organisation of society, in most countries, is the role of the state and its agencies. The state, under any of the four definitions of politics outlined earlier, 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.

While this constitutes a clear argument for the political nature of public health-relevant services, an external observer could be forgiven for interpreting the roles of NHS public health practitioners as purely bureaucratic. Certainly this was the case between 1974 and 1988, when the NHS 'community physicians' who replaced the pre-1974 local government-based Medical Officers of Health fulfilled an explicitly techno-bureaucratic role. But even after the 1988 Acheson report (Secretary of State for Social Services, 1988) and the resulting 'reinvention of public health' (Anon, 1988), its political nature was – and arguably remains – barely apparent. On the whole, as is the case with other NHS 'managers', public health practitioners sing to the current government's hymn-sheet – however unhealthy or reactionary they find it to be.

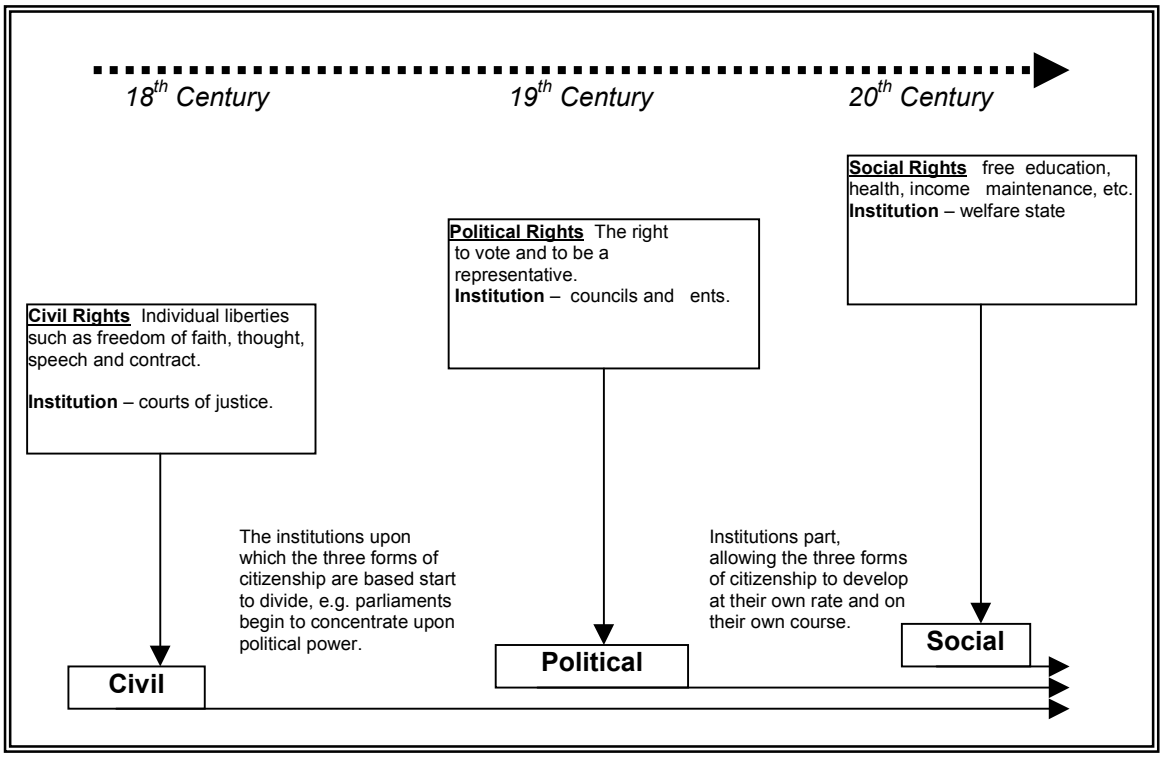
Citizenship

> *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* (United Nations, 1948).

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; IFDH, 2002), is an important aspect of social citizenship. Citizenship is interwoven with politics and political struggle because, whilst the emergence of civil, political and social rights accompanied the development of capitalism (see Figure 4 below), their incorporation into citizenship was only gained as a result of political and social struggle.

It is possible to assign the formative period in the life of each aspect of citizenship to a different century, thus:

Figure 4: The historical development of citizenship (Adapted from Marshall, 1963).



Despite their parallel development, the relationship between capitalism and citizenship is not an easy or 'natural' one: *'It is clear that in the 20th century, citizenship and the capitalist class system have been at war'* (Marshall, 1963). Health is a strong example of this tense relationship as, under a capitalist economic system health is, like everything else, commodified. Commodification is *'the process whereby everything becomes identifiable and valued according to its relative desirability within the economic market (of production and consumption)'* (di Viggiani, 1997). Health became extensively commodified during the industrial revolution as workers became entirely dependent upon the market for their survival: *'as markets became universal and hegemonic … the welfare of individuals (came) to depend entirely on the cash nexus'* (Esping-Andersen, 1990). In the 20th century, the introduction of social citizenship, which entailed an entitlement to health and social welfare, brought about a 'loosening' of the pure commodity status of health. The welfare state

decommodified health because certain health services and a certain standard of living became a right of citizenship: *'decommodification occurs when a service is rendered as a matter of right….without reliance on the market'* (Esping-Andersen, 1990). However, it must be noted that under capitalism, whilst the total commodification of health is possible, its total decommodification is not (O'Connor, 1996). In short, capitalism and citizenship represent very different values: the former, inequality and the latter, equality. This tension means that the implementation of the right to health, despite its position in social citizenship and in the UN Universal Declaration of Human Rights, is a continued and constant source of political struggle both nationally and internationally.

Globalisation

The flow of information, goods, capital and people across political and economic boundaries has of course been going on for centuries. What is of growing concern is the scale and pace of change. Lee (2000) defines globalisation as:

The process of closer interaction of human activity across a range of spheres, including the economic, social, political and cultural, experienced along three dimensions: spatial, temporal and cognitive.

What this means is that 'the death of distance' has made the world feel smaller, our perceptions of time have changed (due to an electronic revolution), and there is global spread and interaction of ideas, cultures and values (Walt, 2000). On the one hand this has clear advantages such as reuniting diasporic communities and the potential to develop more tolerance of difference; on the other, it represents the imposition of a neo-liberal ideology and economics that systematically neglects the basic needs of the disadvantaged in its pursuit of the accumulation of money, property and natural resources. This is resulting in a widening gap in wealth, health and quality of life, both between countries and within them (Berlinguer, 1999; Brundtland, 1999; Navarro, 1999).

The World Trade Organisation (WTO) in particular is perceived to be supporting and sustaining trade agreements globally in the primary interest of transnational corporations. The deregulation of trade, and the unregulated search for profits (Navarro, 1999) has brought increasing inequality and inequity of health and has escalated environmental degradation, rapidly exhausting the planet's ecosystems (Capra, 1997). The amoral behaviour of these organisations has provoked the emergence of new global political movements that have taken action against corporate companies, international organisations and national governments (eg the mid-1990s GAP boycott in the USA, 'anti-globalisation' demonstrations against the WTO in Seattle 1999, and the civil disturbances in France 1995).

We now face a complexity of worldwide crises - social, economic, ecological and ethical - that impact upon us all and contribute to ill health and avoidable deaths.

4: Why has health been apolitical?

It is perhaps puzzling that despite its evident political nature, the politics of health has been marginalised: it has not been widely considered or discussed as a political entity within academic debates or, more importantly, broader societal ones. Unfortunately there is no simple solution, as the treatment of health as apolitical is almost certainly the result of a complex interaction of a number of different factors. We suggest some reasons for this below, though we would not claim that this speculative list is exhaustive.

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 the 'State or market?' debate about NHS funding and organisation, or such as NHS service delivery

and efficiency, or the demographic pressures on the future provision of health care facilities. The same applies in most other – especially 'developed' – countries.

The limited, one-dimensional 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 (biomedical definition) and as a commodity (economic definition). These both focus on individuals, as opposed to society, as the basis of health: 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.

> *The political basis of our health services is the view of health as a commodity, a function of individuals rather than of societies; something to be valued, exchanged (bought and sold in many societies), and in every way determined by the actions of individuals* (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. In order to tackle these inequalities, political attention is placed upon the variable that is most amenable to manipulation – the healthcare system.

It is important to note that this limiting, one-dimensional view of health is common across the ideological spectrum, with left-wing versus right-wing health debates usually consisting of a more / less NHS dichotomy. Orthodox left wing politics is guilty of placing health care and the NHS at the centre of its discussions and struggles about health. This 'NHS illusion' has resulted in the naive perspective

amongst health activists that societal ill-health can be cured by more and better NHS services (Carpenter, 1980). At best, this perspective is slowly changing – as shown by the enthusiasm of some for New Labour's emphasis on tackling health inequalities through the NHS – while it simultaneously widens them through its neo-liberal macroeconomic, trade and foreign policies.

Health and concepts of politics

Earlier in this paper, 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. Other aspects of health, such as health inequalities or health and citizenship, are excluded from this narrow popular definition of politics and are thereby seen as non-political. 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. Equity of access to health care should also be seen as a key citizenship right.

Health and political science

Health has not been seriously studied within political science – nor for that matter has politics within public 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, only one minor aspect of health care: the health care system – the NHS. Some political scientists will argue that they do study health as a political entity; indeed the Political Studies Association has its own 'Health Politics Group'. However, what is actually under analysis is the politics of health care.

The roots of this focus on health care derive from the dominance of certain schools of thought within political science and of their corresponding definitions of the political. Table 3 outlined the different schools of thought in political science and their respective

conceptualisations of politics. These schools are not of equal weight within 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. The politics of health care is the politics of institutions, systems, funding, and elite interactions, all of which fit the priorities of these hegemonic schools of political science like a glove. Health, in its broader sense, is therefore apolitical and should only be the concern of disciplines such as sociology, public health or medicine.

In this way specified aspects of health, namely health care issues, are politically defined as political while all other aspects are not.

Responsibility and authority

> *When we conceive of ill-health as episodes of disease manageable by the delivery of healthcare, we are .... transferring the responsibility for health from society as a whole to an elite possessing what we define as the necessary professional and technical expertise for the management of disease* (Scott-Samuel, 1979)

The conceptualisation of health as non-political is also in part due to medicalisation – the transfer of power over and responsibility for health from individuals, the public and therefore political life, to powerful elites, namely the medical and health professions and the multinational pharmaceutical companies. However, unlike the impression given in the above quote, this transfer of responsibility is not always voluntary. Drug companies and the medical profession have taken the power and responsibility for health for themselves (Illich, 1977). They have thus been able to determine what health is and therefore, how political it is or, more usually, is not.

Their historic power over the definition of health has resulted in its depoliticisation via medicalisation: health is something that doctors are responsible for, they are the providers, and we are the recipients.

Their authority and responsibility over health has further emphasised its commodity status – when ill, an individual visits a doctor and / or purchases drugs (commodity) to regain health (another, albeit less obvious commodity). Ill health is a transient state caused by the presence of disease. It can be ended by the appropriate application of medical technology. This depoliticisation of health, via the transfer of power and responsibility to these professional groups, means that we do not have power over our own health or autonomy over our own bodies.

Health policy

> *We sat after lunch, five of us, arguing about the meaning of health policy. For the economist from the World Bank it was about the allocation of scarce resources. For the Ugandan health planner it was about influencing the determinants of health in order to improve public health. For the British physician it was about government policy for the health service. The Brazilian smiled. 'In Portuguese the word "politica" means both policy and politics', she said. For her, health policy was synonymous with health politics.* (Walt, 1996)

As Walt goes on to point out, for most people, health policy is synonymous with policy *content*. Certainly in the UK it is relatively unusual to find discussions of health policy which are not focused on the pros and cons of particular courses of action in relation to particular political parties. In reality, however, health policy is part of a broader body of knowledge (social policy and public policy), whose practical aspects consist of a dynamic, multi-stage policy process which in turn is inextricably linked with politics. Public policy also forms the knowledge base of a social science (policy science) which is characterised by a range of theories, models and constructs. (Our working definition of public policy is 'purposive action within the sphere of government influence').

Given all the above, the reduction of 'health policy' to 'the content of health policies' can be viewed as a form of commodification, which diverts attention from, and renders invisible the political nature of the

policy process. In reality, both content and process are crucially important. For example, the fundamental requirement within capitalism for inequality (between those who labour and those who profit) makes the meaning of government policies to 'tackle inequalities' at best highly questionable. It is only when one 'refocuses upstream' from the polarised political debates over the content of inequalities policies to the dynamics of their implementation that this fundamental contradiction can become fully apparent. To put it simply, no capitalist government will (or can) support a policy process which permits the full implementation of radical equity policy. Current Government policy in this area effectively consists of (loudly trumpeted) minor reform, in the context of an underdeveloped and inappropriate policy process whereby strategy and responsibility for reducing inequalities are handed – in the name of 'devolved autonomy' – to local managers with no knowledge or experience in this area. Unsurprisingly, little research is undertaken on the equity policy process (Sihto and Keskimaki, 2000; Exworthy et al, 2002).

Meanwhile, no policy connections are made with the macro-political causes of the major economic, social and health inequalities, such as neo-liberal macroeconomic and trade policy, defence policy and foreign policy. None of these featured in the Treasury's Cross Cutting Spending Review (HM Treasury and Department of Health, 2002), which was intended to examine the impact on health inequalities of the expenditure programmes of all government departments. Nor of course are the actions of the World Trade Organisation, of transnational corporations, of the World Bank and of US foreign policy taken into account.

It could perhaps be suggested that the globalised context of these policy areas makes it unsurprising that their major contributions to the generation of health inequalities go unrecognised.The same cannot as readily be said, however, of the one domestic area where effective policy action could have radical impact – that of gender equity. Arguably, gendered differences relating to power and control underlie all inequality. Yet this issue – which cuts across social class, ethnic and other social dimensions – is barely acknowledged in domestic policies

relating to the relevant action areas of (male) parenting and socialisation.

One important conclusion regarding this failure to see the wood for the trees is that there is an important need for health policy research and commentary which draw upon policy theory (eg Bartley, 1992; Bryant, 2002) and on an explicit awareness of the dynamics of the policy process (eg Draper, 1989; Hunter, 1990; Whitehead et al, 2000).

5: Why here? Why now? The case for action

> *The public ideas – and the language associated with them – which currently envelop us are those of the market, corporatism, fiscal restraint, and globalization, ideas which are driving the near universal dismantling of the welfare state, and eroding any notion we might have of the common good (Robertson, 1999)*

The way in which social problems are perceived has a direct effect on the type of policies implemented by those in power. George and Wilding (1994) suggest that social problems are viewed either as problems of deviance or problems of social disorganisation and that economic inequalities are often ignored as fundamental causes of social problems. This was evident in New Right philosophy during the 80s and 90s, exemplified by the expansion of prisons, harsher punishments and increased police powers. The New Right era saw increased poverty, unemployment and greater inequity of health outcomes. When New Labour came into power they sought to promote social cooperation and recreate a sense of community, encouraging individuals to not only fight for their rights but also to fulfil their responsibilities in the creation of a nation state. Their social reforms were based on long term strategies, seeking to 'invest in human and social capital', searching for a balance between individualism and social obligations within a whole systems approach

But despite this progressive veneer, there has been relatively little substantive change. What has gone on in the health field reflects New Labour's ambiguous approach in many other areas of public policy. On the one hand, there have been genuine reforms in the processes of government: 'joined-up policy making' and the cross-governmental strategies of the Social Exclusion Unit, the Cabinet Office and (latterly) the Office of the Deputy Prime Minister have made worthwhile contributions to both healthy public policy and public health policy. On the other hand, Whitehall departmentalism continues – as shown by the failure of key departments to contribute to the Cross Cutting Spending Review on health inequalities; and, more importantly, by the government's ever more determined pursuit of neo-liberal economic and trade policies and its deferential attachment to President Bush's neo-conservative programme. The steady opening up of the NHS to the private sector is of course wholly consistent with this.

The impact of this culture of government is increasingly affecting the NHS. The Private Finance Initiative – for whose disastrous effects on both services and budgets there is now widespread evidence (Commission on Public Private Partnerships, 2001; Pollock et al, 2001) – is increasingly being used as the basis for hospital expansion. And the 'creeping privatisation' represented by the increasing involvement of the private sector in the management of public sector health services is fast approaching the point of irreversibility, with the Prime Minister recently telling private healthcare executives that he wanted 'to open the whole of the NHS to outside competition' (Gulland, 2003).

And perhaps most worryingly, there is no sign of any reduction in health inequalities (Donkn et al, 2002; Davey Smith et al, 2002).

Politics is about values as well as about policies. The government often denies espousing any specific values, claiming that these are linked to the Old Labour past and that the way forward is value-free evidence-based policy and politics. There have been insufficient challenges to this empty assertion – not least because of the government's large majority, its controlling tendencies, and the extent to which the opposition shares many of its current attitudes. We would argue not

only that the evidence confirms that the government's policies are not working, but that the continuing failure to genuinely espouse participatory, egalitarian values (while from time to time paying lip service to them) and to acknowledge the political nature of health, can only be damaging to the future health of us all.

6: Politicising health: the Politics of Health Group

Western neo-liberal capitalism, combined with Cartesian reductionism, has become a powerful hegemonic force, nurturing the perception of people as customers and consumers and transforming the wonderful diversity of human 'being' and the process of living into a bland sameness - what Shiva (1993) calls a 'monoculture of the mind.' In essence, we are losing the perception of people as human beings with feelings, needs and relationships and are creating a way of life that makes us sick. The neo-liberal ideology that emerged from the Thatcherism and Reaganomics of the 80s is now a feature of 'socialist' governments both here in the UK and globally, testifying to its hegemonic nature. Therefore to continue to think that a welfare state could indefinitely 'exist in an island of socialism in a sea of capitalism' (Novak, 1988) is delusional.

Many, if not all, members of the new Politics of Health Group (POHG) are already involved in action to promote well-being and reduce inequalities. Since inequity is by definition unjust, the pursuit of equity can similarly be viewed as a political struggle for social justice. POHG must systematically support, develop and amplify this struggle. Like Adams, Amos and Munro (2002), we believe that *'health and illness are not primarily the result of individual choices or a genetic lottery … but of the social structures and economic interests that surround us'*. The Politics of Health Group should enable like-minded individuals to work together in synthesising theory and practice, developing practical solutions to the complexity of issues linking politics and health, and challenging the inequities in the distribution of resources and power relations. In effect, refocusing our efforts

upstream (McKinlay and Marceau, 2000). **Critical thought leads to critical action.**

What is to be done?

What action can we take, individually and collectively, to change things for the better, for the common good?

The core aims of the POHG might be:

- To discuss and develop ideas on the theoretical issues relating to the impact of power and ideology on the health of the public
- To campaign around these issues
- To undertake between- and within-country comparisons of important political determinants of health inequality

To achieve these aims we could:

1. develop a constitution
2. develop a seminar series
3. identify areas for collaborative research / reviews within and beyond the UK
4. develop a communication network – whilst an active e-mail discussion group has already been established, some thought should be given to the development of a website for the group's work
5. launch the Politics of Health Group nationally to raise the group's profile: this paper provides a natural vehicle. Onwards!

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