10. Action around the social determination of health[1]

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Introduction

The social determination of health has been starkly present in human societies from the beginning. The inequitable distribution of food is a long standing example. Migrations, wars and revolutions have been driven, at least in part, by hunger or poverty consequent upon social conditions. The 'environmental determinants of health' (from air pollution, to poor sanitation, to climate change) have likewise accompanied humanity throughout our evolution; often, but not always, amenable to social amelioration.

With civilisation the social determination of health emerged on the policy agenda (although not necessarily understood in terms of 'health' objectives) which led to innovations such as collective food stores, public water supply and new institutions and norms to govern distribution.

Modern public health, as a political project and a professional vocation, arose in the context of the Industrial Revolution although its antecedents can be traced back thousands of years in many different cultures. Public health refers to a project (seeking to protect and improve the health of populations); a profession (people with training and qualifications); and a set of institutions (government officials, legislation, inspections, etc). However, different projects, professions and institutions developed in parallel in other social 'sectors'. Town planners, educators, union officials, civic activists and political theorists also saw things which were bad or wrong. These were often the same wrongs which concerned the public health people but people in other sectors described, explained and advocated in different languages and adopted different logics, procedures and institutions to deal with them.

The term 'social determinants of health' has been widely used as a way of referring in aggregate to the various exposures and vulnerabilities which arise from the ways in which societies work (see, in particular, Commission on Social Determinants of Health 2008). However, Breilh (2008, 2013) and other epidemiologists in Latin America prefer to speak about the *social determination* of health; moving the focus from the factors and pathways (determinants) to the social relations within which the health of different groups is determined. The *social determination* paradigm does not disregard the factors and pathways but insists on locating them within a particular configuration of social relations and relations between society and the wider environment. The social determination paradigm encompasses

1. Work in progress. Feedback to dlegge(at)phmovement.org appreciated.

both social *and* environmental determinants (factors) insofar as they are socially (politically, economically) determined. I treat social and environmental determinants of health together in this chapter. While the specific hazards associated with the physical environment (radiation, contaminated water, insect vectors, etc) are very different from those of the social environment (powerlessness, alienation, obesogenic food environments, etc), the social and political determination of such exposures, vulnerabilities and protective have much in common.

Objectives

In this chapter I treat the topic 'Action around the social determination of health' from the perspective of the health activist (and perhaps the progressive activist more generally). I seek to address the following questions:

- Understanding. How might the activist understand (make sense of) the prevalence and distribution of preventable ill health globally?
- Strategy. What are the key strategic principles which might guide activist practice? What are the main domains of action which the activist needs to follow? What are the priorities for action?
- Practice. What are the forms of action to be deployed? What knowledges and skills will be needed?
- Capacity building. How to build the necessary skills, information, knowledge, relationships, organisation, culture, movement?

I approach these questions through a series of case studies regarding the social determination of population health. I then review the public health tradition, the formal institutions and professions which take as their explicit task the monitoring, protection and improvement of population health. I then draw out some generalisations, both from the case studies and from the public health tradition, which appear necessary to any comprehensive account of activism around the social determination of health. Finally I formulate some strategic principles which might inform the practice of activists. The discussion on activist practice in this chapter should be read in conjunction with Chapter 13 on activism, and Chapter 14 on building the people's health movement.

Cases

In this section I review a number of case studies involving activism around the social determination of health. These deal variously with hazards in the physical environment, in the social environment and risks which are incurred through individual behaviour. My purpose in reviewing these cases is to set out an empirical base from which we may draw out and test strategic principles to guide health activists in this area.

Sanitation and electoral reform

Edwin Chadwick was born in 1800 near Manchester in the UK. He trained as a lawyer and worked for a while for Jeremy Bentham, the social reformer. In 1832 he was employed by the Royal Commission into the operation of the Elizabethan poor laws. Later he was appointed as a commissioner. The Poor Law Commission was set up because of the increasing cost to the parish of welfare payments to poor but employed workers. The

Commission recommended (1834) the scrapping of 'outdoor relief', meaning that poor people had to be admitted to the 'workhouse' as a condition of receiving parish relief. Chadwick was appointed as secretary to the new Poor Law Commission set up to administer this new system and it was in this role that his 1842 report on the Sanitary Condition of the Labouring Population was produced. While his 1842 report canvasses a range of public health problems its main focus was on the threat of cholera (a threat to the whole population, not just the poor) and the most important recommendations concerned water supply, drainage and sewerage. He recommended a range of new legislative provisions to protect public health including improved statistics through the Registrar General and a 'central board of health'.

The structural model which Chadwick pioneered involved a single central board of health with a policy, directive and monitoring role over 'local boards of health' (based in local government) which would be responsible for building the infrastructure and inspecting and enforcing standards. Infrastructure costs would be met by local government rates on property owners. Under the Public Health Act of 1848 local governments were authorised but not obligated to set up local boards of health. The central board of health was set up in 1848 with Chadwick as sanitation commissioner and with the responsibility to drive local government authorities to clean up their municipalities. By 1854 (six years later) Chadwick had accumulated so many enemies among the property owning rate payers that he was forced to retire. He died in 1890.

Chadwick is remembered within the public health tradition for his indefatigable advocacy for sanitary reform. He is less celebrated for his role in the creation and management of the workhouse, a particularly nasty instrument of class discipline. It is important to locate Chadwick in the history of the times. Chadwick was born in 1800, 11 years after the British aristocracy was shocked by the French Revolution and the rising but disenfranchised capitalist class was inspired by the democratic vision.

Chadwick's appointment to the Poor Law Commission came in the same year as the Reform Act of 1832 which included major reforms to parliamentary electorates and extension of voting entitlement to males with a household worth more than £10. The electoral system had not been reformed since the Tudors and was notorious for 'rotten boroughs' through which a seat in the House of Commons was effectively owned by the local squire. In the early years of the Industrial Revolution the cities of Birmingham and Manchester grew rapidly but were effectively without representation in the House of Commons. Inspired in part by the French Revolution there was a growing social movement for electoral reform since 1789. In 1819 a demonstration in Manchester for electoral representation was suppressed with 15 deaths and up to 700 injuries (the Peterloo Massacre). There were further riots in Nottingham and Bristol in 1831 while the various reform bills were being debated in the Commons.

Manchester had been the centre of epidemiological research and public health advocacy from before the revolution in France including advocacy around typhus (with a focus on housing standards and public baths), typhoid and cholera (and the need for water supply and sanitation) and occupational safety. Dr Thomas Percival (1740-1804) was a leading figure in public health advocacy in Manchester at this time. While the main focus of the reform movement in Manchester, and in other parts of industrial England, was on electoral reform it was conducted in the context of continuing research, publicity and discussion regarding the public health issues.

Water supply, contagion and stink

John Snow (1813-1858) was 41 when in 1854 he urged the Board of Guardians of St James's parish in Soho in London to remove the pump handle from the Broad Street pump. Snow had conducted a careful survey of the distribution of cholera deaths and demonstrated that almost all had drunk from the Broad Street well which passed within a few yards of the sewer from Marshall Street 'where some cases of cholera had occurred before the great outbreak'(Snow 1854).

Snow was admirably cautious in claiming that the removal of the pump handle had caused the decline in the epidemic: *"The number of attacks of cholera had been diminished before this measure was adopted, but whether they had diminished in a greater proportion than might be accounted for by the flight of the great bulk of the population I am unable to say. In two or three days after the use of the water was discontinued the number of fresh attacks became very few."* However, having regard to comparable evidence from other episodes Snow was persuaded that outbreaks of cholera, and perhaps typhoid, were due to faecal contamination of water supply from cesspits, leaking sewers and stagnant drains.

Snow is rightly celebrated in the public health tradition, for his systematic mapping of the distribution of the cholera deaths and for his prompt action in recommending the removal of the pump handle. In the history of contagion his demonstration of direct contamination of the water supply is celebrated as further evidence in support of germ theory against the theory of miasma.

However, Snow's evidence from St James parish was not central to the policy making which finally led to the reconstruction of London's sewerage system and therefore the resolution of the hazard of sewage contamination of drinking water. Londoners had drawn on the River Thames for drinking water for hundreds of years and until 1815 household waste was not permitted to be dumped or drained into the Thames. Rather human waste was discharged into the soil via cess pits under houses which were supposed to be emptied periodically. As the population of London increased the frequency of cesspits overflowing or being emptied in the Thames increased with increasing contamination of the water supply. This was greatly exacerbated by the introduction of the water closet or the flush toilet from the 1850s onwards and the policies of the Metropolitan Commission of Sewers (1848-1856) (including the redoubtable Chadwick as a commissioner) which sought to close all cess pits and connect latrines to the network of legacy sewerage systems which flowed into the Thames (and then back to the city's water supplies). Around 30,000 cesspits were closed in this time and the flow redirected via the network of variously constructed sewers into the River (Bazalgette 1865).

The final decision to proceed with the construction of a new sewerage system for London was precipitated, not by Snow's meticulous epidemiology, but by the Great Stink of 1858 which made the houses of parliament an extremely unpleasant workplace for the politicians. The Great Stink was fully compatible with miasma theory although Joseph Bazalgette, the chief engineer who led the re-construction of the sewerage system from 1859 commented (1865) that,

> "In 1849 the deaths were 18,036, and in 1854, nearly 20,000; and although great differences of opinion existed, and continue to exist, as to the causes of the disease, yet an inspection of the houses in which deaths occurred was sufficient to show that, however

> occult might be the connection between death and defective drainage, the places formerly most favourable to the spread of disease became quite free from it, when afterwards properly drained."

The delay in sewerage reconstruction was less due to science and more to the politics of local government. Following the Reform Act of 1832 (which reformed parliamentary electorates and voting entitlements) came the Municipal Corporations Act of 1835 which was designed to encourage the establishment of elected local government bodies with responsibilities including urban infrastructure such as sewerage works – to be funded by rate payers. The rate payers of the City of London, however, were able to keep the reformers away from the City and delayed until 1855 the establishment of the Metropolitan Board of Works which, following the Great Stink in 1858, finally undertook the reconstruction of London's sewers (including the diversion of the outfall to much further downstream) from 1859.

It is not to diminish the achievement of John Snow to point out how the politics of local government, including the power of the landlord class and the special privileges of the City of London, held up the establishment of sewerage; how the Great Stink achieved what hundreds of thousands of deaths had failed to do; and how irrelevant to the engineering of London's sewers was the debate between miasma and germ theory. It is well to remember that the reconstruction of the sewerage system in Paris was undertaken under instruction from Napoleon between 1805 and 1812. Interrogation of the history of the sewerage of London might be best cast in terms of why it took so long rather than the role of germs versus miasma in shaping public policy.

John Snow's unfortunate contribution to policy making around the occupational hazards of 'offensive trades' (and the stinging criticism this earned him from Thomas Wakely, the founding editor of The Lancet) is less well remembered than his indictment of the Broad Street pump. [To be elaborated upon shortly].

Housing, poverty and economic development

Rudolf Virchow (1821-1902) is claimed as an ancestor by both pathology and public health. He also made important contributions to anthropology. Virchow graduated in 1843 and from 1843 to 1849 undertook ground breaking research in pathology (including in cell biology and blood clotting). In 1848 he was commissioned by the Prussian government to investigate an outbreak of hunger/typhus in Upper Silesia; his particular brief was 'to carry out a close investigation of the epidemic in the interest of science'.

Upper Silesia is now a province of Poland but at the time of the epidemic it had been a Polish speaking province of Prussia. Virchow (2006[1848]) describes it as economically backward, dominated by feudal land-owners and the Catholic Church; and badly neglected by the government in Berlin; he is particularly critical of the Minister of the Interior for this neglect. It is not clear how many people died in the famine-epidemic but Virchow estimates it at around 10% of the population which was around 1 million. Virchow describes bad harvests for the preceding three years and is scathing about the failures of disaster relief.

Virchow provides a meticulous description of the clinical features of epidemic typhus and explores in some depth what can be learned from the epidemic about the origins and transmission of the various diseases. It is of interest to read his reflections on marsh miasma

as the cause of malaria and the origins of typhus in a miasma of animal origin. In relation to the dysentery he contemplates unripe and indigestible vegetable matter. He points out that the wells from which people draw their drinking water are not deep and could be polluted by 'decomposing vegetable products'. He reviews the necessary arrangements for managing the epidemic including the observation that patients should be nursed at home because the mortality rates for hospitalised patients were significantly higher.

Virchow provides a detailed account of the living conditions (in particular bodily hygiene and housing); of the social and political conditions (including their very recent emancipation from serfdom); and of the economy. His comments on the possibilities for strategic investments which could boost the local economy are worth noting. He comments that the region is rich in mining resources and some local people make a living from transport of the produce of the mine. He comments that a relatively small investment in roads could boost the earnings of the local people from cartage of mining products. He comments on the scope for development of weaving and fishing both of which are constrained by tariff barriers to export.

Virchow describes a cowered population, subservient and slothful and addicted in the extreme to the use of spirits but 'it should nevertheless not be forgotten under what conditions, under how long and heavy a pressure, this unhappy people has groaned'. He then elaborates on German colonialism, feudalism, oppression via the Church and the Prussian bureaucracy.

In the final section of his report Virchow puts together his recommendations for preventing famine typhus epidemics in future. In short it is 'free and unlimited democracy'. He reviews the failure of the organised Prussian bureaucracy to prevent or manage the epidemic, despite the institutions which were notionally obligated to do so. This failure of bureaucracy he demonstrates is due to the lack of accountability to the people of Upper Silesia. He rails against the dominance of the economy by feudal landlords who exploit the small farmers and hold back economic development. This brief summary does not do justice to the clarity and force of his text which should be read in full. (See pp 88-99 in Virchow 2006[1848].)

Following his return to Berlin from Upper Silesia Virchow was involved in the democracy movement which led to the revolution of 1848 and was for a time forced to give up his appointment at the prestigious Charité hospital and go and work in Wurzburg. His long and distinguished career includes a period as a member of parliament, a famous duel with Bismarck and further important research findings. He is particularly remembered in the public health community for 'politics is nothing but medicine at a larger scale'.

Virchow serves as a symbol for a number of important principles of continuing and sharp relevance for health activists. Commitment to, and achievement in, biomedicine is not incompatible with a sophisticated understanding of social and political sciences nor with political action around the social determination of health. On the other hand the necessarily close relationship of statutory public health to government carries risks of bureaucratic failure. The fact that Virchow was working with a miasmatist explanation for contagion and did not understand the microbiological cause of typhus and its transmission did not stop him from accurately diagnosing the economic, political and governance dynamics which drove the epidemic nor from pointing clearly towards the economic, political and governance

reforms which might 'safeguard the future'. On the other hand a clearer understanding of the role of the louse in the transmission of typhus would have added weight to his findings regarding cleanliness and decent housing.

Economic development versus institutional reform

19th century England provides a useful context for exploring another important domain of public health debate, centring around the contributions to health improvement of various different influences, including: economic development (funding for public infrastructure, wider household choices); public health institutions (regulations, inspections, education, etc); changes in social relationships (eg between labour and capital, men and women, etc) and changes in the institutions and norms of governance (franchise, freedoms, dialogue, etc).

In a series of papers and books from the 1950s the British demographer, Thomas McKeown (1979) elaborated an influential account of the causes of health improvement in late 19th century Britain. McKeown was working at a time of rapid technological development in clinical medicine, accompanying which was a confidence, bordering on arrogance, regarding the limitless future of diagnostic and therapeutic technologies. McKeown and his colleagues sought to caution against such clinical hubris by demonstrating the very limited role of medicine in the improvement of population health in the 19th century in comparison to the roles of public health and economic development.

McKeown categorised the major causes of death across the period in accordance with patterns of causation. He acknowledged the role of water supply and sanitation in reducing water-borne diseases but concluded that the major contributing factor was improved nutrition associated with increased household income due to economic growth and increased wages.

Simon Szreter (1988) has criticised McKeown's conclusions on methological grounds and offers more complex interpretation. Szreter argues that McKeown underestimated the decline in waterborne diseases as a consequence of the progressive development of clean water, drainage and sewerage in the provincial cities as well as in London. Szreter argues that McKeown's focus on improved nutrition through the 'invisible hand' of economic growth, as well as being empirically incorrect also risks overlooking the importance of sanitation and the advocacy of the public health movement. Szreter locates the public health advocacy within the wider struggle for universal suffrage which was achieved finally in 1927. However, there were many small battles along the way from the Reform Act of 1832 (and the abolition of the rotten boroughs), to the Municipal Reform Act of 1835 which commenced the process of opening up local government, through to the progressive widening of suffrage to adult males, and then to women.

According to Szreter the main focus of public health reform in the latter part of the 19th century moved from London to the provincial cities where the political conditions for public health reform were more supportive, partly because local government in the provincial cities was more progressive than in London (owing to the resistance of the City of London to any reform). In London as well as in the provincial cities there was a vigorous public health movement; one of the most prominent organs of this movement was the Health of Towns Association with similar organisations around the country(Porter 1999, Hamlin 2012).

During the 19th century there was a continuing interplay between specific public health and other social issues and the governance issues of electoral reform, the widening suffrage

and the central versus local debates. Thus sanitation (like child labour, food adulteration, factory safety and hours of work) figured prominently among the grievances of the trade unions and the various reform movements (the 'radicals') but the political demands were more focused on governance reform.

Virchow's comments about how to prevent future famine – epidemics in Upper Silesia point to similar relationships. Virchow pointed out how economic development had been neglected, pointing particularly to road building, but attributed this to governance failure which he attributed to the continued dominance of the land owners and the colonial relationship of the Prussians to the Polish speaking people of Upper Silesia.

Asbestos

There are important lessons to be drawn also from the field of occupational health and safety. LaDou (2004) estimates that the asbestos cancer epidemic may take as many as 10 million lives before asbestos is banned worldwide and exposures are brought to an end. Many more will have been killed or disabled by asbestosis. Dalton (1979) tells of a British asbestos spinner aged 32 who in 1899 told his chest specialist that he was the last survivor of ten workers in the shop with whom he first started working. They had all died at around 30. He died the following year. Dust exposure standards were finally adopted in 1933 but they were not inspected.

From 1945 to 1976 in outback Australia a small Aboriginal community provided the workforce for a small asbestos mine (McCulloch 2007). Conditions were foul. Asbestos dust in the mine and in the mill was often so dense as to reduce visibility. *'When you walked in it was impossible to see anywhere. Even the operator standing beside you was practically invisible'* (Jerry Burke, evidence before the 1983-84 Inquiry, Sydney, 7 February 1984; cited by McCulloch 2007). The dusty workers' clothes were washed by their wives in the local creek and they too were exposed. Tailings from the mine were used to level the roads and driveways.

LaDou (2004) claims that the asbestos cancer epidemic would have been largely preventable if the World Health Organization (WHO) and the International Labor Organization (ILO) had responded earlier and responsibly. He attributes the weaknesses in the WHO and ILO recommendations to the influence of asbestos industry advocates, including technical bodies dominated by industry personnel. Tomatis (2004), a sometime director of the International Agency for Research on Cancer, acknowledges the weaknesses of the ILO and WHO recommendations but points out that the policy making of these organisations is strongly influenced by member states, many of whom have long ignored the hazards of asbestos (eg Canada, USA, Russia).

Intergovernmental bodies like WHO and ILO are part of the OHS system but the 'system' which has prevented a universal ban (Collegium Ramazzini 2010) also includes the national occupational safety and health authorities, researchers, company doctors, unions and corporations. The decline of the trade unions in recent decades has further weakened the accountability of this 'system'. By 2010, only 52 countries had banned asbestos use.

Another important institution in the global governance of asbestos is the Rotterdam Convention on the trade in hazardous chemicals. The Rotterdam Convention (1998) provides that for certain hazardous chemicals (those listed on Annex III) 'prior informed consent'

(PIC) must be obtained from the importing country before those chemicals can be traded. While blue asbestos (crocidolite) and brown asbestos (amosite) are listed and are being progressively replaced in production, the Russian industry is mounting a rearguard action to prevent chrysotile ('white asbestos') from being listed.

Since 2004 the Russian Federation, on behalf of its asbestos industry and with the assistance of Kazakhstan, Canada and a handful of other countries, has fought to prevent chrysotile from being listed in Annex III of the Rotterdam Convention.

The WHO-sponsored International Agency for Research on Cancer (IARC) advises (IARC 2013) that chrysotile is a human carcinogen but that the expected cancer burden from chrysotile will be mainly lung cancer rather than mesothelioma. It appears that while crocidolite is a powerful cause of both lung cancer and mesothelioma, the cancer burden from chrysotile tilts much more towards lung cancer than mesothelioma.

WHO and IARC have concluded that all forms of asbestos are carcinogenic; that no safe threshold has been identified; and that it is extremely difficult to control asbestos exposure in the workplace (Fukuda 2013). However, Russia and Kazakhstan (supported until recently by Canada) argue that the mining and processing of white asbestos can be made safe (Ustinov and Karagulova 2013). Even if this contention were supported by the evidence, which it is not, it has no bearing on the logic of Annex III of Rotterdam which is that countries, to which Russia and Kazakhstan hope to export their chrysotile, should have the right to give or refrain from giving prior informed consent or to place conditions on such prior informed consent.

In a previous round in this debate, a delegation from importing countries lobbied the Canadians over the export of chrysotile asbestos, arguing that many Asian countries have poor or non-existent asbestos regulations in workplaces, and those that exist are poorly enforced (Kirby 2010). More recently (May 2013) a WHO representative warned the 6th Conference of the Parties to the Rotterdam Convention that: "…owing to the widespread use of chrysotile in building materials and other asbestos products it was not possible to prevent the exposure of workers and the general public. Furthermore, the chemical could not be used safely owing to the way in which products containing it were produced and handled and degraded in situ, as well as the challenges that they presented in decommissioning and subsequent waste management. She added that WHO and IARC had conducted an evaluation of fibrous chrysotile asbestos substitutes and had concluded that safer alternatives were available". Nonetheless the chrysotile exporters were able to prevent listing of chrysotile yet again (COP6 2013).

Matt Peacock's (2009) chronology of the greed, cynicism and dishonesty of business people, lawyers, doctors, politicians and spin doctors associated with James Hardie (for many years the largest producer of asbestos products in Australia and latterly the only producer) provides useful insight into the continuing struggle to control asbestos exposure globally. Some of the key elements of this background include the following.

- By the 1920s it was known that occupational exposure to asbestos led to fibrous scarring of the lungs (asbestosis) and a high death rate. By the 1950s it was known that occupational exposure was associated with a much higher rate of lung cancer deaths than would otherwise be expected. By the 1960s it was

known that occupational exposure led to mesothelioma, a cancer of the lining of the chest wall or abdominal wall. By the 1960s it was also clear that public exposure to asbestos dust (dumped tailings, working with building materials, washing family members work clothes, etc) was associated with asbestosis and probably lung cancer, mesothelioma and other cancers.

- Despite the science, James Hardie directors and executives, supported by lawyers, spin doctors, occupational physicians, government officials and pliant politicians, continued to deny, diminish and obfuscate the hazards of asbestos. However, in 2004 Meredith Hellicar, then board chair, explained to Peacock that it was just a 'big mistake'.
- The exposure of the reality was due to the courage and commitment of (some) unionists (such as Bernie Banton) and officials; the integrity of (some) scientists; the persistence and competence of (some) litigation lawyers; and the professionalism of journalists such as Peacock and before him Paul Brodeur (1974).
- Ultimately it was the pressure of litigation and compensation which forced asbestos out of the manufacturing supply chain in Australia, rather than effective statutory regulation.

Peacock's book also documents the withholding of information from workers; failure to implement the most basic occupational protections; the widespread dumping of tailings; the role of hessian bags in exposing both workers and public; deliberate court delays so that litigants would die before settlement; and much more.

From 1989 Hardies had built what became a highly profitable subsidiary in the USA (not involving asbestos containing products) and was therefore less dependent on asbestos based products in Australia. However, in the late 1990s the tsunami of compensation claims was approaching (from occupational and public exposure) and the board adopted a devious plan to cap its exposure to such claims. This plan involved:

- moving the parent company to Holland partly because of its low taxes and partly because Australia did not have a treaty with Holland for the reciprocal enforcement of legal judgements;
- setting up the Medical Research and Compensation Foundation with the public promise that it would be 'fully funded';
- hiding and minimising the actuarial predictions of likely successful claims into the future against Hardies;
- locating the rump of Hardie's assets in Australia as a subsidiary to the foundation and selling shares in the Australian shell to the Dutch parent, but not fully paying for the shares;
- partially funding the foundation up front but promising that in the event of a shortfall the shares would be fully paid for entailing a substantial reinfusion of money to the foundation; and
- finally and secretly cancelling the shares.

The plan sort of worked. The foundation was established in 2001 but the directors of the foundation discovered sooner than expected that they were seriously underfunded and

relations with Hardies deteriorated. So, instead of locating the Australian shell in the foundation, a new company was formed for this purpose with the partly paid shares vested in the new company. This enabled the board of Hardies to cancel the shares (in 2003) without the knowledge or cooperation of the foundation.

In the years following the establishment of the foundation the directors of the foundation complained increasingly about underfunding. Hardies argued that the problem was laxity in the statutory compensation arrangements in New South Wales (NSW) and argued for legislation to curb compensation payments. By 2004 the rat was smelling worse and the NSW government set up a special commission, the Jackson Commission, to investigate how a fully funded foundation had run out of money and whether the problem was skulduggery or overly generous compensation payments.

The bomb exploded when the Commission was told about the cancellation of the shares and that the Supreme Court had not been told of the share cancellation when it sanctioned the transfer to the Netherlands. The Commission's report (2004) was not kind to Hardie's directors, executives or its lawyers. However, it did not recommend criminal prosecution.

A long period of brutal negotiation over Hardies funding obligation followed the Jackson Commission. Hardies refused to make good its promises of full funding but the NSW government stood firm and progressively upped the pressure on Hardies: the findings of the Commission were shared with the US Securities and Exchange Commission; legislation was passed to allow all the documents collected by the Jackson Commission to be shared with the Australian Securities and Investment Commission (ASIC) and the Australian Consumer and Competition Commission (ACCC); legislation was foreshadowed to unwind the transfer to the Netherlands. Finally (February 2007) a deal was done and Hardies agreed to further funds for the foundation. However, a year later the sub-prime mortgage crisis hit the housing market in the USA and Hardie's US profits plummeted. Finally, the Commonwealth and NSW governments were forced to step in to support the foundation.

On the 15th February 2007, one week after Hardies and the NSW government signed their truce and one day before the statute of limitations would expire regarding the setting up of the foundation, ASIC launched civil proceedings against a number of directors, executives and advisors. The proceedings turned on the promise of a fully funded foundation which was clearly deceit. The ruling of the NSW Supreme Court (April 2009), ultimately supported by the High Court (in 2012), was extremely critical of the Hardies team. However, no-one has gone to gaol and the liars and cheats continue to protest their integrity and enjoy their wealth.

John Della Bosca, the NSW industrial relations minister during this period, described to Peacock an interview he had with then CEO of Hardies, Peter Macdonald, in February 2004, just before the Jackson Commission was announced.

> *He wasn't angry, he wasn't rude, he just very calmly said to me: 'You can't do this to us. You're a pissy little provincial government. You can't stop us. We're now a global company and we have done what we think was in our shareholders' interests. That's my job and that's what I have done. And if you have a different view, well, you go get yourself a multi-billion-dollar company, become its chief executive and you can have a different view. (p 247)*

So, what kind of light does the Hardies saga throw upon the defence, by the Russians, Canadians and Kazakhstanis, of their right to continue to export asbestos products to developing countries with weak regulatory structures without ‘prior informed consent’?

The tactics are remarkably similar: lies and spin, drawing on tame professionals to obfuscate and delay, and leaning on government officials and diplomats to front the play. The stakes are also comparable. Peacock ends his book with a reference to 20,000 Australian families which have been affected by Hardie’s products. We do not have an estimate of the numbers of families who have been and will be affected by the export of Canadian, Russian and Kazakhstani asbestos but it likely to be many orders of magnitude greater.

Is there something about asbestos (or tobacco or banking) which poisons the morality of businesspeople, lawyers, consultants and officials? Or do these cases simply reveal more clearly how the disciplines of capitalism work because of the longer lag times, the higher profits, and the more appalling consequences.

And what are the omens for effective regulation or honourable business practices under neoliberal globalisation? The power of money and spin to corrupt democratic process is not new but globalisation has given new powers to the corporate sector: the race to the bottom through competitive deregulation. To this is now added the pressure to incorporate investor state dispute settlement into trade agreements (such as the Trans Pacific Partnership Agreement), threatening governments (particularly small governments) with hugely expensive litigation from transnational corporations with very deep pockets and close friends on the tribunals.

In the halls and corridors of global health governance the new jargon is multi-stakeholder forums, collaboration with the private sector, and win-win outcomes. Indeed it is regarded as poor form to even mention regulation. What are the implications of the asbestos case study for the regulation of pharmaceutical marketing or for junk food?

Aggressive marketing by big pharma drives the over use and misuse of pharmaceuticals with consequences for health care expenditure and corporate profits. In the case of antibiotics it is driving antimicrobial resistance and the obsolescence of most of our antibiotics. Getting big pharma to accept effective regulation of pharmaceutical marketing is less likely than Russia and Kazakhstan accepting the Rotterdam Convention.

The asbestos example does not bode well for more effective regulation. As more countries get locked into investor state dispute settlement provisions through trade agreements meaningful regulation at either national or global levels will become much more difficult.

Effective regulation of the corporate sector at the national level is difficult; much more difficult at the international level (Braithwaite and Drahos 2000). Understanding the political economy of particular industries and of the wider economy within which they are embedded is a basic prerequisite. However, building a constituency across sectors and countries that can overcome the threats, spin, and bribes of the corporate sector, at both the national and international levels, is where the deep challenge lies.

There are important lessons from the asbestos story. First, it is clear that the corporations will go to extraordinary lengths to maintain their rights to expose workers and

communities to health hazards if moving to alternative technologies carry significant extra costs. In contested industrial environments governments will not mandate effective prevention nor inspect nor prosecute their own standards unless there is a sufficiently powerful constituency based in the trade unions, in public health and in the wider community.

The science in such cases is never neutral. The companies have always been able to recruit doctors and hygienists who are willing to lend their professional authority to the defence of the corporation. Likewise scientists and public health advocates who argue for effective regulation of asbestos exposure and who testify in litigation around asbestos disease can expect to be vilified as partisan and not objective. It should be no surprise that the ideological world views that characterise different social classes are to be found within the professions of public health, occupational health and health promotion.

However there are also certain values which characterise the professional mindset of health professions including public health and medical research and these include valuing good health highly and condemning preventable toxic exposures.

However, there is also a certain bureaucratisation of professional and institutional culture which places a high value on remaining in that field of exclusive claimed expertise and avoiding straying beyond professional boundaries the consequence of which is a professional avoidance of the social, political and economic in favour of the specific hazard and specific intervention; and a failure to see past the reductionist research paradigm.

More stories from the asbestos tragedy can be found in Berman (1978) and Selikoff and Lee (1978).

Tobacco control

[In a future version of this chapter there will appear an account of the successes and failures of the campaign against tobacco use.

We will trace how the many different strands of this story have intersected and inter-related:

- the emerging science
- the early social marketing campaigns
- the encroaching regulation
- the rise of litigation around second hand tobacco smoke exposure
- the interplay between litigation and regulation
- the struggle for the FCTC
- the release of the documents

Our purpose in this section will be to trace what can be achieved, in terms of corporate regulation, in relation to a universally reviled industry and what this tells us about the regulation of food and alcohol and other health damaging industries.

Much has been achieved in relation to tobacco control on a one industry basis but it is likely that further progress in relation to other health damaging industries will need more far-reaching regulatory reform bringing transnational corporations under democratic control.]

Mutton flaps and turkey tails

Trade relations (the flow of goods, services, people and capital) affect health. For several hundred years the main involvement which public health officials had with trade concerned quarantine of ships in cases of plague or yellow fever or other epidemics. A sequence of international conferences, involving public health and trade officials, during the 19th century, evolved into the League of Nations Health Organisation and from 1948, the World Health Organisation. The agreements regarding quarantine and infectious disease notification became the International Health Regulations.

However, from the formation of the World Trade Organisation in 1994 concerns about the implications of trade agreements for public health were expressed increasingly commonly in the World Health Assembly.

- Resolution WHA49.14 (May 1996) on the Revised Drug Strategy in which the implications of the TRIPS Agreement for access to medicines is highlighted;
- the October 1998 Geneva workshop on the Revised Drug Strategy in which the importance of TRIPS flexibilities was highlighted and in which Dr Brundtland foreshadowed the importance of WHO engaging with the issues of policy coherence across trade and health;
- Resolution WHA52.19 (May 1999), again on the Revised Drug Strategy, which requests the DG to assist members (at their request) in developing policies and regulations which address the implications for pharmaceutical and health policy objectives from trade agreements and assist countries to 'maximize the positive and mitigate the negative impact of those agreements';
- the Doha Declaration on Public Health adopted by the WTO Ministerial Council in 2001; clearly the discussions within WHO contributed to the support for the full use of TRIPS flexibilities which is reflected in that Statement;
- the 2002 WHO and WTO report on the intersections between trade and public health which foreshadows clearly the institutional mechanisms needed to support policy coherence across trade and health;
- Resolution WHA56.27 in 2003 on Intellectual Property, Innovation and Public Health which highlights the need for member states to make full use of the flexibilities of the TRIPS agreement in enacting the corresponding domestic law;
- the 2003 the Western Pacific Regional Office of WHO (WPRO) produced a report on the use of domestic law in the fight against obesity which includes an extended discussion of the implications for the Agreement on Agriculture, the SPS Agreement and the TBT Agreement in seeking to reshape the Pacific food environment;
- the inter-regional workshop on trade and health hosted by SEARO in 2004 explored a range of issues associated with trade health policy coherence;
- in May 2006 the WHA adopted resolution WHA59.26 on trade and health which urged member states to be conscious of the need for policy coherence across trade and health and authorised the WHO to provide advice as required regarding the intersections of these fields.

WHO's work in the field of trade and health has been very controversial with repeated criticisms and harassment from the USA in particular. WHO depends heavily on donor funding to implement the resolutions of the WHA and there has been very little support from the donor states and other bodies for WHO's work in this field.

The experience of the Western Pacific Regional Office of WHO in seeking to address the implications of trade for health, primarily in the context of NCDs in the Pacific, is salutary. The 2003 WPRO report on the use of domestic law in the fight against obesity (WPRO 2003) canvasses in some detail the intersections between regulation for health and the agreements on Agriculture, SPS and TBT.

Among the more contentious issues in the Pacific were the attempts of Samoa to restrict the import of turkey tails (largely from the US) and Fiji and Tonga to restrict the import of mutton flaps (from Australia and New Zealand).

As consumers in the US, Australia and NZ have cut back on their intake of animal fat, the prices of very fatty cuts, in particular turkey tails and mutton flaps, has fallen. Since the market for these cuts in the US, Australia and NZ is shrinking, producers look to the export market and to developing countries where low prices plus the taste of fatty meat supports significant sales.

Among public health advocates in the Pacific Island countries cheap fatty meat cuts are seen as important contributors to the growing prevalence of obesity and non-communicable diseases. In this context the interplay between trade relations and public health is of critical importance.

Thow and her colleagues (Thow, Swinburn et al. 2009) describes how the Government of Samoa banned turkey tail imports in August 2007[2].

> "The ban was a response to concern over both the impact of fatty meat on health and the 'dumping' of perceived 'low quality' food on the market. Samoa has very high rates of non-communicable diseases (NCDs), and medical treatment costs are also high. Fatty meat consumption is perceived as a major risk factor for NCDs, and the Ministry of Health has actively raised awareness among policy makers of the importance of healthy diets for disease prevention. In relation to dumping, there has been longstanding awareness and concern regarding the import of large quantities of cheap, perceived 'low quality' food."
>
> "As a direct outcome of the ban, turkey tail imports ceased from August 2007. As turkey tails imports were duty free, banning them did not cause a loss of government revenue. The Ministry of Commerce and retailers reported receiving only a few consumer complaints – there was a slow decrease in turkey tail supply and customers knew that they were banned. Retailers and wholesalers did not report any loss of profits from the ban..."

Thow reports that Samoa received a request from the USA for further information about the ban. "Samoa was at that stage in the process of acceding to the World Trade Organization (WTO) … concerns were raised by public servants that the ban was never 'justified' appropriately."

A subsequent report from Bloomberg (Gale 2011) updates this story.

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[2]. References deleted from the excerpts from Thow et al.

> “After a 13-year wait, the South Pacific island nation of Samoa should win approval to join the World Trade Organization next month after dropping its ban on turkey tails. The WTO welcomed the nation, with a population of about 193,000 (a bit more than Knoxville, Tenn.) once Samoa agreed to end its ban on the fatty poultry scraps and impose import tariffs instead. That’s good news for U.S. turkey farmers, who will regain a market for the low-value trimmings that often end up in pet food, says Roman Grynberg, a trade official for the Pacific region until 2009.”
>
> “For Samoa, one of the world’s most obese nations, the deal is a mixed blessing. These are the contradictions we have to face—where health is compromised for the sake of trade and development,” says Palanitina Tupuimatagi Toelupe, Samoa’s director general of health. The U.S. food industry sees the issue differently. “We feel it’s the consumers’ right to determine what foods they wish to consume, not the government’s,” says James H. Sumner, president of the USA Poultry & Egg Export Council.”
>
> “Samoan negotiators defend ending the ban as the only way to enjoy the increased trade and lowered costs of imports that WTO membership confers. “It filters down to the normal customer who will now have access to a wider variety of goods,” Namulauulu Sami Leota, president of the Chamber of Commerce, told the Samoa Observer newspaper. Reaching an agreement “was not an easy task,” added Namulauulu, who was involved in the final talks. Keith Rockwell, a spokesman for the WTO in Geneva, says the ban “was an issue on which Samoa took quite a tough line.”

Thow et al also describe how Tonga considered a similar ban on the import of lamb flaps:

> “In early 2004, the Tongan Minister for Health and other members of Cabinet offered in-principle support to the development of a draft cabinet paper restricting mutton flap imports. The paper was commissioned by the WHO Western Pacific Regional Office as a component of the recently developed NCD strategic plan, and the work was carried out by a team from Deakin University, Australia. The resulting draft ‘Fatty meat import quota Act’ was part of a broader paper designed to support the Government of Tonga in developing and implementing legislation to support healthy food consumption. However, the Act was not submitted to Cabinet due to concerns that it would complicate Tonga’s negotiations for accession to the WTO, which was in process at the time.”
>
> “The proposal was to apply an import quota (restriction on volume imported) to any product that had >40% energy from fat, was readily identifiable by import coding, and contributed significantly to fat and saturated fat consumption of Tongans. At the time, only mutton flaps fulfilled all criteria. The authors calculated that replacing 50% of mutton flap consumption with the same weight of fish would reduce energy intake by a clinically important magnitude of about 400 kJ/week per person (approx 100 kCal). An import quota was chosen as the strategy because availability appeared more significant than price in determining consumption. […] “
>
> “The detailed proposal included strategies for policy implementation and monitoring. The proposal acknowledged the potential issues with the WTO inherent in restricting trade through the use of a quota, but concluded that the restriction was justified because of the obvious health effects. High levels of mutton flap consumption, linked to rising rates of diet-related chronic disease, had been perceived as a problem in Tonga for at least a decade. […]”

> "The proposal was first articulated at an NCD workshop in October 2003, at which "participants recommended reducing availability of imported fatty meats as a priority activity to prevent obesity". The Minister for Health supported this recommendation and raised the proposal at a Cabinet meeting. However, concerns about the policy's acceptability in light of ongoing WTO accession negotiations by the Ministry of Labour (focus for WTO negotiations) resulted in the submission of the paper to Cabinet being postponed. Under WTO trade rules quotas are perceived as highly trade distorting because they prevent (international) supply from responding completely to (domestic) demand. Additionally, the fact that Australia and New Zealand are the main source country for flaps – as well as being significant sources of aid for development – means that Tongan policy makers on the WTO accession committee were concerned that proposing an initiative to reduce the supply of mutton flaps would reopen negotiations with Australia and New Zealand."

Bloomberg (Gale 2011) provides further detail:

> "Fiji and Tonga waged a fight similar to Samoa's a decade ago when they tried to curb imports from New Zealand and Australia of an especially fatty cut of meat known as lamb or mutton flaps. Fiji banned flaps in 2000. When Tonga considered imposing a quota, New Zealand embarked on a campaign against it, says Timothy Gill, principal research fellow at the University of Sydney's Boden Institute of Obesity, Nutrition, Exercise, and Eating Disorders. "We couldn't work out why there was such a big thing about a relatively small segment of the market," Gill says, adding that the New Zealanders pressed their case at a Commonwealth Health Ministers meeting in Christchurch in November 2001. "From the Prime Minister down, they were all there lobbying."
>
> "Trade bans on selected items are unlikely to be effective in addressing obesity and health issues," a spokeswoman for Tim Groser, New Zealand's Minister of Trade, said in an e-mail. […]"
>
> "Tatafu Moeaki, Tonga's Secretary for Labour, Commerce and Industries, says that after studying the issue in more detail, policymakers found that higher import duties on the flaps wouldn't dent demand enough to improve public health. Moeaki says Tonga, which joined the WTO in 2005, is now preparing food standards that will determine which items fall outside a healthy range and warrant higher taxes to deter consumption. He says the importing nations have been left to figure out which foreign goods are detrimental to health—a "relatively expensive" process for a small country."

Further insight into the stories from Samoa and Tonga comes from the debate within the WPR Regional Committee in 2008 over the WPR Regional Action Plan for NCDs (WPRO 2009). The draft regional action plan submitted to the Regional Committee includes a passage (page 13) which says that Member States shall:

> "engage with other Member States and relevant regional and international bodies to address NCD risk factors and disease issues that cross national borders. As examples, consider the public health impact on respiratory health during cross-country discussions on haze control, and *incorporate health impacts of unhealthy products in trade agreements*, such as those arising from the Association of South East Asian Nations (ASEAN) and the Pacific Island Countries Trade Agreement (PICTA)" [emphasis added].

Further, on p 33, the draft Regional Action Plan included among the recommended actions for WHO:

> "assist Member States to establish and use cross-country alliances, networks and partnerships for NCD capacity-building, advocacy, research and surveillance (e.g. Alliance for Healthy Cities, MOANA). Cross-country alliances can also facilitate unified responses to transnational issues that affect non-communicable diseases, *such as trade issues and global marketing of unhealthy lifestyles*. For example, follow-up on the conclusions of the Meeting of the Ministers of Health of the Pacific Island Countries in Vanuatu, which call for engagement with the food and trade sectors to ensure that the health impact of trade agreements on diet is minimized" [emphasis added].

The intervention of the US in this debate, intervening by virtue of its status as a colonial power in the Pacific, provides some insight into the underlying dynamics (WPRC 2008, page 147-8).

> "Mr Villagomez (United States of America), commenting that effective control of chronic diseases required wise programming and wise use of resources, said that the proposed Regional Action Plan overlapped with a number of others that had been adopted globally. Rather than duplicating those initiatives, the Regional Office should ensure that Member States fulfilled their obligations to implement the global strategies. They were relevant throughout the Region, for all political, language, cultural and at-risk groups; therefore, their implementation would be effective and sustainable and improve health at country level."
>
> "Globalization and urbanization were important factors in the treatment and surveillance of non-communicable diseases, *but they were not "conduits for the promotion of unhealthy lifestyles"*. Furthermore, the document advocated transnational environmental control by regional forums such as the Association of South East Asian Nations (ASEAN), whereas the Regional Office's primary role was to make health-based interventions. The key to reducing morbidity and mortality from non-communicable diseases was prevention. The Regional Office should focus on surveillance, setting norms and standards and designing models for the organization of care. Prevention should be done at the community or even individual level, whereas the document focused on interventions by governments, industry and nongovernmental organizations. *Diet, physical activity and health behaviour involved complex personal choices and individual priorities. The Regional Action Plan should address those complexities and the responsibility of individuals in changing their behaviour*." [Emphasis added]

As a consequence of Mr Villagomez's intervention a new clause was added to the resolution adopting the regional action plan, acknowledging the importance of personal responsibility for individual behaviour. However the Regional Action Plan was adopted by the Regional Committee.

Many of the same issues came up at the Pacific Food Summit held in April 2010 in Port Vila, Vanuatu[3]. Out of the Food Summit came 'Towards a Food Secure Pacific: Framework for Action' (Food Secure Pacific 2010). This Framework includes a number of practical recommendations,

[3]. Organised by WPRO with the UN Food and Agriculture Organization (FAO), the Global Health Institute (GHI) (Sydney West Area Health Service), the Pacific Island Forum Secretariat (PIFS), the Secretariat of the Pacific Community (SPC) and the United Nations Children's Fund (UNICEF).

Strategy 1/4.5: Ensure food security is a priority consideration within Free Trade Agreements such as PICTA/PACER, and that resources promoting free trade agreements support progress towards a food secure Pacific.

Strategy 2/1: Strengthen relevant legislative frameworks and harmonize standards, based on internationally-recognized standards in accordance with national needs and international trade agreements.

Strategy 3/1.3: 3. Strengthen capacity in data collection, analysis and dissemination of agricultural production and trade findings as well as develop more robust trade policy formulation and negotiation.

Strategy 3/5.4: 4. Support WTO-consistent, non-trade distorting special measures aimed at creating incentives for smallholder farmers, enabling them to compete on a more equal footing in world markets.

In early 2013 WHO, with UNDP and the Secretariat of the Pacific Community, co-sponsored a week long workshop in Fiji on policy coherence trade and health which was attended by trade and health officials from nine Pacific Island countries.

Notwithstanding a devastating epidemic of NCDs, the Pacific Island countries have not been able impose restrictions on the import of cheap fatty meats. This has been largely because of threats from the colonial powers, in particular the US and NZ. However, under growing pressure from the transnational corporations the US and Europe are driving a new generation of trade agreements which include investor protection provisions which give new powers to corporations to threaten and coerce small countries. Investor protection provisions in trade and investment agreements provide scope for foreign corporations to sue governments (investor state dispute settlement or ISDS) when they believe the value of their investment has been diminished by government policy. The cost, in money and senior officials' time, involved in responding to such claims can be considerable. This plus the risk of huge compensation awards can have a powerful chilling effect on public health regulation(Lee, Sridhar et al. 2009, Tienhaara 2010, Voon and Mitchell 2011, Kelsey and Wallach 2012, Vallely 2012).

Alcohol marketing

[In a future edition of this chapter there will be an extended treatment of the alcohol industry and strategies for regulation of alcohol marketing and use. We will explore the alcopops episode as a case of marketing to children and volumetric taxation as a regulatory strategy.

We will explore the different social uses of alcohol, variously as social lubricant, existential analgesic or anaesthetic and disinhibitor of aggression and violence. We will reflect also upon the roots of the existential pain and anger which may be revealed by alcohol use.

We will explore the range of discourses within which alcohol use is framed in various cultures and the range of regulatory strategies which have been put in place to address the various risks which alcohol is seen as carrying.

We will compare the social and regulatory dynamics through which tobacco control has been achieved with the scope for similar control of alcohol marketing. We will conclude that

the limited regulatory control that has been achieved over tobacco reflects unique features of this product and comparable levels of control over food or alcohol are unlikely to be achieved on an industry by industry basis. Rather they will depend on structural changes in global governance which have the effect of bringing transnational corporations generally under democratic control.]

MAIS non!

[In a future edition of this chapter there will be an account of the manoeuvring of transnational corporations (supported by their transnational capitalist class) for the implementation of binding international treaties which protect TNCs from any forms of regulation which might reduce their profits.

The immediate pressure points are the proposed Trans Pacific Partnership Agreement and the proposed Trans Atlantic Trade and Investment Agreement. In both cases big coy is seeking to investor protection provisions including investor state dispute settlement provisions (ISDS).

We will illustrate the significance of ISDS provisions in relation to Chevron's eco-vandalism in Ecuador and the attempts of big tobacco to use ISDS provisions to dismantle Australia's plain packaging regulations.

We will go back to the Uruguay round of negotiations which led to the WTO and its suite of so-called 'trade' agreements (more accurately, economic integration agreements) and in this context we will trace the debates over the inclusion of investor protection agreements among the WTO agreements.

This was not agreed to (and we shall trace the debates and conflicts which led to the rejection of these initiatives) but the US and the EU continued to drive for the inclusion of investor protection under the WTO. This is the story of the 'Singapore issues'.

However, the focus of the case study will be on the 2001 initiative driven through the OECD for a new agreement called the Multilateral Agreement on Investment (MAI). We will explore in some detail the role of civil society activism in the defeat of this initiative.

Progressive forces won that battle but in the background a volcano of new bilateral investment treaties were being negotiated creating a global network of investor protection provisions.

We will analyse the pressures that LMICs have been under to agree to investor protection provisions and the challenges facing civil society advocates and L&MICs in resisting these pressures.

The action takes place at international events, particularly the negotiating events, but it is within the national politic that nation state positions are formed and this is a key focus of action for civil society advocates.

In this section (to appear here in a future edition of this chapter) there be some reference to the wider context (global crisis and neoliberalism) and the workings of investor protection in preventing regulation for public goods purposes but the focus will be on the challenges of activism and the building of a global social movement.]

The Aboriginal men who said, 'sorry'

In July 2008 400 Aboriginal men from Central Australia and beyond, came together for four days at a remote location to discuss a range of health issues; the meeting was styled as a male health summit. Many questions were discussed but the central issue concerned violence including sexual violence, intimate partner violence and child sexual abuse. At the end of these discussions the Inteyerrkwe Statement was adopted.

> *"We the Aboriginal males from Central Australia and our visitor brothers from around Australia gathered at Inteyerrkwe in July 2008 to develop strategies to ensure our future roles as grandfathers, fathers, uncles, nephews, brothers, grandsons, and sons in caring for our children in a safe family environment that will lead to a happier, longer life that reflects opportunities experienced by the wider community.*
>
> *"We acknowledge and say sorry for the hurt, pain and suffering caused by Aboriginal males to our wives, to our children, to our mothers, to our grandmothers, to our granddaughters, to our aunties, to our nieces and to our sisters.*
>
> *"We also acknowledge that we need the love and support of our Aboriginal women to help us move forward."*

The background to this statement was a highly controversial initiative by the Australian Federal Government in June 2007 officially described as the Northern Territory Emergency Response (NTER) but more widely known as the Northern Territory Intervention. The Intervention evolved rapidly over the next few years but in its initial form it involved a strong focus on child sexual assault within the Aboriginal community, including an early promise of screening medical examinations.

The Intervention also included alcohol restrictions including the imposition of 'income management' on Aboriginal people who were in receipt of social security payments. The income management provisions required Aboriginal people to shop at selected stores with special debit cards which could not be used for alcohol. Certain provisions of the Racial Discrimination Act were suspended to allow income management to be imposed. Many Aboriginal people required to do their shopping under these arrangements found it quite demeaning.

The Intervention also included a compulsory 5 year take-over by the Federal government of most of the Aboriginal settlements with the intention of expediting necessary improvements to housing and infrastructure. However, the work was all done by outside contractors often without consultation with those communities. There was much comment regarding the investment in housing and salaries for the contractors and coordinators which to many appeared to take priority.

There was much more to The Intervention including some much needed funding increases for primary health care services and police.

The Intervention was announced in June 2007 just two months after the release of a report, commissioned by the Northern Territory Government, into the protection of Aboriginal children from sexual abuse. This report by Pat Anderson and Rex Wild conveyed the deep concern felt by many in the Aboriginal community about child sexual abuse and called for urgent responses. It also noted that there were many communities which it appeared did not have this problem. The Anderson/Wild report contextualised child sexual

abuse very clearly in relation to the fragile community structures, family breakdown, depression and anger. The Report noted how many previous experts had described all of these problems and the commitments of previous governments to take necessary actions. The report demonstrated that the child protection and police services had failed in many respects. Wild and Anderson emphasised the importance of a response which built on the concerns and strengths of the communities.

Two months later the Federal Government announced the NT *Emergency Intervention* with an urgency which recalled 9/11, including widespread mobilisation of the Australian military. This was a conservative (Liberal National coalition) government, led by John Howard, which was facing an election in four months with the polls predicting defeat. Many commentators believed that the rhetoric of *emergency* and *intervention* was designed to take political advantage of the widespread concern about child sexual assault; to convey images of firm decisive action against moral decay. In the lead up to a previous election (November 2001) the Howard government had misused photographs of refugees seeking asylum in Australia claiming that they showed refugees threatening to throw they children into the see (the Children Overboard affair). It was a deliberate attempt to stoke xenophobia regarding asylum seekers and in subsequent months was shown to be based on a lie. However, the government was re-elected. (See David Marr, 2006.)

This was the background to the Aboriginal Male Health Summit in Inteyerrkwe (Ross River) in early July 2008. The Summit was organised through the Male Health Program (Ingkintja) of the Central Australian Aboriginal Congress Medical Service led by John Liddle, an experienced Aboriginal primary health care leader in Central Australia.

The participants at the Summit were distressed at the very loose language which had accompanied The Intervention and which was seen as implying that all Aboriginal men were either perpetrators of intimate partner violence or sex offenders or both. Nevertheless they recognised that they needed to "acknowledge and say sorry for the hurt, pain and suffering caused by Aboriginal males to our wives, to our children, to our mothers, to our grandmothers, to our granddaughters, to our aunties, to our nieces and to our sisters."

In his speech on the final day of the Summit, Liddle described the alienation that many Aboriginal people experience from both their cultural traditions and from contemporary society:

> *"When you add to this the rapid changes in the role of males within that colonising society and the consequent dislocation of non-Aboriginal males and their struggle to define new self-images, it is no wonder that Aboriginal males may struggle to make sense of the contemporary world.*
>
> *And if those critical views of us as Aboriginal males are expressed with no effort to understand our cultural values, or the pressures caused by the colonial relationships and contemporary social transformations, then we become alienated from this society.*
>
> *This alienation is at the core of the struggle for male health and wellbeing, as it acts to debase men, stripping away their dignity and the meaning in their lives. We therefore need to confront these social relationships that shape our health.*
>
> *This does not excuse inappropriate behaviour, but I believe may help explain our silences about the behaviour of those we know to be doing wrong."*

Among the recommendations coming out of the Summit were

1. *Establishment of community-based violence prevention programs, including programs specific to Aboriginal men.*
2. *Establishment of places of healing for Aboriginal men, including men's shelters/'sheds', short term 'drying out' places for men, and more resources for long-term rehabilitation of Aboriginal men with alcohol and other drug problems, preferably within their own community.*
   Also 'half-way' houses to either give 'time out' or time to move slowly back into work/family/training, preferably to be run by Aboriginal men.
3. *Tax-free status for three years for identified communities for Aboriginal and non-Aboriginal professionals to attract much-needed doctors, health workers, teachers and police. Also incentives to employ Aboriginal people in similar positions.*
4. *Building the capacity of Aboriginal men in literacy and numeracy to access locally-based jobs, and better support for establishing local Aboriginal-controlled businesses to tap into the minerals boom, agriculture, aquaculture or whatever business activity is relevant to their traditional country. Also the linking of education and training to locally-based employment.*

The idea that health is socially determined (rather than the product of a range of disembodied 'social determinants') is epitomised in the many diverse forms of human violence, including those variously described in terms of violence against women, intimate partner violence, gender based violence and sexual violence. Such violence reflects unequal power relations, nowhere more so than when it involves children. However, the incidents of violence may themselves reflect higher order oppressions and alienations as is reflected in this story of the Inteyerrkwe Statement.

Community level activism in relation to such kinds of violence commonly starts with initiatives directed to caring for victims: immediate medical care, protection from further violence, and deep recovery over time. In the Northern Territory story it was in large part a consequence of Aboriginal women insisting on action; insisting that the 'loss of face' which might be the consequence of acknowledging the problem could not justify continuing silence.

There is an extensive literature regarding violence against women (see for example, Terry 2007, WHO and LSHTM 2010). This literature points to a number of strategic principles which are of relevance to most cases of action in relation to such violence:

- Action around culture change (including working with men);
- Development of services, such as refuges for victims of violence;
- Highlighting and reducing specific vulnerability;
- Pressure on service providers to recognise, react, report and refer;
- Contributing to international statements, declarations; and generating pressure on governments to fulfil their obligations under such statements.

A high prevalence of VAW generally reflects cultural norms which in some degree sanction such violence. However, individuals are not all bound to the same degree by cultural taboos and in situations of cultural disruption (colonisation, war, humanitarian emergencies) such taboos may lose some of their grip. In some settings alcohol or drug use can loosen such controls.

Nevertheless action for cultural change (often referred to as ‘awareness raising’) is one of the common strategies adopted to prevent VAW. However, this raises questions about who shall drive culture change (imposed or adopted) and the less evident ramifications in various particular cultural settings.

It is a common experience that women’s groups established to address the immediate needs of shelter, counselling and legal advice also take the lead in driving action for cultural change. Hayes (2007) describes a range of different strategies and programs including the Canadian White Ribbon campaign, the 16 Days of Activism Against Gender Violence, Community Based Action Teams in Ghana, regional tribunals in Peru and Bolivia, and speak outs regarding property grabbing in East and Southern Africa (Izumi 2007).

Easton and his colleagues (2007) describe how an adult literacy program in Senegal, working with women in rural villages and including a human rights and health module led to the participants working with their community and electing to abandon female genital cutting.

During the rise of ‘second wave feminism’ during the 1960s and 1970s many women (and a few men) formed consciousness raising groups as part of reflecting on the values and norms of patriarchy and how such norms can shape the expectations of both women and men. This movement was sometimes associated with quite confrontational feminism which included a strong focus on changing the discourse and on how the ordinary patterns of daily life can reflect unequal power relations and under valuing of women.

Hayes describes knitting workshops in Peru as a place where Indigenous victims of rape in war were able to come together for self-help and sharing.

It is self-evident that culture change involves challenging men’s consciousness as well as empowering women and various campaigns and programs have explored different ways of approaching this, from social marketing (eg involving sporting codes in support of White Ribbon Day) to men’s groups to schools programs.

In reflecting on how action for culture change can be driven it is important to keep other forms of gender violence in focus, in particular, violence of various kinds against people who identify as gay, lesbian, bisexual, transgender or queer. While the term ‘violence against women’ explicitly restricts the focus, the term ‘gender based violence’ encompasses also violence against those who transgress the heterosexual norm.

Activist women’s groups have taken the lead in many cultures in pioneering the development of services for survivors of violence against women. These have commonly included refuges of various kinds but the experience gained in helping individuals has led to the policy work and advocacy that has driven official programs.

Having regard to situations of heightened vulnerability is an important principle in prevention although such situations vary widely between cultures.

Chynoweth and Patrick (2007) describe firewood collection in displaced persons camps as an activity of particular threat. Some of the solutions they suggest include: proper security; delivered firewood (or other fuels) fuel efficient technologies and safer ways for women to generate income in refugee settings.

Izumi (2007) describes HIV widows as being at particular risk of property grabbing in Southern and East Africa. She points to the need for enforceable property rights and for the enforcement of such rights as are in place and for communities of support for widows and people living with HIV.

In other settings, where alcohol plays a role in releasing aggression the vulnerability of less powerful people might be linked to pay day.

Alcohol plays a role in violence, including intimate partner abuse, in many cultures but it is a complex relationship (World Health Organisation, London School of Hygiene and Tropical Medicine et al. 2013). It may have a disinhibiting effect on men, releasing anger which may reflect the alienation and marginalisation of the perpetrators. In some cases the victims of violence may also use alcohol as a way of managing chronic traumatic stress; such use may also contribute to conflict.

Activists working on gender based violence have contributed to the development of international covenants such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Beijing Platform for Action, partly as a strategy for entrenching the application of the human rights discourse to gender violence but also providing leverage over national governments regarding ratification, legislation and enforcement.

Hayes (Hayes 2007) describes the production of CEDAW shadow reports as a tool for holding governments accountable and the use of national and regional tribunals in Peru and Bolivia where international norms regarding rights can be used to highlight what is wrong.

Likewise Izumi (2007) describes how the Protocol on the Rights of Women in Africa (of the African Charter on Human and People's Rights) has been used to argue for legislation and enforcement of property rights to protect women from property grabbing.

One of the common themes of activism around gender violence has been the need to put pressure on generic service providers (including in health care and policing) to fulfil their obligations to provide prevention, protection and appropriate care.

One of the main criticisms of the Wild/Patterson report, described above in relation to the Northern Territory Intervention, was the failure of law enforcement and child protection.

Prieto-Carrón and her colleagues (2007) tell a very similar story in relation to femicide in Mexico and Central America. "These are deaths that cause no political stir and no stutter in the rhythm of the region's neo-liberal economy because, overwhelmingly, state authorities fail to investigate them, and the perpetrators go unpunished."

One size does not fit all and understanding the cultural, economic and political context of different patterns of violence in different settings is quite critical in applying these 'action principles'.

Hayes (2007) emphasises the link between political participation and women's access to protection, advice and support and the ability to challenge the power structures where patriarchy in the home or the street is backed up by patriarchy in the police, judiciary and the clinic.

Economic powerlessness adds to vulnerability and restricts choices for women who have to leave. Such powerlessness may reflect patterns in family relationships, the workings of the labour market and the legal rights and entitlements. Property grabbing in Southern and Eastern Africa (often HIV widows) appears to reflect power imbalances at all three levels.

On the other hand it appears that some of the cases of femicide in Northern Mexico are linked to economic empowerment through wage employment: *"Femicide represents a backlash against women who are empowered, for instance by wage employment, and have moved away from traditional female roles"* (Prieto-Carrón, Thomson et al. 2007).

This brief review of international experience around violence against women provides some wider context in which to review the Northern Territory case and the men who said 'sorry'. The stories which had been assembled by the Wild Patterson report, of intimate partner violence and of child sexual abuse, were shocking. It maybe that a few of the men at Ross River had been perpetrators but most of the men were apologising for having collectively allowed the cultural norms of their communities to lapse; for having turned a blind eye to violence and abuse. But they too were victims of violence and abuse; the direct and lateral violence of racism and the abuse of continued colonial expropriation, and this violence and abuse they share with their women and their children. The men and women of the Northern Territory have a complex path to navigate in moving forward.

The Green Area of Morro da Policia

This story (Giugliani, Nascimento et al. 2011) concerns a community in the city of Porto Alegre whose health chances are constrained by their living circumstances, an informal settlement on land reserved as a conservation area because of the natural springs. Their experience is common to other communities dealing with rapid urbanisation without adequate infrastructure but in the context of Brazil, with its stark racial inequalities, the community faces further marginalisation as Afro-descendants. The health problems faced by the community include rat and mosquito infestation, high communicable disease rates and exclusion from supposedly universal health care. Violence and drug trafficking, which reflect the poverty, racism and exclusion, are further challenges.

Community members had, for some years, sought official recognition and support in terms of infrastructure and services but without much progress. This case study starts with a seminar sponsored by the municipal Health Surveillance Department entitled, 'The divinity of water' to which members of the Morro da Policia community were invited. Community members were inspired by the linking of the environmental and spiritual dimensions of water and saw this initiative as very relevant to their situation.

Over the next three years a range of initiatives were undertaken, driven largely by the Women's Association but supported by practitioners from the Health Surveillance Department and a growing number of other official and established organisations. These initiatives included cleaning up the common space and instituting a regular waste collection; improved amenity with flower beds replacing strewn waste; negotiations with the water supply and sanitation departments for infrastructure provision; and registration of the families with the local health centre so that they could access health care.

These initiatives have led to dramatic improvements in appearance and amenity. In terms of improved health status there is strong anecdotal evidence of improved health;

improved child and infant health in particular. However, there have also been profound changes in the spirit and confidence of the community, reflected, for example, in a low key 'community discipline' imposed by the leaders of the Women's Association on the drug traffickers.

The achievements of the community of Morro da Policia have been co-produced by community members and by practitioners and managers of the Health Surveillance Department and other public and civic officials. However, the spark which ignited the project was lit at the Divinity of Water seminar and tendered by the partnership which formed between the environmental health practitioners and the leaders of the Women's Association.

The project was sustained at two levels: the creativity and partnership of individuals and the growing understanding and trust between the community and the public institutions which were reaching out to provide support. In terms of lessons for the formal health sector this project has implications at various levels: practitioner skills and values; management vision and leadership; and policy imagination and commitment.

This story is unique and in its details not reproducible. The specific chemistry of the relationships, the specific circumstances of the community, the policy environment of Porto Alegre; these are unique contingencies of time and place. However, at a more general level, this kind of story can be 'scaled up' where practitioners are given the skills, confidence and freedom to engage with communities in a respectful way and where the values and principles reflected in this story are manifest at the practitioner, management and policy levels.

This is a case of ongoing action and interventions are continuing: the city’s Sewerage Department is working on the cleaning of the brooks; the city’s Water Department is planning water provision for the area; the square where children play and where families hang out is clean and taken care of by the neighbourhood. The Health Surveillance Department is planning other mobilization actions together with AMUE, and the intersectoral meetings, involving different public sectors, are still taking place. AMUE has now an organized schedule of activities and is negotiating to have an office.

The case of the green area of Morro da Policia teaches us important lessons about how communities and health practitioners can work together to address the social determinants of health. It tells us about the importance of individual interactions (and friendships) as well as institutional and policy reform. Individuals, the women of the AMUE and the key practitioners from the Health Surveillance Department, were critical to the success of the project, as well as the institutions, especially the different municipal departments that supported the project. The project reflects successful interaction between individual and policy level engagement. The project was unleashed by special individuals, who were committed and willing to create an alternative space for explosive manifestations of creativity. The focus on water and spirituality made huge sense to the community and broadened the spectrum of action to address other aspects of people’s living conditions as well as their health.

There are several levels of responsibility for successful implementation including policy, management and practice. We can still identify the interaction between these different levels in this case. While the skills, values and confidence of the practitioners (as well as the community leaders) were the catalysts of action that ignited the project, this interaction at the

individual level was supported by broader interaction involving managers (of the health centre and municipal departments involved) and the policy makers (the public institutions as actors themselves, including the Health Surveillance Department and the Health Waste Department).

One of the clearest examples of how inequities can be reduced by community action was the pressure to register the population of the green area at the health centre. As soon as this was achieved these people were formally recognized as citizens living in a given space and full holders of the right to health care. Moreover, improving life conditions promotes inclusiveness and encourages people to participate in a process for change. Having concrete results is a catalyst for ongoing and growing mobilization. And the fact that people are socializing more creates more solidarity, which is a powerful force for change.

A key lesson from this story is that social policy has to make space for unpredictable but powerful community expressions of creativity and leadership. There is a need for policy frameworks that are structured around the agency (autonomy, will) of communities and community leaders, including the appropriate use of technology in keeping with communities' demands. In this case, the policy context in Brazil (where social participation and intersectoral action are endorsed) made space for this experience which was implemented by individuals with institutional support. For experiences like this to happen, policy makers have to listen and consider respectfully what people have to say and health practitioners need to develop the skills to work with their communities.

Despite this process bringing many successful outcomes, which certainly motivated many people living in the green area, community mobilization is still limited at Morro da Policia. In Brazil, we have been talking about a crisis of the social movements, which are relatively weak and fragmented compared with the 1970s and 1980s, the period of the redemocratization struggle, when the Health Sector Reform was being built. It seems that the political effervescence of that time is not present anymore. The space occupied by popular movements, once very powerful, has been emptied and occupied by other actors such as the drug traffickers. Contemporary initiatives seeking to work with community action need to consider this aspect and the story of the Green Area teaches us one way of dealing with it.

This story has many highly specific features; the way this process developed was linked with this particular setting and these particular people. It is not a project to be extrapolated to other settings ('scaled up') exactly as it was implemented in this case. Nonetheless, the values and principles reflected in this particular story (policy makers listening to communities, institutions opening space for community action and creativity and strengthening community leadership, improvement of life conditions by creating inclusiveness and solidarity, for instance) can be scaled up for broader application. These values and principles are at the heart of a healthier society.

The documentation of this and other similar case studies was undertaken by activists of the People's Health Movement, as part of a research project entitled "Community Action for Health". The pilot phase of this project was conducted in the city of Porto Alegre. Thus, this is an example of how social movements can have a fruitful role in the process of promoting sustainable public policies that are community oriented.

The public health tradition

Public health is variously a social project, a bureaucratic sector and an identified field of professional practice. In many ways public health, as a social project, has been constrained by its necessary association with government and the professionalization (institutionalisation) of its practitioners.

In this section I review some of the strategies and models of practice which have been developed within the public health tradition:

- infrastructure development;
- regulation;
- health education/social marketing;
- clinical services;
- primary health care;
- health promotion and the 'new public health';
- emergency health response in humanitarian disasters;
- research, evaluation, teaching.

There is much of value in this tradition from which activists can draw; indeed activism is an important element of the public health tradition. However, the institutions of public health are largely embedded in the bureaucracies of the state, which is both a strength and a weakness. In some cases it enables public health officials to deploy the financial and regulatory power of the state to protect and promote health. In other cases the public health project is held hostage by the superior political muscle of other commercial and political interests; this has often been the case in occupational health and safety. Activists need to be conscious of the ways in which the culture and ethics of the public health establishment have adapted to this ambivalence.

Infrastructure

Infrastructure development is one of the earliest public health strategies, including sewerage, safe reticulated water supply, housing standards and safe roads. While public health advocates have played an important role in research and advocacy, in most jurisdictions these utilities are administered in other portfolios.

In many fields the public health contribution to infrastructure development has been mediated through its regulatory powers. In Melbourne, Australia, in the 19th century the public health authorities progressively ratcheted up the regulatory standards governing cess pits and then pan system contractors until the cost to householders of pan replacement contractors exceeded the cost to residential ratepayers of a metropolitan sewerage system.

Regulation

Like infrastructure, regulation is a core strategy of public health and likewise underpins the need for the institutions of public health to have a strong base within government.

Quarantine is one of the earliest examples of regulation directed at protecting population health, followed by occupational safety, a safe food supply, the safe management of drugs and poisons and car safety.

A recurring feature of public health regulation is the local central regulatory model. This involves a central standard setting body working with local government which manages the inspection role.

In recent decades regulatory thinking in some areas has moved away from prescriptive standards to codes of practice or principles linked with various forms of accreditation to provide assurance that the system is working.

In the specific case of occupational health and safety the earlier focus on regulatory strategies (and the role of the state) has transformed as occupational safety and health has moved into the institutions of management labour relations and as public investment in monitoring and enforcement has been cut back.

The rise of the transnational corporation and globalisation has led to a continuing attack on regulatory standards and mechanisms with a rising discourse about covert protectionism and a drive through international trade law for lowest common denominator regulatory standards. As domestic regulation comes under the influence of international trade and investment agreements, international standard setting bodies such as the Codex Alimentarius come to exercise greater sway. Not surprisingly the corporates invest heavily in maintaining their influence over the decisions of such bodies.

From health education to social marketing

The provision of advice to the public has traditionally been a core function of public health.

Campaigns within armies about avoiding sexually transmitted diseases were among the earliest applications of this advisory function. During the early years of the 20th century public health focused increased attention on maternal and child health and in this context the practices of health education developed: leaflets, posters and signs.

By the middle of the 20th century the focus was increasingly on smoking, diet and exercise and during this period ‘health education’ morphed into ‘social marketing’, using the principles and techniques of commercial marketing to change ‘life style’ behaviours.

In the 1980s with the advent of AIDS social marketing as a tool for public health was further professionalised.

Clinical services

The provision of clinical services for conditions of public health importance of for particularly vulnerable populations has been part of public health since at least the development of military programs for STDs.

Subsequent applications of this strategy have encompassed TB services, vaccination programs, occupational health and safety, and screening and support services for mothers and infants and school children.

Primary health care

The Alma-Ata Declaration on Primary Health Care in 1978 gave new prominence to some key public health strategies:

- harnessing primary care practitioners and agencies in prevention and health promotion as well as sick care;
- intersectoral collaboration;
- community involvement and social movement engagement;
- international South South solidarity.

The idea of involving primary care practitioners in caring for populations as well as individuals was not completely new. There had always been community practitioners who cared about, investigated and advocated around the needs of their communities as well as the presenting symptoms of their patients. In jurisdictions which followed the British tradition of the medical officer of health a small number of volunteer general practitioner were directly involved in thinking about population health.

However, the PHC model broke new ground, suggesting that all primary care practitioners and agencies had a responsibility for worrying about population health and working with their communities to explore the possibilities for community action around population health. Experience suggests that there will always be practitioners who practise in this way but a supportive institutional culture would be necessary if all primary care practitioners were to practise like this.

Alma-Ata did not invent intersectoral collaboration; public health advocates had been seeking to engage stakeholders in other sectors for centuries, but Alma-Ata highlighted the necessity for such collaboration as part of creating healthy community environments. It is worth emphasising that intersectoral collaboration is much broader than 'health in all policies' which focuses on the practices of government departments. Intersectoral collaboration at the local level means primary care practitioners talking with local teachers or police or local businesses. Both are essential.

Community involvement was central to the Alma-Ata model. Changing the norms and practices of local communities or mounting campaigns for higher level policy change is not the prerogative of health care practitioners but they can share their expertise and their concerns with their local communities and work with them if there is enthusiasm to engage in the social determination of health. Community involvement should not be read simply as local; rather it includes engagement with more broadly based social movements where these are working towards Health for All outcomes.

What was new in the Alma-Ata Declaration was the commitment to the anti-colonial struggle of that era and to the development aspirations of the newly independent countries expressed in the call for a new international economic order (NIEO). The significance of this tends to be overlooked in much commentary on the PHC movement.

Health promotion and 'the new public health'

Health promotion as a field of work and a vocation emerged in the mid 20th century although core elements of health promotion had been implemented in many public health engagements and in primary health care programs for decades before then. Health promotion was in large degree a response to the bureaucratisation of 'public health' and the 'victim-blaming' focus on individual behaviour change. Closely related to health promotion was the

movement which identified as the 'new public health' which was a reaction to both the bureaucratisation of public health and the behavioural focus of much social marketing.

The conceptual base of health promotion was elaborated first in the Ottawa Charter of 1986 and subsequently in the WHO Health Promotion Conferences which followed: 'Healthy public policy' in Adelaide in 1988, 'Supportive environments' in Sundsvall in 1991, 'Leading health promotion' in Jakarta in 1997, Mexico Ministerial Statement in 2000, 'Health promotion in a globalised world' in Bangkok in 2005 and 'Health in all policies' in Helsinki in 2013 (WHO 2009).

Health promotion draws on many of the insights previously associated with PHC but in ways which could be adapted to industrialised rich countries with strong private sector dominating medical care provision.

One of the key contributions to public health generally which has emerged from the discipline of health promotion has the practice of comprehensive program planning. This involves clarifying objectives, explicating broad strategies and articulating clearly the initiatives through which those strategies are to be implemented. A core feature of this approach is the development and measurement of both process and outcome indicators so that progress can be monitored and strategies adjusted

The 'settings approach' is another important contribution of health promotion, most commonly associated with Healthy Cities. In many respects the settings approach is a re-working of the principle of intersectoral collaboration but with the benefits of the 'branding' of the model.

The 'new public health' follows many of the precepts of health promotion but with a stronger focus on social justice and addressing inequities in health outcomes and in the influences which shape population health. The 'new public health' has developed more as a social movement, as a collectivity of committed practitioners in contrast to the more technical and more institutionalised body of health promotion. See Baum's best selling text (2008) for a more detailed and more systematic account of the new public health.

Health response in emergency settings

The disciplines involved in contributing health expertise in emergency settings are an important part of public health. The Sphere Project (2011) sets out minimum standards for health systems, communicable disease, child health, sexual and reproductive health, injury, mental health, and non-communicable disease. It also underlines the importance of systematic assessment, monitoring and surveillance.

Limitations of the public health tradition

There is a great deal in the public health tradition for the health activist to build on but not uncritically. I shall mention some important limitations or disabilities of this tradition:

- the limitations associated with being in government;
- the security which comes from staying within the boundaries of expertise and authority;
- the influence of class, gender, ethnicity etc on the world view of the public health practitioner;

- reductionism and specific causation; and
- interventionism.

Many of the core institutions of public health are necessarily part of government. However, in a political climate of neoliberalism, the philosophies and objectives of the neoliberal program are inevitably expressed to some degree in the work of the state institutions of public health and the corresponding inter-governmental institutions.

At the national level this is commonly reflected in the panicked tone in which population aging, and fate of the welfare state, are commonly discussed. Part of the neoliberal program is the continued winding back of corporate taxation and of government expenditure. However, these propositions assume that the structures and dynamics of neoliberal globalised capitalism will (and perhaps should) continue to frame the world economy. This is a regime which is presently driving ecological instability and widening inequality. There are other scenarios within which we might talk quite differently about population aging or the welfare state.

The influence of neoliberalism on discourses of public health at the global level is reflected in ways in which discourses of 'security' and 'productivity' wind their way through much policy commentary suggesting that the reason rich countries should give financial assistance to developing countries is to shore up their own security (Commission on Macroeconomics and Health 2001) or that the reason that population health matters in public policy is because it promotes workforce productivity (World Bank 1993).

The constraints associated with 'being in government' are ameliorated to some degree where the professional bodies which bring public health practitioners together include academics, practitioners and activists who are based outside government. There is also a minority of public health practitioners working in government who are nonetheless able to maintain critical perspective regarding the pressures to which they are subject although it is not easy.

A certain personal authority is carried by public health officials and comes with the membership of a professional group with highly valued expertise. This authority contributes in some degree to one's confidence and self-esteem. However, the professional and institutional role boundaries associated with the institutions of public health can encourage practitioners to restrict their attention to the more technical dimensions of public health (specific hazards, vulnerabilities and protectives) which may appear to lie more securely within the boundaries of 'exclusive expertise' and perhaps neglect to some extent questions of social justice, economic policy and governance which powerfully affect population health but lie beyond those boundaries.

The people who staff the institutions and programs of public health generally bring to their work the values and world views of their own class, gender and ethnic backgrounds.

The development of 'tropical medicine' as part of European and US colonialism is a stark illustration. Closely linked to this was the influence of eugenics on public health, variously concerned with disability (Sigerist 1962[1942]) and racial purity (Hicks 1978, eg, p 157). A counter example is provided by the many public health practitioners who are committed to values of social justice and ecological sustainability, notwithstanding straying beyond the secure boundaries of public health.

The culture of public health places a strong emphasis on the disciplines of documentation, measurement, research and evaluation. This is a core value of the discipline and a powerful strength. However, there is a tendency within some fields of public health towards reductionist methodologies which constrain conceptions of causation and strategy.

Dubos spoke (in 1959) about the limitations of reductionism in terms of the rise of specific aetiology (and specific response); in other words specific causes for specific diseases and singular 'magic bullets' to address the specific causes (a pill for every ill). Dubos was emphasising the need to understand the ecology of disease; the ways in which different influences, operating at very different levels of scale and term, influence causation and prevention. Supporting this argument, Turshen (1989) explores the contrary idea of non-specific mortality, citing a measles immunisation program in a poorly nourished population. It appears that many of the children who didn't die of measles, because they had been immunised, may nevertheless gone on to die of other causes, perhaps diarrhoea or other acute respiratory illnesses, hence the idea of non-specific mortality.

Specific aetiology is an artefact of scientific reductionism. The power of reductionist research lies in its ability to 'control out' various contingencies which are specific to the cases in order to focus on factors which are common to all the cases. The archetype of reductionist research, the randomised controlled trial, illustrates this. By randomising cases to experiment or control, we 'control out' all those factors which are contingent and specific to each case and focus only on those characteristics or dynamics which are common.

The power of reductionism is to be celebrated but it needs to be balanced with a countervailing paradigm of synthesis and integration. This is not an insuperable challenge as the Virchow report discussed earlier shows. Virchow was able to draw upon a number of partial stories from economics, politics and governance, as well as epidemiology to make sense, in a holistic way, of the specifics of causation and prevention of typhus in Upper Silesia.

The Virchow example also points to the ways in which class relations (or power relations more generally) may determine which factors will be duly considered and which factors will be blatantly ignored. The landed aristocracy of Upper Silesia were more willing to recognise behavioural factors, such as alcohol use, apathy and lack of cleanliness, rather than their own role in the starvation of the poor people of Upper Silesia. The significance of this case, moving to the present day, is that government committees and philanthropies are more likely to support research and recommendations which focus on specific aetiologies than those which indict the prevailing social, economic and governance structures; those structures which have demonstrated their virtues by recognising those committee men and raising them to their prominence.

The interplay of reductionist thinking and class blindness is well illustrated in the interventionism of the World Bank's 1993 World Development Report, 'Investing in health', which sought to identify two minimal packages of cost effective clinical and public health interventions which might be subsidised. The identification of cost effective interventions was clearly based in reductionist science in that the interventions were all abstracted out of their ecological context and the contingencies of local implementation. For example, the Bank determined that the health improvement from water supply and sanitation was not cost effective if all of the costs of such infrastructure provision (the cost) are assigned to the health

sector alone (the benefit): *"if publicly financed investments in these services are being considered for health reasons, it should be noted that such investments generally cost more per DALY gained than other health interventions recommended in this Report"*. (World Bank 1993). As the report acknowledged this would value at zero the benefits regarding the commercial use of water, women's time collecting water and social amenity from clean streets.

In this case the reductionism of the argument was deployed in the service of a neoliberal political agenda; namely, to promote the idea that health improvement in L&MICs countries could be achieved relatively cheaply without disrupting the project of global economic integration under transnational capitalism; defending structural adjustment and the odious debt regime.

Health activists need to understand the specific hazards, exposures, vulnerabilities and mediations and the specific methods for prevention, protection and amelioration. However, they also need to consider the social relations of power and solidarity, economic interests and drivers and the politics and structures of governance.

The attraction of reductionism is that it *reduces* complexity by controlling out diverse contingencies we avoid having to make sense of the interactions between different influences which may need to be understood in terms of different levels of term or scale, or in different disciplinary frameworks. A full understanding measles in a poor community might require integrating our knowledge of the specific pathology of measles with nutritional information including the economics of food security. Conversely the agronomist might choose to 'control out' the presence of measles in seeking to understand the nutritional status of the community and agricultural priorities. This points to the ways in which our own purposes are embedded in the knowledges (vaccination or agronomy) that we rely upon.

The social determination of population health

In this section I draw together some key insights emerging from our case studies above and our review of the strengths and limitations of the public health tradition.

Knowledge is carried in partial stories

Knowledge is central to action around the social determination of health: description, measurement, explanation, evaluation, prescription. The concept of evidence is central but there are different kinds of evidence: the evidence which supports generality and the evidence regarding contingency. Effective action depends on both.

The knowledges which we need to support action around the SDH overlap unknowably; the frameworks we deploy to make sense of specific hazards overlap unknowably with the wider knowledges of economics and politics which speak about the wider world. The frameworks we draw upon to make sense of the local and immediate overlap unknowably with the frameworks in which we think about the large scale and the long term.

Knowledges are structured around particular ways of seeing the world, particular purposes and particular domains of influence (or agency). They are stories told from particular subject positions.

The knowledges we draw upon in practice (the general and the contingent; the different disciplines; the different subject positions) are incommensurate; they do not follow the same rules; they do not picture the world in the same ways. Sometimes it is convenient to assume that our knowledge bears a representational relationship to a singular reality which we all share but in dealing with the social world there are too many incommensurate truths: the truths of different agents, of different disciplines, of different levels of scale.

The integration of incommensurate knowledges takes place in practice: we assemble all of the partial stories that we can handle; we do not seek to 'integrate' them within a singular coherent framework; we manage them like balls in the air; we iterate between them; we decide; we act; and if it works it (the sum of partial stories) was 'true'. (Horkheimer is quoted by Held (1980, p192) as saying that 'truth inheres in a moment of correct practice').

Different stories can be told about the social determination of health

It is clear that understanding and engaging in the determination of population health requires understanding more than simply the technical hazards, vulnerabilities and protective. We also need to understand economic capability and drivers, relations of power and solidarity and issues of governance and politics. The model depicted in Figure 1, below involves working in parallel with four different (but inter-related) perspectives on the social determination of health:

- specific hazards, vulnerabilities and protections;
- relations of power and solidarity;
- economic capability, stakeholders and drivers; and
- governance, regulation and politics.

These are not separate domains; rather they are different perspectives on the same messy world. They are different 'partial stories' which can be drawn upon in framing narratives of explanation and scenarios of action in relation to the local and specific issues which activists are facing.

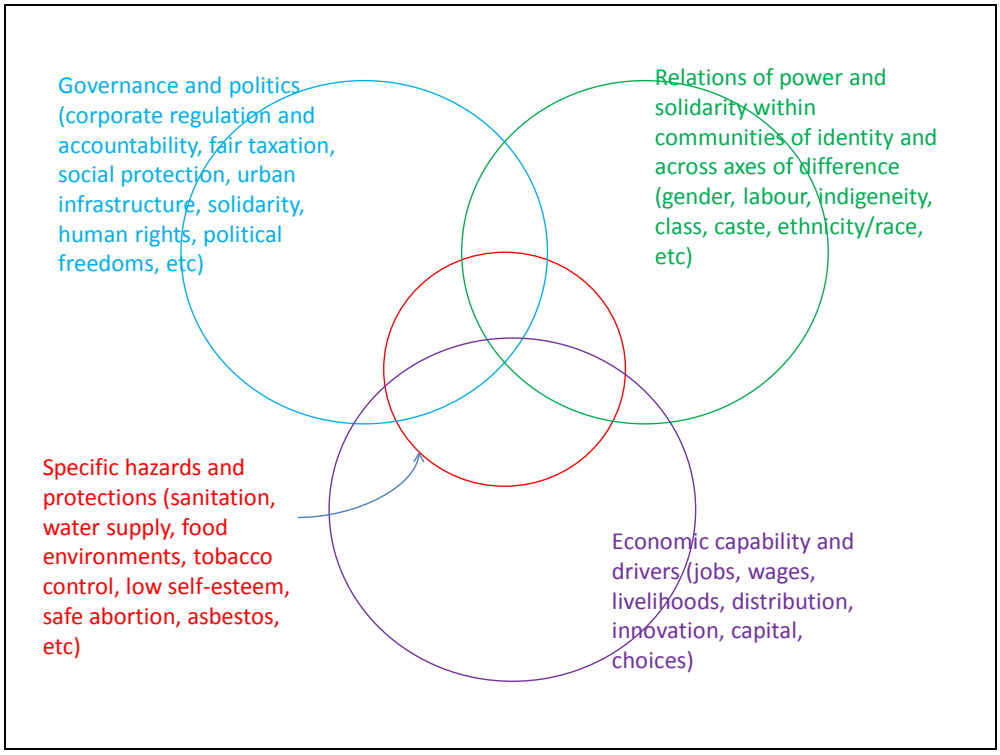

Figure 1. The social determination of health: four perspectives on causation; four fields of action

Specific hazards, vulnerabilities and protections

The conventional wisdom in public health is that population health is a function of a wide range of quite specific hazards and vulnerabilities and protecting population health requires corresponding preventive and protective interventions. These material hazards include:

- physical risks such as asbestos, radiation, toxins (such as tobacco);
- societal risks (access to safe abortion, security from violence);
- microbial threat such as malaria, HIV, polio; and
- nutrition and metabolic risks such as excess energy or not enough protein.

Exposure to such hazards is a function of:

- individual and collective behaviours (such as smoking, violence, food choices, etc); and
- environmental prevalence (such as coal dust in poorly ventilated mines; marketing of junk foods).

The consequence of such exposures is also a function of various specific vulnerabilities:

- in many settings women are particularly vulnerable to violence; women are also vulnerable to the particular risks of childbirth;
- children are particularly vulnerable to bad nutritional environments;
- disabled people may be more vulnerable to particular hazards but such vulnerabilities can be managed through policies, services, aids, environmental change.

The understood vocation of public health, as an institution and as a profession, is the development and implementation of all of the various preventive and protective strategies required to control these exposures and take care of the vulnerabilities.

- educational and regulatory strategies to control risky behaviours
- specific protectives to reduce environmental exposures or to reduce their impact (mine ventilation, gun control, air bags, regulation of the food environment, secure meaningful employment, adequate appropriate nutrition, loving meaningful relationships)
- special attention to needs of vulnerable populations.

These kinds of strategies are generally based on some kind of understanding of causal mediation. These include divine, physical, microbiological, metabolic, genetic and behavioural mediations. In many cases causation is mediated through a mix of these pathways.

Particularly controversial are:

- phenomenological/behavioural mediations (including powerlessness, alienation from work and alienation from land and culture contributing to higher levels of behavioural risk factors and subcultures which normalise such behaviours) and;
- emotional/physiological mediations (perhaps involving high levels of steroid hormones consequent upon chronic pressure in situations of relative powerlessness leading to dysfunctions in the blood clotting systems).

The first of these pathways, phenomenological and behavioural mediations, has been recognised for centuries. People whose experience is teaches them that they are worth less than others are discouraged from investing in their own future. If their experience is of not having any control over their own lives then it does not make sense to try to sacrifice the present for the future. These kinds of links between experience and behaviour are not in themselves controversial; what is contentious is whether they should be treated as imposed and unfair or as matters of personal choice. The latter view is more common among those who are relatively powerful rather than relatively powerless.

The relations between experience and behaviour invoke a core debate in the determination of human behaviour regarding the relative influence of environmental pressures and individual choice. Crude accounts of this debate might argue either that peoples' behaviours are structurally determined (availabilities, prices, opportunities, cultural pressures, etc) or that they reflect personal choices. This dichotomy is too simple; first, because it is generally a matter of degree, depending on circumstances; second, because personal choice, in particular, collective personal choice, can reshape structural determinants.

The idea of emotional/physiological mediations has been circulating for many years although the idea that stress causes peptic ulcer no longer has any currency. In the Whitehall studies Marmot and colleagues have demonstrated a consistent gradient in health outcomes (after correction for known risk factors) across all levels of seniority in the British civil service with the most senior being the most healthy. Since the middle and upper middle civil servants all have adequate salaries it is unlikely to be explained by material deprivation. Marmot has demonstrated variations in hormonal and blood clotting variables which also

show a gradient according to seniority. They hypothesize that declining workplace discretion from top to bottom associated with pressures to deliver increasingly specified outcomes creates a stress which impacts on steroids, cytokinds and clotting and through these pathways leads to increasing morbidity (Steptoe and Marmot 2004). Some caution is called for in extrapolating from the British civil service to the gross inequalities in health status between countries and between rich and poor in highly unequal societies.

The specific hazards, vulnerabilities and protectives approach is necessary but not sufficient. It does not account for the unequal distribution of aggregate disease burden; why poor and marginalised people generally carry a heavier disease burden across a range of diseases, risk factors and vulnerabilities, than do the rich and powerful in those same cultures.

The specific hazards approach positions the public health actors as somehow outside the field, coming in to impose various protectives. This fails to consider the political determinants of what public health can do and fails to locate the institutions of public health within the same institutional and political structures as generate the hazards and vulnerabilities.

Economic capability, stakeholders, drivers and regulation

Understanding the social determination of health in terms of relations of power and solidarity is necessary but not sufficient. Further insights into causation and strategy can be gained by taking a more economic perspective; tracing the determination of health in relation to economic capability, economic drivers and the options for economic regulation.

Material resources are critical for creating the conditions for population health:

- draining the marshes and controlling malaria;
- putting in place sewerage, water supply and sanitation and the control of water-borne disease;
- housing;
- energy for heating, cooling, industry and transport;
- food security for huge urban populations;
- footpaths and support services for disabled people.

However, the conditions for population health also depend on distributional issues:

- distribution of wealth and income;
- distribution of investment;
- distribution of job opportunities.

Capitalism, combining entrepreneurship, competition, innovation and profit, is a powerful system for creating wealth; potentially contributing resources for population health. However, capitalism offers no guarantees regarding healthy (and fairly remunerated) employment; the production of healthy environmentally friendly consumer goods; the equitable distribution of wealth; or healthy investment policies.

A key issue in terms of building economic capability to create the conditions for population health is economic development, understood as the accumulation of capital (physical capital, technology and human resources as well as finance) which is available for nationally determined investment. The neoliberal ‘model’ for economic development (the

Washington consensus) is really about non-development, the developed countries pulling up the ladder. Samir Amin has described the key features of an alternative model, drawing in some degree on dependency theory, based on a kind of regionalism (see Chapter 2).

Effective regulation of capitalism is a pre-requisite for effective action around the social determination of population health; in the present era this must operate at the global as well as national levels.

Unconstrained capitalism creates wealth but also creates inequality, environmental destruction and a wide range of health hazards. It is useful to think about the economic drivers or incentives which lead to such adverse outcomes. Understanding the drivers will be useful in thinking about the regulatory strategies needed to promote population health.

Work under unconstrained capitalism can be dangerous; consider for example, the high death rates of coal miners in China and the deaths of 1100 garment workers in a factory fire in Bangladesh in early 2013. The immediate context involves an entrepreneur exploiting workers whose families desperately need the wages. At the larger scale, the Bangladeshi women died because of the power of transnational fashion brands to dictate prices on a take it or leave it basis. Neoliberalism has created a global auction room forcing poor countries into a race to the bottom in order to attract orders. In both China and Bangladesh national policy makers turn a blind eye to execrable working conditions as a necessary cost of economic development in a hostile global environment.

Work under capitalism is often alienating as well as dangerous. The product of work, a transformed material object or a contribution to someone else's wellbeing, can be much more than a mere commodity. It also has significance in terms of the worker's relationships with colleagues, with suppliers and purchasers, and with end users. In the context of such relationships the product of work can be a gift, an expression of creativity, a source of pride. Workers are alienated from the product of their labour when they are subject to unreasonable pressure but have no control over how they will work; have no scope for creativity or judgement in their work; and have no meaningful relationship with end users. In these circumstances the worker is reduced to an object and the product of their labour a mere commodity.

Alienation is bad for your health in various ways. To be treated as an object; to have your labour is forced from you without scope for creativity, pride or generosity; can have a big impact on how you view yourself, including lowered sense of self-worth, shame and anger. People who have a lowered sense of self-worth are less likely to place a high value on their future health and be less strongly motivated to adopt healthy behaviours and work for a health supporting environment. People who in some degree are ashamed of the way their labour is appropriated may be more likely to turn to mood altering drugs such as alcohol. People who resent being objectified and controlled may take out their anger on those closest to them, particularly if they are disinhibited through the use of alcohol. In many work settings, allowing space for creativity, pride, and generosity is not compatible with maximising profit, with the entrepreneur's freedom to exploit. The entrepreneur who allows space for creativity, pride and generosity may find his/her competitors taking advantage of such humanity.

Capitalism without decent social protection drives increasing inequality in income and with unequal income unequal political power and control over one's destiny. Unregulated capitalism has no consideration for full employment, far less for meaningful work. Workers are told to curb wage demands because of the impact of higher wages on job numbers. The corporate threat to take jobs off shore is very real under neoliberal globalisation. An 'underclass' of inter-generationally unemployed families is a fixture in the heart lands of capitalism, even while the income gap between the top 1% and the bottom 99% widens.

Low income and unemployed people are generally exposed to more hazards, and are protected less effectively by public health measures. In addition the experience of marginalisation and exclusion carry a powerful message about self-worth (and motivation for 'looking after one's health') and about the likelihood that effort invested in 'healthy behaviours' could ever yield the promised benefits.

Capitalism powerfully shapes the institutions and norms of social practice through marketing (and money politics) regardless of the social and health benefits or otherwise. The constant pressure of junk food marketing is driving a non-communicable diseases epidemic in both the rich and poor worlds but governments appear unable to regulate the large transnational food corporations. Likewise the tobacco industry has demonstrated its power to prevent effective regulation. The US is pushing with increasing urgency for the extension of investor state dispute settlement laws which will prevent countries from regulating foreign companies whether they are selling junk food, guns or tobacco.

Under capitalism capital belongs to the rich and can only be used to make more capital. Out of this arises the gross misuse of capital in misdirected investment: armaments, motor cars and sky scrapers instead of decent housing, public transport and community facilities. Unconstrained capitalism is destroying the global environment; not just through global warming but loss of biodiversity, resource depletion and diverse toxic exposures.

Capitalism is reshaping fundamental cultural norms about what it means to be human and the meaning of the social. Partly through corporate marketing; partly through the ways in which work is structured; and partly through direct ideological propaganda, the values of individualism, competition and materialism are powerfully cultivated and alternative values are dismissed and derided. The rise of individualism supports the project of reducing taxation and the 'size' of government and in making space for privatisation of a range of social and community functions. It also weakens the drive for social solidarity (including decent social protection); for greater equity in income distribution; and for effective public health protection.

The rise in materialism helps to motivate workers to work harder and earn more in order that they can spend more on faster cars, more recent phones and more expensive clothes. The combination of individualism and materialism normalises the scramble for possessions and normalises the poverty and exclusion of those who fail in the scramble; it normalises the gross and widening inequalities in wealth and income, in and between countries.

Competitiveness plus individualism and materialism motivates workers and drives consumption. It also creates insecurity, increasing as the safety net is dropped, and with insecurity comes xenophobia. It is particularly unlovely when xenophobia is cultivated

against refugees from wars which were initiated by national authorities of those states in which are cultivated the xenophobes.

Unconstrained capitalism treats the biophysical environment purely as a source of resources and a sink for waste. This attitude has created any number of disasters at the local level (Bhopal, DeepWater Horizon, Chevron in Ecuador, etc) and is driving global warming, with uncertain but far reaching health consequences. The exploitative / utilitarian attitude to the earth stands in sharp contrast to indigenous perspectives on the relationship of humans to the land. Resistance to the eco-destruction of capitalism starts with learning from the indigenous understanding of our relationship to mother earth.

The enlightenment dream of society shaping its own future through dialogue, deliberation and democracy has been subject to continuing ideological attack under slogans of small government and deregulation with a view to replacing it with the neoliberal myth of the blind beneficence of market forces. Confronting this drive in an era when TNCs operate in a domain separate from nation state decision making will require powerful international action.

The commercial interests of powerful stakeholders have always loomed large in the struggle for health. The nobility and financiers of the City of London resisted paying for sewerage for London for more than 50 years after Bonaparte had implemented it in Paris. The tobacco industry is commonly demonised as if their morality is an order of magnitude worse than that of other businesses. The asbestos story above suggests otherwise; likewise the support provided through the big oil companies for global warming denialism.

It needs to be acknowledged that the corporations are not intrinsically committed to destroying people's health. Indeed many technological advances carried to market by private enterprise, eg refrigeration and information technologies, have contributed to convenience and to the determination of health. The electronics, plastics and pharmaceutical industries have contributed greatly to the effectiveness of modern health care.

However, the incentives embedded in the capitalist system and its corporate structures mobilise and deploy fear and greed in very powerful ways, in particular, the pressure of the share market to maximise shareholder value and the incentives on executives to deliver on this obligation. Where the opportunity for profit cuts across public good objectives it is to be expected that most corporations will exhibit the same morality as the tobacco, asbestos and oil industries.

The need, from the activist point of view, is to identify the vulnerabilities of corporations, and the tools and strategies which have been used successfully to curb their most health damaging propensities.

The tobacco control experience points out how a range of different strategies can complement each other. Social marketing and patient education in the clinical setting contributed to changing public opinion and to creating an environment in which more aggressive regulation (such as the ban on advertising) could be implemented. When the research evidence pointing to the dangers of second hand tobacco smoke became widely known it supported union activity around occupational health and civil litigation around exposure in public places. Successful civil litigation further shifted public opinion around domestic regulation and then an international treaty, the FCTC.

Public opinion does not always align so closely with public health objectives, particularly where the corporations are big advertisers and there is a strong right wing media presence in tabloid TV and shock jock radio.

Not all industries are equally sensitive to public opinion. It may be that the leading fashion houses are more sensitive to bad publicity (as with the Bangladesh fire) than seed and pesticide companies such as Monsanto.

Domestic regulation of, for example, the marketing of alcohol to children, may be seen as having a political cost while the onward march of 'investor protection' and ISDS in trade and investment agreements looks set to impose a serious chill on such strategies.

Strategies aimed at leveraging share holder opinion, in particular the votes of institutional shareholders, such as pension funds, appears to have potential but is difficult to implement.

The challenge is to create and maintain the institutions of regulation which will address the distributional deficiencies of unconstrained capitalism. However, in the present era the rise of TNCs and neoliberal globalisation has seriously tilted the balance between regulation and capitalist brutality – towards the latter.

We need to approach the idea of 'regulation' broadly, including:

- local and national regulation;
- global level regulation;
- public subsidy and public investment as well as restrictive regulation; and
- civil society refusal (environmental activists, workers, consumers, communities, investors) as a powerful element of effective regulation.

Meanwhile transnational capitalism is already putting in place an alternative set of structures for international regulation through a wide range of mechanisms, including the IMF, the US Trade Act, the Patriot missile, the CIA's drones and investor state dispute settlement in trade and investment treaties.

Relations of power and solidarity

Approaching the social determination of health within a framework of 'relations of power and solidarity' involves exploring how such relations explain the distribution and burden of hazards and harms and involves developing forms of action which are directed to re-shaping such relations for equity, compassion and health. Relations of power and solidarity can also help to explain forces and dynamics operating in the domains of economics and politics (see further below).

Relations of power and solidarity operate across axes of difference and across communities of identity.

Familiar examples of the relations of power operating across axes of difference include class relations (and work related injury and disease), racism (and violence or stress), patriarchy (and violence or unsafe abortion), castism (and environmental risks), disablism (and exclusion), heteronormativity (and violence or exclusion), religious sectarianism (and violence), communalism (and violence) and colonisation (and the marginalisation of

indigenous peoples). The health impact of oppressive relations across these axes can be devastating.

It is more complex in reality because no one's identity can be defined solely in relation to one of these axes. Thus for working women of colour who are oppressed across class, race and gender the hazards are multiplied and the protections dissipated.

Relations of oppression is only half of the story. We also need to consider relations of solidarity across axes of difference and across communities of identity. Simplistic slogans which enjoin solidarity within a single dimension of identity (working class solidarity, feminist solidarity, ethnic solidarity) can have some leverage in relation to particular issues at particular times but across time such solidarity can fragment because other axes of difference have been obscured (women have complained about being rendered invisible in discourses of class solidarity; lesbian and disabled women and women of colour have complained about being rendered invisible in discourses of feminist solidarity).

We need to unpack these concepts of oppression and solidarity. Oppression involves deploying power (force, money, knowledge, etc) to force 'the other' to behave in a particular way. In this degree 'the other' is objectified, is treated as an object. Solidarity is an expression of love relations rather than power relations. 'The other' is not an object; he/she is my brother or sister. This can be understood as 'inter-subjectivity'; when 'I' blends into 'we'. However, inter-subjectivity is not just a more plural subject; it also involves, in some degree, a closer alignment of our world views; the way we see the world.

These questions are fundamental to the activist project. Social change involves contention and conflict as well as dialogue and consensus. An unequal, unfair and unhealthy world order can be sustained when a small class of privileged folk (for example, the 'transnational capitalist class', see Chapter 2) are able to maintain control of resources and a disproportionate flow of income through maintaining suspicion and hostility among those who are disadvantaged. Driving change towards more equal, more compassionate and healthier societies requires the building of solidarity across axes of difference as well as within communities of identity.

However, building solidarity requires more than sloganizing. Creating relations akin to brotherhood or sisterhood involves learning enough about the lived experiences of 'the other' to identify with that person's experience; not simply projecting one's own values and expectations but deeply hearing how it feels. This is not a one directional relation; it is reciprocal; the building of inter-subjectivity; the building of 'us'. This involves acting together (as well as deep listening) and, in action, deepening communication (a more deeply shared language) and bringing our different world views into closer alignment.

Health activists need to understand the relations of power and solidarity which tend to reproduce hazards and exposures and which deny protection for the vulnerable. Health activists need strategies which respond at the socio-political level as well as the more technical level of preventives and protective; not as exclusive alternatives but as synergistic dynamics within a package of strategies; addressing the immediate needs in ways which also contribute to new social relations of health, well-being, equity and sustainability.

Approaching the social determination of health in terms of relations of power and solidarity involves a sharp departure from the conventional location of public health

professionals within the institutional structures of governance, providing advice to the sovereign. The power and solidarity perspective points instead to engagement in social and political movements for empowerment and reconciliation

- Indigenous struggles, eg for land rights;
- Struggles for gender equity, eg equal access to education, overcoming boy child preference;
- Occupational health struggles for safe, meaningful and adequately remunerated work.

It is useful to think about political movements as a somewhat different category from social movements although they overlap. The main difference is that political movements tend to address a much wider range of policy questions and prosecute a program which reflects a whole of society vision rather than focusing on a narrower set of issues. The idea of a political movement is complicated by the political party or parties which may represent it in the electoral process or which may provide leadership in other ways.

The social movement approach to better health (and a better world) depends on masses of people standing together: Health for All Now!

In many of the cases we have reviewed different alignments of interests and power across the axes of class, gender, ethnicity, religion, caste, ability have been central to stability or change. A classic case was the role of middle class and religious morality in the struggle against slavery. Likewise middle class concern was a significant driver in the health of towns movement in 19th century England.

The building of solidarity across these axes is necessary but there are significant constraints: different world views, different material interests. Competition for security and resources is commonly a wedge which prevents such solidarity as in the material insecurity which drives xenophobia.

Ultimately the building of such solidarity will depend on the sharing of experience; moving 'the other' from object to sibling; building (some degree of) inter subjectivity.

Governance, regulation and politics

Approaching the determination of health from a hazards and protectives perspective highlights the various technical measures that can be put in place to reduce exposures to hazards, with additional protection for those with specific vulnerabilities.

Approaching the determination of health from a 'social relations of power and solidarity' perspective highlights the challenges involved in building stronger alliances which can prevail in working towards a healthier, more equitable and sustainable world.

Approaching the determination of health from the economic perspective highlights the need for economic capability to achieve a healthier world and the need for regulatory structures (broadly understood) which can correct the distributional distortions introduced by perverse economic drivers and incentives.

All three perspectives point to the need for closer attention to the domain of governance, regulation and politics; the institutions and norms of dialogue, decision and democracy. It is clear that the norms and institutions of governance are critical intermediaries

in the social determination of population health; as well as being critical in the creation of an equitable, convivial, sustainable world.

The term ‘governance’ has come into widespread use in recent years, partly because of the obvious absence of anything which looks like *government* at the international level. Governance then speaks of the more complicated field of dialogue and determination. The phrase ‘multi-stakeholder dialogue’ is commonly heard in this conversation which is often code for recognising the power of the transnational corporations and the transnational capitalist class and finding ways to engage nation states and transnational corporations in determining the future of the world. This more pluralistic use of the term governance is also applied at the nation-state level where it helps to rationalise the closer involvement of the corporate sector in government decision making.

Notwithstanding its use in normalising the political power of the corporation the governance framework can assist democracy activists. It provides a useful framework for analysing the structures of decision making and in focusing people’s movements on the most strategic structural reforms needed to curb the corporate project and establish decision structures which prioritise people and the biosphere rather than the profits flowing to elites.

In Chapter 5 I introduced a framework for thinking about global health governance:

- Formal intergovernmental institutions and agreements (including the UN, WHO, IMF, WB, WTO);
- Empires, big powers and nation-states, including military capability and economic coercion;
- Transnational corporations including transnational finance (and their peak bodies);
- Disciplines of the market place (and the power available to large players to wield the disciplines of exchange rates, stock prices and credit ratings);
- Classes, constituencies and social movements;
- Ideas, information, knowledges, ideologies and discourses; and
- Influential individuals.

A similar analytical framework can apply at the national level. It would include more space for considering national governments and the specific dynamics of electoral politics. See Chapter 5 for more detail.

A few cases may help to explore the application of this governance framework in the social determination of population health; understanding causes and strategies of engagement. Consider:

- the governance of the global food environment;
- ‘the dance of legitimation’ around odious debt, structural adjustment and ‘development assistance’;
- the role of investor state dispute settlement in preventing public health regulation;
- the resistance of the fossil fuels lobby and associated industries to action around global warming;

- decisions driving the integration of the global economy with consequences for rising inequality, the continued exclusion of countries and classes from economic participation and the destabilisation of the biosphere.

The processes of social and political change

In Chapter 11 I have explored in some detail the processes of social change and the implications for the activist.

Here I underline three points from that chapter which are of particular significance to the activist working around the social determination of health. These are:

- complexity and unpredictability;
- unpredictability and windows of opportunity; and
- incrementalism, coherence and vision.

Society is very complex; it is impossible to predict what will happen beyond a surprisingly close horizon of predictability. Windows of opportunity will emerge but it is hard to predict when, or where, or in what sector or at what level of administration.

The Great Stink of London in 1858 was the 'opportunity' that advocates for sewerage renewal had been waiting for just as Bonaparte was the 'opportunity' in relation to the sewerage of Paris.

The release of massive quantities of tobacco company documents in the context of the Master Settlement Agreement (between the US state attorneys general and four tobacco giants) in 1998 in the US was a huge, and unpredictable, opportunity for the tobacco control lobby, providing further evidence to support advocacy for regulatory control and to drive public opinion further from any support to big tobacco.

The implications of the unpredictable windows of opportunity concept are first, to be as ready as possible for such unforeseen breakthroughs (the top drawer principle) and second, to work in various ways to unfreeze the old structures and to create the windows of opportunity.

Social change takes place incrementally, occasionally in large increments but mainly in small dispersed increments, variously driven by technological change, population movements, cultural change and almost any other driver conceivable. From the point of view of the activist the critical question is whether the aggregate outcome of a sequence of dispersed incremental transformations takes us closer to a more equitable, convivial, sustainable world or not.

It is impossible to predict where the next incremental change will take place although we can predict that there will be civil society activists watching and engaging with the change process.

A key strategic question is how to impart a degree of coherence to the civil society response to each of these dispersed opportunities for incremental change. Such coherence will not involve any detailed master plan; the world is just too complex. However, some degree of coherence in the civil society response to these dispersed engagements can be expected where there is a common vision, a high level sense of where we are trying to go rather than a master plan of how to get there.

The parallel engagements of public health advocacy and electoral reform during the sanitary revolution in Britain illustrates the idea of a common vision of a better society informing parallel engagements.

Changing attitudes to gender relations provides another example; opportunities for change arise unpredictably in many different settings but civil society responses are given some degree of coherence when there is a vision of the future which is in some degree shared by activists engaging around these different opportunities.

The need to tame transnational capitalism and the struggle against investor protection takes place in many different settings: the Uruguay Round, the MAI, and innumerable FTAs. A shared vision of a democratic, sustainable and egalitarian world in which corporate greed is contained will help to give coherence to progressive struggles in these many different struggles.

Civil society activism

My objective in this chapter is to reflect on the knowledge base and practical experience which activists draw upon in working to improve the social conditions which shape the health of communities.

The critical test, of the usefulness of these reflections, is the Monday morning test: how shall I practice? My focus in this final section is on the strategic principles and forms of action which the activist deploys; the organisational frameworks and ways of working which sustain such activist practice; and the capacity building needed to maintain and build this movement.

Strategic principles

Activists work from a variety of different settings: community based organisations, larger NGOs, primary health care facilities, public health units, academic settings, etc. These different types of organisation vary very widely and are accustomed to different ways of working. Likewise the issues themselves vary widely as do the entry points for action.

For these reasons the strategic principles, which can be drawn from the history, the cases and the theory covered in this chapter, must be formulated in relatively general terms.

1. Draw up a broad program but be flexible in terms of where you put your efforts; be alert to the structures which are currently open to change;
2. Invest in creating opportunities for change (unfreezing institutional and political structures);
3. Priority setting and campaigning have movement building objectives as well as external change objectives;
4. Build constituency; build alliances;
5. Critically engage with the professional disciplines and established institutions;
6. Be cautious of the reductionism of empiricist science;
7. Project a vision and build commitment around that vision;
8. Understand the links between the four perspectives (specific hazards, power relations, economic drivers, governance structures) and the implications of these links for strategy;

9. Understand the ways in which dynamics operating at different levels of scale (local, national, & global) interact to reproduce the hazards, oppressions, exploitations and corruptions (and can be changed to redress them); and
10. Trace, and test, the scenarios of change which might follow particular strategies (immediate, decades, generations).

1. *Draw up a broad program but be flexible in terms of where you put your efforts; be alert to the structures which are currently open to change*

Promoting the social conditions for Health for All can involve action in different domains (specific hazards, power and solidarity, economic drivers, governance structures); at different levels (local, national, global); and in different sectors.

Windows of opportunity can open in many different places; when the institutional and political structures unfreeze, a window of opportunity opens; the emergence of opportunity can be quite unpredictable; keep an open eye and open mind.

Be prepared; the window may be open for only a short time; we need to have policy ideas and campaign strategies ready; not finalised but the deep thinking needs to have been done (the top drawer principle).

2. *Invest in creating opportunities for change (unfreezing institutional and political structures)*

The emergence of opportunities for change can be very unpredictable; but we can make them more likely: policy research, policy dialogue, awareness raising, constituency building, capacity building. When the standard ways of dealing with a problem are frozen consider the scope for forum shifting and issue transformation.

3. *Priority setting and campaigning have movement building objectives as well as external change objectives*

Consider the opportunities for movement building as well as for achieving social change objectives in setting priorities for action.

4. *Build constituency; build alliances*

Effecting change through social movements depends on numbers in action and this depends on building constituency and building alliances. Map your publics and your allies; map the stakeholders around particular issues and struggles. Building constituency involves communication and engagement; building alliances involves communication, respect, reciprocity, trust building, building on small collaborations.

5. *Critically engage with the professional disciplines and established institutions*

Access to the full the knowledges, skills and strategies of the professional disciplines (public health, epidemiology, economics, political science, etc) whilst being critically aware of the institutional affiliations, power relations, class and gender commitments of those disciplines, their controversies (and the politics of those controversies) and their world views (and blindspots). Utilise to the full the established institutional systems of public health, law, governance etc whilst being critically aware of their class and gender commitments and their world views and blindspots.

6. *Be cautious of the reductionism of empiricist science*

Access critically the knowledges produced through reductionist empiricism; such knowledges are commonly *reduced* to the causal relationships which can be discerned once context and contingency have been 'controlled out'. Action to change the world must factor in context and contingency as well as generalisations. Reductionism produces knowledges which claim to correspond to a singular reality but statements about how society works always reflect a particular world view, a particular subjectivity.

Collect your own partial stories of description, explanation, and prediction; the stories of contingency and the generalisations of theory. The integration of incommensurate knowledges takes place in practice: we assemble all of the partial stories that we can handle; we iterate between them; we decide; we act; and, if it works in practice, it (the sum of partial stories) was 'true'.

7. *Project a vision and build commitment around that vision*

Change takes place incrementally, across time, space, sector and level. The objectives and strategies adopted for different engagements (at different times, in different places and sectors and at different levels) will vary widely. Change in the aggregate is the sum of these incremental changes; progressive change depends on a consistency and coherence across these different struggles. Developing and building support for a shared vision regarding our broad directions will contribute to greater coherence across such struggles.

8. *Understand the links between the four perspectives and the implications of these links for strategy*

Understand the specific hazards; causes, vulnerabilities; and protective.

Identify the unequal power relations which reproduce those hazards and vulnerabilities and which restrict effective protection; work towards redressing those unequal power relations (new alliances, new information flows) and building stronger relations of solidarity across difference (dialogue, sharing, collaboration).

Contextualise the hazards, power relations and governance issues within an economic framework: economic capability, distributional issues, economic drivers, relations with globalisation, economic reform, and economic development.

Contexualise the hazards, power relations and economic dynamics within a governance framework, at both national and global level. Factor governance reform into the action program.

Campaign in terms of which ever approach (or mix of approaches) is most strategic in relation to opportunities for change (unfrozen structures), movement building, and alliance building.

9. *Understand the ways in which dynamics operating at different levels of scale (local, national, & global) interact to reproduce the hazards, oppressions, exploitations and corruptions*

Reflect on how local experiences and perceptions shape and are shaped by wider political dynamics; how national options are shaped by global dynamics; alliances and collaborations which can challenge those global structures; how global dynamics are

supported by or could be changed through national level action (eg national positions in trade agreements) involving policy advocacy and movement building.

10. Trace, and test, the scenarios of change which might follow particular strategies (immediate, decades, generations)

Elaborate narratives of possible engagements (scenarios) which meld in the most coherent ways the strategies and forms of action suggested by the different ways of framing the problem. Test those stories against the likely responses of various stakeholders and possible unforeseen complications. Identify the horizon of confident prediction; look for strategies to build capacity further down the track, beyond the horizon of confidence.

Forms of action

Refer to Chapter 13 for discussion of the different forms which activist practice can take:

- Information strategies, including research, through which the forces for change may be emboldened and the dominant ideologies delegitimised;
- Cultural action which throws new light on the familiar and helps to articulate alternatives;
- Networking and dialogue leading to stronger alliances and more coherent action; for example, alliances between the health movement and the environment movement;
- Community engagement, such as PHM's right to health initiatives, through which people and communities gain new confidence in their power to change, while addressing priority issues; campaigns, demonstrations, write-ins etc;
- Policy critique and advocacy;
- Service development reforms, creating health systems that address the structural determinants of health as well as the biomedical;
- Institutional reform, creating institutions that are accountable and responsive and which clear the path for progressive change;
- Personal behaviour change (eg away from patriarchy, away from materialism); changes which are both individual and collective; intentional and cultural; personal and political;
- Movement building.

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