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Health Governance: The Health Society

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1. Introduction

Health and disease have physical realities, but they are also social constructs that are continuously redefined and lead to changing forms of health governance. The changing nature of health is related to and builds upon other contemporary societal trends of modernity such as individualization, differentiation, and globalization; it also contributes significantly to the concrete manifestation of these critical components of modern life. This means that health, as we understand it and live it today, is not only an outcome of other social and economic developments but a significant defining factor. The most obvious example is the increased health and life expectancy in modern societies which is redefining nearly every arena of social life and policy. Due to a lack of theory in health promotion we have not yet analyzed sufficiently how integral health is to Western modernity and who we are today.

This chapter will trace some of the developments that have made health central to modern societies and have led to the development of health promotion as a new form of health governance. It makes use of a range of sociological and historical studies with a clear bias towards the understanding of modernity as developed by Anthony Giddens (1990) and Ulrich Beck (1992).

Modernity in this understanding encompasses a long time period starting with the European enlightenment through to the present. The development of modernity is not one grand narrative, even though it is helpful to distinguish as some authors do—such as Beck (1992) and Baumann (2000)—between specific phases within it. Even these authors, however, underline that modernity is an uneven development which is characterized by its discontinuities and its double-edged character. While some authors like Bauman maintain that we have reached the end of modernity and are now in a period of post-modernity, I concur with Giddens who takes the view that we are presently moving into a period of late modernity "in which the consequences of modernity are becoming more radicalized and universalised than ever before." (1990) Following the period of the industrial revolution—which Beck calls simple modernity—we now experience the consequences and new risks of the human-constructed technological and social development that have followed in its wake.

Modernity has brought with it both vastly increased opportunities and vastly increased risks, great leaps in social development on the one hand and brutal totalitarian regimes on the other (Mazower, 1999). Giddens (1992) describes the key features of these discontinuities as being: the speed of change, the scope of change and the abstract nature of modern institutions. He also makes clear that modernity is inherently globalizing and produces new forms of interdependence. This "global risk society" (Beck, 1992) poses new challenges to governance and shows the limits of governing structures that were developed to answer the problems of industrialization. It also replaces the industrial notion of control and discipline with the late modern notion of flexibility and reinvention of self, (Sennet, 1998).

Modernity is highly dynamic and it has one big message: expansion. By definition modernity sees itself as infinite: more is always possible, something else is always possible, there is a multiplicity of choices in everyday live. This drives the continuous increase of options, the increased participation in these options and the extension of rights to minimal participation in the options that are available. Inherent in the notion of expansion is the premise of progress: more is better, (Gross, 1994).

An important dimension of the debate on modernity is the manifestation of risk and choice in everyday life—indeed much of the political agenda in the risk society is set by social groups and their perception and definition of risk as well as their understanding of identity, (Giddens, 1991). Since the risk society is also a knowledge society with wide access to media and information, agendas are frequently set in the social rather than the political sphere. Beck calls this "subpolitical activity": every problem of everyday life can be transformed into a political issue and a wide range of groups not involved in the "normal" political process, set agendas related to their lifestyles and "lifeworlds", (Giddens, 1998). As a consequence a "reinvention of politics" takes place. It creates a new political space with an ever increasing cast of social actors setting new themes driven by "reflexive modernization"—that is self-confrontation with the effects of risk society.

It is in such a way that individualization and differentiation not only lead to fragmentation—the patch work society or the patchwork personality—but also bring together like minded actors based on a wide variety of social definitions—women, gays, patients, persons with disabilities, environmentalists, anti globalization activists. They act for their interests beyond their relationship with economic activity in terms of class identity and classic ideological party politics of simple modernity. Giddens calls this life politics: "Life politics concern political issues which flow from processes of self actualization in post-traditional contexts, where globalising influences intrude deeply into the reflexive projects of the self, and conversely, where processes of self-realisation influence global strategiesM (Giddens, 1991, 214).

Within modernity health has taken on a new meaning and has become a major driving force in society. Health has shaped the nature of the modern nation state and its social institutions, (Porter, 1994), it has powered social movements, defined rights of citizenship, it has contributed to the construction of the modern self and its aspirations. This chapter will attempt to describe some components of the changing

nature of health by introducing the concept of the "health society". The dynamics and discontinuities in health today are generated through the interaction of three expansion processes: do-ability, territory and reflexivity.

2. The Beginning: The Enlightenment

Health is integral to the new *"modes of social life or organization which emerged in Europe from about the 17th century onwards and which subsequently became more or less worldwide in their influence*" (Giddens, 1990, 1). The creation of the health society of the 21st century has been a process long in the making and this short chapter can only highlight some of the key dimensions and turning points. To some extent the four domains of what we call the health system—personal health, public health, medical health and the health market—also represent the historical sequence of the dynamics that lead to the health society. While the systems of personal health and public health dominated the 18th and 19th centuries, during the 2oth century the medical health system gained increasing strength both in terms of its power of definition over the social construction of health and the dominance of its governance structures. It is specific to the health society that all four domains of the health system continue more or less to expand but there is a growing dominance of the market and a newly defined role of the citizen in health.

From the very beginning, the modern health discourse was characterized by the simultaneous upheaval in two spheres of life: the public and the private, the political and the personal. Health as a major new driving force shapes the state, society and politics through the creation of new social institutions and organizations while at the same time it changes the most intimate dimensions of personal and daily life. Michel Foucault stated categorically that the modern (sic) body is a "product of governance", which he analyzes primarily as a process of increased medicalization and control (Foucault, 1994). In order to fully understand the nature of the health society under conditions of late modernity it is necessary to shift this perspective to one that understands the body—and by extension health—as a core part of the construction of modern self identity and reflexivity.

With the enlightenment came the vision of being able to achieve perfect health and freedom from disease as a result of both rational science and social progress. The articles on *hygiene* and *health* by Diderot and d'Alembert in the Encyclopedie of 1776 (Sarasin, 2001) sound the beginning of the new age of reason. Disease is transformed from fate to risk: like nature disease can and must be conquered, tamed and civilized. The European enlightenment freed health from religion but linked it to morality, to the extent that health took the place of redemption. Physical health and moral health were considered to be closely interrelated and frequently the attempt to make people healthier was the entry point to make them morally better. Health was understood as the most perfect expression of the human condition, not only in the physical but in the metaphysical sense. To this day this utopian quality is reflected in many definitions of health, the most prominent being the definition adopted by the World Health Organization and included in its

Constitution: *"Health is a state of complete physical, mental and social well being, and not merely the absence of disease*" (WHO, 1948). Access to health and later to medical care became a synonym for social progress, social justice and in a historical breakthrough, the right to health was codified as a human right in the Declaration of Human Rights in 1948.

This link between health, science, governance and progress has served many ideologies, the most dangerous being those that set health as an ultimate value and combined the goal of health and of a society free of disease with totalitarian concepts of the perfect society and the perfect human being (Mazower 1998). Yet in principle the promise of health and freedom from disease through good governance combined with the application of medical and scientific discovery was achieved to an extraordinary extent and with remarkable speed in European societies. Within a very short historical time span—about 100 years—a long and more or less healthy life has become a demographic fact and a popular expectation. This success of health is in turn a driving force for many other policy developments and personal and social expectations in the health society. Indeed the very success of health creates new problems and ambiguities.

3. The Modern Governance of Health

It is one of the characteristics of the health society that **the do-ability of health** has expanded far beyond the ever rising expectations of the curative medical care and repair system. Health is considered a right and its do-ability is driven not only by universal access to the medical health system but also by the salutogenic (Antonovsky 1987) promise that *health* can be created, managed and produced by addressing the determinants of health as well as by influencing behavior and lifestyles. *More health is always possible.* Health governance in late modernity follows a conceptualization of health as "well being beyond the absence of disease" as defined by the World Health Organization in its constitution; health is linked to the capabilities and resources of individuals, communities and for society as a whole. This infinite nature of health has consequences for all four domains of the health system: it opens up new manifestations, such as wellness, and allows for the growth of a health market which attaches the added value "health" to an ever growing set of products and services. Additionally, it systematically expands the role of the state in health through new types of regulations which influence the behavior of individuals and their role in the production of health.

A modern nation state is usually seen to fulfill a number of essential functions for its members: security, rule of law, welfare and physical well being and common identity. Systems of government incorporate two principle elements: the basic institutions of governance and the organizations of governance. In governance theory, institutions are defined as the rules, norms and principles along which governance occurs and *"which define the meaning and identity of the actors and the patterns of appropriate economic, political and cultural activity engaged in by those individuals"*. In short institutions are the rules of the game. The organizations of governance

are the *"material entities established to administer the provisions of governance systems"*. (Young, 1997) A health governance system in consequence must be analyzed with both the institutions and the organizations of governance in mind.

Before the industrial revolution, the state's role in securing health was limited to the cordon sanitaire and the quarantine. This was used as an attempt to defend against disease transmission and major outbreaks in order to ensure security and trade. Beyond these measures, the only existing organization of health governance, more of less, was the charitable hospital for the poor, an institution that every citizen aimed to avoid, and "bedside medicine" which was accessible for those that were better off. With the 18th century comes a revolutionary break with the past and the development of a new approach to health governance that moves it beyond security to the others functions of the modern state and the modern citizen. In their Encyclopédie Diderot and d'Alembert in 1776 (Sarasin, 2001) address the two intersecting dimensions of health governance: the public and the private. It becomes part of the role of the state to ensure health as a common good *(l'hygiène publique*) but at the same time health becomes (as *l' hygiène privée)* part of the civic and moral duty role of the individual citizen.

In modernity health **expands its territory** to become an integral part of the rules, norms and principles of social progress and the 19th century is witness to a significant expansion of both health governance organizations and institutions. In the process of modernity health becomes part of all other governing functions. The introduction and first phase of modern health governance in Europe—or what today we call the first of sanitary public health revolution (Terris, 1985) led to improved sanitation, better housing and nutrition, improved working conditions, family planning programs, compulsory immunization, maternal and child care through an extraordinary amount of laws introduced to ensure population health: vaccination acts, sanitary laws, laws that deal with living and working conditions, laws that ensure food safety as well as laws that aim to control "vices" such as alcohol and prostitution. In his later work on bio-politics in lectures held at the College de France in 1978–1979 Foucault underlines the difference between strategies developed to ensure security within everyday life and those that discipline everyday life (Foucault, 2004). We must also not forget that modern health governance was not introduced without conflict. Particularly the drastic measures taken by authorities on occasion of major outbreaks, such as small pox or cholera epidemics had great impact on the everyday lives and livelihoods of people and were often met with strong opposition (Bliss, 1991).

The link between health security and the nation state begins as early as 1810 as a number of countries on the European continent introduce compulsory small pox vaccination. In England in 1848 the first Public Health Act is adopted and in 1855 a permanent medical officer is appointed to advise the government. In the newly established German Reich the Iron Chancellor Bismarck uses the introduction of health insurance in 1883 as a mechanism to integrate the political opposition and shape the identity of the modern German nation state. In 1918 the new Soviet Union includes the right to health as one of the first articles in its new constitution. After the Second World War many European countries introduce universal access

to medical care as part of the democratic entitlements of citizenship and a defining characteristic of the modern welfare state. Increasingly health governance is expanded to include safety, security and control measures, welfare and access to medical care rights and ensuring quality of life and citizen identity. Health is a driving force of the continuous expansion of the welfare state and the changing expectations of its citizens.

One of the characteristics of modern societies is that they establish abstract systems of expertise and governance to assess and manage risk. These systems represent a central feature of modernity: a disembedded mechanism "which removes social relations from the immediacy of context," (Giddens, 1990, 21). The first public health revolution was so successful because it was so essentially modern in its approach. It developed a totally new abstract system of understanding population based health risks which was provided by the realization that disease distribution is not random. While initially disease was seen to reside in the environment and attack individuals and society from the outside, the new science of statistics and the birth of epidemiology provided data which painstakingly mapped the causes of disease from within society.

This realization then structured the great debates about do-ability (intervention) and responsibility (territory) and drew the battle lines of the public health debate to this very day: does ill health produce poverty or does poverty produce ill-health? do we blame the victim or society? do we intervene with the individual or on the structural determinants? The debates around state intervention in the context of public health were not at all dissimilar to the debates around government intervention in "healthy lifestyles" today. While Edwin Chadwick, the great British reformer, found the key relationship to be between disease and dirt, Louis-René Villermé, the great French health statistician defined death as a social disease and outlined how medicine, guided by political economy, must and will become a social science. This view was later echoed by Rudolf Virchow and all those committed to what would be called "social medicine". What united these very different political orientations was their joint expectation that one day there would be an end point, when the battle against disease will have been won through the efforts of society. "All believed", says J.N. Hays of the great sanitarians "in the power of civilization to eradicate disease," (Hays, 1998).

This changed, as in the 20th century health governance the power to eradicate disease shifted from society and public health to medicine. The triumph of the germ theory over environmental approaches began on March 24, 1882, when Robert Koch announced that the tubercle bacillus was the cause of tuberculosis. Health became do-able in a new and, it seemed, much more efficient way. The new medical knowledge allowed the focused attack on the agent of the disease—the germ, the bacillus, the virus—rather than having to deal with a complex environment or difficult populations. As drugs and technology became increasingly available, the power to eradicate disease was seen to reside with medicine rather than with social progress, indeed the progress of medicine was equated with social progress and the sanitary and the social perspective made way for an individualistic view of health and disease, (Porter, 1997).

Yet it was the very success of the social perspective and the political public health that made the success of the medical system possible. Mortality had been reduced by an extraordinary extent in a very short period of time, (McKeown, 1980), and by the early decades of the 20th century living conditions had improved considerably and led to new social expectations. For example the high levels of maternal and infant death were no longer socially and politically acceptable, particularly to women who had gained rights of citizenship and could cast their vote. In addition European nations were suffering from the impact of the 1914–18 war and the 1918 flu epidemic. There was strong pressure on politicians to instigate measures that would provide hope for the future and bind voters and the political demand that emerged (and has remained to this day) was for more access to medicine and its promise.

It is at this point that the health governance perspective shifts radically and moves into the dominant mode of expert medical care provision—which rapidly gains more power than the by now established public health system. It also overshadows the system of self determined personal health. The term health loses its many dimensions and part of its power of emancipation and becomes synonymous with medical care. In Europe, this is achieved through an extraordinary coalition between medicine and the expanding welfare state, which begins to guarantee an increasing number of social rights. The—wrongly named—health system grows at an astonishing speed and through new financing mechanisms such as medical insurance (usually linked to the workplace) increasing numbers of the population gain access. European countries reach near universal coverage by the mid 20th century, and medical and technological developments, as well as demographic shifts, drive its continuous expansion. The leading health governance principle in the welfare state had paradoxically shifted from addressing the needs of population health to treating the individual citizen; in the process, it transformed the ideal of the participating and knowledgeable citizen of the enlightenment era into the passive and compliant patient who follows the physician's instruction.

4. The Expansion of the Territory of Health

Yet only fifty years later the shift towards the health society sets in. The expansion of life and health expectancy, the high level of security in welfare states, the increase in education levels and health knowledge and the democratization of society continue to drive the ever increasing expectations towards the medical system and what it can do—but they also drive individualization and increase the reflexivity about the very process. As health increases so do personal expectations of ever better health and the recognition that modern society itself has become a "risk environment" for health. The body is perennially at risk even in the most familiar surroundings (Giddens, 1990), risks lurk in food, in the air, at home, at work, in the street and the most intimate pleasures become risk behaviors. Health security threats are also consistently referred to as one of the most disturbing consequences of globalization, either as terrorist threats (for example anthrax or small pox virus) or infectious disease threats, such as the avian flu, (Chen et al. 2003).

Not only were the expectations that had been generated by the marriage of modernity and medical progress only partially fulfilled, the germ based cause effect model was also ever more difficult to apply to the health profile of late modernity which had shifted to non infectious diseases, also frequently referred to as lifestyle diseases. Initially the medical system turns to a personal health model and delegates the prevention challenge into ever increasing expectations towards individuals to choose rational and responsible health behaviors The limits of such a model became clear at many levels: not only do health choices depend on many factors other than knowledge, but the equation of the enlightenment as formulated by Immanuel Kant "to know and to be certain" no longer applies under conditions of late modernity. There is always more to know and what is considered healthy today may not be healthy tomorrow as illustrated in the decade long struggle over the effects of alcohol on health.

Healthy choices are complex within a "risk society" where unknown and unexpected risks emerge over which the individual has no control whatsoever and which are a consequence of progress itself, such as environmental risks. Or where old risks are communicated in new ways and are suddenly in the center of attention, such as certain rules of nutrition. The most intimate actions—such as nursing a child or having sex with strangers—are connected to distant outbreaks (such as the events of Tschernobyl or the advent of HIV/AIDS) and are subject to new knowledge and revisions of behavior. They constantly alter their character, (Giddens, 1990, 38), and in contradictory turnabouts the breast is not always best and sexual adventures need to be practiced as "safe sex".

The risk profile of late modernity emplies that solutions need to be found beyond the medical health system and that health policy needs to concern itself with investments in other parts of society. Finally the growth of the medical health system itself begins to be seen as counterproductive: "A society that spends so much on health care that it cannot or will not spend adequately on other health enhancing activities may actually be reducing the health of its population." (Evans & Stoddard, 1994).

The massive health education campaigns that were conducted in this period alter both the perception and the experience of health risk and support an increasing awareness of limitations of medical expertise and the application of the cause effect model. Health moves out of the expert medical system into the context of everyday life and everyday behavior and becomes ever more open to social rather then medical definitions and constructions. This drives the **expansion of the territory of health.** *Health is everywhere*. It is created—to quote the Ottawa Charter for Health Promotion, the seminal WHO document that originated in 1986—"where people live, love, work and play". (WHO, 1986)

A broad understanding of health determinants beyond the classic determinants of income and poverty—ranging from social support to the hierarchical structures of society, from gender to race, the organization of work to the social cohesion and social capital of communities—not only expands the health policy arena into wide range of other sectors but also expand its policy reach into the most intimate areas of personal life and behavior.(Blane et al, 1996) These health determinants are

complex and do not respond to simple cause and effect models, they are frequently not visible, build up over long time periods and usually need a cluster of responses and interventions that present policy and administrative structures do not allow.

The contradictions inherent to the health society and its expansions make health a prominent feature in social and political discourse. Modernity's promise of universality and inclusive citizenship and its reality of systemic exclusion (Breman, 2004) are perhaps more tangible in health than in other policy arenas. An ever increasing array of health actors participate in the shaping of a 21st century understanding of health and its role for the individual and for society. A major expression is the rise of identity politics in health, through which groups which define themselves through a common health claim or disease characteristic come together as political actors to demand more recognition, more prevention, more research or more services. The dominant issue at stake is no longer "medicalization" and the power of the medical profession, rather the debate evolves around privatization and commercialization, empowerment and participation, social inclusion and exclusion, public and private.

This is exemplified through the wellness revolution which marries personal health and the market, choice and do-ability. Health translates into a product that can be bought on the market, promises wellbeing and changes the citizen into a consumer. Health is considered "the next big thing of the 21st century . . . . which promises to revolutionize our lives and offers opportunities for tremendous wealth building over the next ten years". (Pilzer, 2002) These health goods and services include the fitness market, cosmetic surgery, lifestyle drugs such as Viagra and the market for vitamins, minerals and health foods. They also include new types of health insurance, which would pay for health not sickness services and which would reimburse the tools and services the new industry has to offer. Calculations indicate that in the United States alone the sales of the wellness industry have already reached approximately $200 billion and that it is set to achieve sales of $ 1 trillion within 10 years. For many existing industries health has become an "active added value" either as a sales pitch or in the form of supplements and product enhancements. Providing access to information on health and new health products and services including e-health becomes one of the greatest business opportunities of the foreseeable future. In the typical ambiguity of developments under modernity the market also provides the opportunity for consumer movements to engage for products and services that create health.

But the danger of widening the health gap grows, as the healthy and better off buy an ever increasing amount of health and wellness while cuts in the public sector not only reduce prevention and health education services for the poor (for example nutrition education) but also weaken public safeguards on harmful goods and services (for example access to and advertising of soft drinks and junk food in US schools).

5. The Expansion of Reflexivity of Health

As do-ability increases so do options, choices and insecurity. *Every choice in daily life potentially becomes a choice for or against health*. This leads to the

expansion of the reflexivity of health. The revolutionary change and promise of health governance that came with the European enlightenment of the 18th century was that health is not a natural state but can be produced and created through the application of scientific progress and knowledge once the will and the commitment to act is generated. Science would provide the basis for rational governance for the common good. But as one of the consequences of modernity this belief in rationality has been shattered: many of the health risks are linked to the development of modernity itself and frequently science—despite its infinite promise of genetics and biotechnology—has no answers for common health problems in everyday life.

At this point of modernity knowledge no longer means certitude. As the risks are frequently not visible and intangible they need to be communicated and above all understood and translated into action. As more and new health information becomes available health practices need to be constantly revisited and revised, a constant reappraisal of actions under conditions of uncertainty, both by policy makers and ordinary citizens is necessary. The expansion of health choices demands an ever higher degree of sophistication, participation and literacy and in consequence there is a growing offer and demand for health information.

With the introduction of public health as a function of the modern state, health moves from a personal ideal of the individual citoyen and man of means to a concern of the emerging working class as well as the larger population. Sarasin provides a nice wordplay on the changes between the 18th and the 19th century conception of personal health: in the 18th century the emancipated citoyen, a member of an exclusive group, needed to know everything about his body, now in the mid 19th century everybody needs to know about health. (Sarasin, 2001, p. 120) This could only be achieved though a major educational effort and democratization of health knowledge and we witness the beginning of the age of mass hygiene education.

Health provides a sense of purpose to a wide range of philanthropic and political societies who saw it as their ultimate goal to improve the health knowledge (and frequently the morals) of the working classes and the excluded members of society. What had been true for the citoyen—empowerment and emancipation through health—now was presented as a message for everybody in a flood of journals, books, lectures and pamphlets—but also as part of political mobilization. For example in 1895 191 journals were published on Paris in the field of medicine and hygiene—21 were for general readers and the most popular was the Journal de la Santé with 29 000 subscribers. (Sarasin, 2001)

But health also forms part of political mobilization and moves into the realm of rights and of equity. Indeed from the 19th century on claims for access to health and access to citizenship increasingly converge and become a driving force of social and political movements while opponents decry the increasing influence of the state on the individual and his health decisions. Walter Holland quotes a Leader in *The Times (1854) which states: "we prefer to take our chance of cholera and the rest than be bullied into health*". (Holland & Stewart,1998) Yet by the early 20th century the role of the modern state in health governance was firmly established through public health systems and social reformers and conservative politicians, radical social movements, professional societies, philanthropies, civil society and

the market, all participate in the attempt to define and order the territory of health. Health governance is always about inclusion and exclusion and health governance debates are always also about social justice. Health became part of the political agenda because increasingly all parts of society understood that health was doable and early death and disease were accepted less and less. A consensus began to emerge that through public health measures society had a responsibility to address health inequalities and protect the population's health.

The citizen/citoyen that Diderot and d'Álembert had in mind was a man. Denial of equal citizenship to women was—as widely documented in the feminist literature—paralleled by the denial of having control over their own bodies, their sexuality and their reproductive capacity. It was the male body that entered the public sphere and that became the norm for what it meant to be healthy. To be female was to be the other, the private, the non-citizen. In consequence the early feminists who fought for the right to vote argued that their bodies (as bearers of children) were as important to the state as the male body (as a soldier defending the nation). Women's health has remained an exemplary area of the interface between health rights and civil, political and social rights to this day. The women's health movement of the 1960ies and 70ies makes personal health into a political program exemplified in slogans such as "the personal is political" or "my body belongs to me". And most recently through the AIDS movements of the 80ies and 90ies health has become a social and political force of integration and access first for the excluded gay community then for the excluded poor in developing countries. The present global drive for access to AIDS medicines for developing nations is the spearhead of a global citizenship movement.

6. Health Promotion: A New Health Governance Map

The development of the health society is part of a general change in social values (Inglehardt, 2000) linked to modernity which are usually described with the following characteristics: Individualization, Differentiation, recognition of the value of autonomy and self-responsibility, subjective/holistic well being, high expectations and quality of life. These social trends correspond with the epidemiological development symbolized by the two public health revolutions that changed the face of health and disease in the 19th and 20th century. The major improvements in living conditions and health make major shifts in the overall organization of modern societies possible. The citizens become participants in health creation and health decision-making with all the ambivalence it implies: the continuous processes of individualization have widened choices and life options (empowerment) but have also led to an increased delegation of risk management to the individual, the family the community. (Lupton, 1999)

A new governance map for health was drawn in the 1970ies with the publication of two seminal reports. The first "A new perspective on the health of Canadians" was developed in 1974 under the responsibility of health minister Marc Lalonde (Lalonde, 1974) and presented a health field concept which was to significantly

influence the health policy approach of many OECD countries for years to come, in particular when used by the WHO as a model for its own policy approach. The second was "Our Bodies—Ourselves" by The Boston Women's Health Collective, a book "by and for women" which shattered all views held so far of women's health and heralded a new level of involvement of people in defining and creating their own health (The Boston Women's Health Collective, 1970). Together they laid the strategic foundations for the third public health revolution and health promotion.

The Lalonde report stated that in order to achieve better population health—or to stay in the terminology of this chapter to address the health risks of late modernity—four fields of determinants must be addressed: biological factors, the physical and social environment, lifestyle factors and health care services. The report highlighted that many if not most of the factors determining population health were outside of the remit of the health services and initiated a new phase of the expansion of the territory of health, which in turn was to nurture the WHO Ottawa Charter on Health Promotion. (WHO, 1986) This charter reframed the Lalonde domains as: healthy public policy, supportive environments, community action, personal skills and reoriented health care systems. The Lalonde Report as well as the Ottawa Charter showed clearly that health care services were only part of the solution; indeed they might also be part of the problem and needed to change radically.

The seventies and eighties saw the ascent of two strategic approaches which tried to move health away from the medical model of production and control. One was through the introduction of technocratic strategies from the private sector into the health arena as exemplified by the US Health Objectives for the Nation which introduced an approach to plan for health by setting measurable goals and targets. (US Public Health Service, 1979) The movement to construct health targets was an attempt to govern the expansion of territory and risk in modern society through professional strategies. In contrast "Our Bodies—Ourselves" by The Boston Women's Health Collective, sounded the start for a new type of citizens involvement for the power of definition in health and showed that many of the issues that were defined as biological differences by science and the medical profession as being social and political. It was the women's health movement that most clearly expressed the direction health was to take at the end of the 20th century as individualization and identity politics become political program: the personal is political and my body belongs to me. This was echoed—albeit in less radical form—in the growth of the self help movement and the many patient organizations where citizens set out to become experts in their own disease. (Kickbusch, 2002a)

Analyzing the Ottawa Charter for Health Promotion through the analytical constructs of modernity theory and the health society shows the extent to which it responded to all three expansion dynamics of the health society. Its success can probably be explained by the fact that it is the first health policy document to fully reflect and codify the role of health in late modernity, an approach that is often referred to as "the new public health". It defined health to be a resource and an integral part of everyday life, it acknowledged and legitimized the expansion of the territory of health and proposed policy actions in all sectors of society through

"healthy public policy", It based its proposals on the salutogenic promise that health is doable: it can be created but at the same time it made clear that this creation involved the citizens and the communities themselves in a participatory process. The definition of health promotion first and foremost recognizes people as social actors and agents and has a focus on their empowerment in the sense of lifepolitics: health promotion is the process to increase control of people over their health.

In consequences some authors (for example Petersen, 1996) contend that this is not a move towards empowerment but an increased privatization of risk. Yet this is much too narrow an interpretation rooted in the control and discipline paradigm, rather than in the paradigm of reflexive modernity. The Charter reflects the ambiguous "fit" with wider social trends under way that define and structure everyday life. We can now—in the words of Lester Breslow, (1999) a leading social epidemiologist—"turn more attention to the nature of health and regard it . . . as a resource for living" and we can focus health promotion strategies on "capacity building for health". He terms this the third public health revolution. Within this revolution *l'hygiène publique and l'hygiene privée* are both necessary and legitimate and intertwined in a wide variety of ways.

A shift to a model of health promotion recognizes the importance of the structural dimensions of a public health approach to health governance as put astutely by Rose (1992): "*the primary determinants of disease are mainly economic and social, therefore its remedies must also be economic and social.*" Yet it assigns a much large role to citizens as social actors in all four domains of the health system. Its premise is that despite all ambiguities social change for health is possible and that systems can be changed through radical engagement and collective action. It is because of this empowerment dimension that health promotion is more than a professional strategy and why frequently it has taken on the character of a social movement. Health promotion reinterprets the message of The Boston Women's Health Collective in the form of modern life politics: the choices we make in health everyday are indeed not just about our weight or our smoking habits; they are political in their own right and have political consequences not only of a local but of a global nature. The litigation cases against the tobacco and the fast food companies are a case in point as is the debate around TRIPS in the World Trade Organization. They attempt—as Beck would put it—a constant day by day answer to the question *"How do we want to live?"*

7. The Deterritorialization of Health

A number of key dimensions define health in the health society.

First: the health society implies that health is present in every dimension of life. In its mirror image it also implies that risk is everywhere. This has significant consequences for how we frame health policies and where we assign responsibilities for health in society. If health is everywhere every place or setting in society

can support or endanger health. Stakeholders in the big health debate are not only the producers of unhealthy products and substances but the arenas of everyday life where they are consumed. One of the consequences of the health society is a shift from material entities and organizations that are clearly defined as "health organizations" (in this case the medical care system we tend to call the health system) to an increased dependence on institutional mechanisms which apply throughout society and which regulate behaviors and the access to or the consumption of products.

Typical examples are smoking regulations: they not only regulate who can buy tobacco products, where and at what price but they also regulate where it is permitted to smoke. Over time smoking restrictions expand to all settings in society: first usually schools and hospitals, then major public places, then all forms of transport, then restaurants and bars until finally—as is the case now in New York, practically no space remains outside the home where smoking is permitted. Smoking laws also regulate the access to images and message through the restriction of advertising for tobacco products. Health it turns out really is everybody's business in a symbolic and a real sense: owners of bars and restaurants, retailers, the management of airports and railway lines to name but a few, all need to be concerned with health. Settings of everyday life become "healthy" settings through a commitment to norms and standards and patterns of appropriate behavior—with laws and regulations sometimes promoting, in other cases following cultural shifts. (Kickbusch, 2003)

Second: we are therefore not only witnessing an expansion of the territory of health—increasingly we are witness to its de-territorialization. Health policy becomes ever more virtual—it moves in a new political space with a new quality, it transcends functional specialization but is clearly subject to increased individualization and differentiation. This raises a number of issues in sociological theory in which the "health system" is frequently referred to as a subsystem which is committed to a certain functional specialization that only it can fulfill. According to Niklas Luhmann (1995) such a functional subsystem is organised around a binary code, which controls the selection of decision belonging to the subsystem. In this case the health system's reference point would be the binary reference code disease—health.

This may well apply to disease and the medical system—which Luhmann probably had in mind—but it does not apply to health. The territory of the medical system continues to grow continuously and can be relatively clearly circumscribed, the territory of health not only grows, it becomes ever less tangible. This de territorialization is of course the reason for the modern health policy paradox: *"One of the great paradoxes in the history of health policy is that, despite all the evidence and understanding that has accrued about determinants of health and the means available to tackle them, the national and international policy arenas are filled with something quite different"*. (Leppo, 1998). Policy in health societies is out of sink and still frames "health" in terms of expenditure and consumption of health care services and very few institutions, organizations and funding programs clearly differentiate between program that focus on *health* and those that focus on health care.

Third: in the health society health has become a "co-produced" good which needs the cooperation of many sectors and actors in society. Not only must the synergy of the four domains of the health system—personal health, public health, medical health and the health market—be harnessed but it is also necessary to gain the support of policy arenas such as environment, labor, agriculture and education to name but a few. Yet there are very few policy mechanisms that allow this to happen in an integrative manner. Each of the health domains in turn has its own contradictory driving forces—control/empowerment, risk/social reform, expert knowledge and profit—and has developed its own set of categories of governance of the body and the body politic. At the same time the role of the state in ensuring health security is subject to major shifts. The governance of what in most of the literature is called the "health system" (but rarely deals with health), is due for a revolutionary overhaul due to financial, technological and demographic developments.

Fourth: in the health society the salutogenic governance premise is investment related to the ubiquity of health. It proposes that the health dollar is best spent by productively reorienting it towards the production of health or, in the terminology of the third public health revolution towards resources and capabilities. The focus of health policy then is to produce a larger health gain for society, irrespective of sectoral divisions. This of course is difficult because no functional system exists within governance systems of late modern societies to respond to a deterritorialized policy arena and policy in late modern societies. This results in what has been called "organized irresponsibility". (Beck) Each policy (sub)system concentrates on it own logic and intentions without regard for the impact on other areas of society. This can only be partially and insufficiently addressed through mechanisms of health impact statements, particularly given the expansion of health in the marketplace.

Fifth: in the health society the domain of personal health returns to the fore in a new form: with increasing autonomy, individualization, and choice. Individuals do not only have an increased interest they also have increased responsibility for their own health. The expansion of rights ensures the expansion coverage and new forms of prevention, for example the rights of non smokers but it also leads to increasing fragmentation in the combination with the increasing do-ablity through medical and pharmaceutical strategies. It raises new questions of solidarity far beyond the basic questions of protection and coverage dealt with by the early health movements. Is infertility and in vitro fertilization an issue for coverage? Should there be higher premiums for people with unhealthy lifestyles?

Finally, as health increasingly drives economic and social development we need to begin to answer the political questions at stake in the health society. How do we want to define health security and health solidarity? What extent of exclusion and inequality will be politically accepted? What social, political and financial price are we willing to pay for better health both individually and as a community, both at the local and at the global level? While it seems unfair that

some parts of society can buy better health in the marketplace—where do we see the limits? While it seems appropriate to strive for more health should we not also critically consider the limits of this quest? These questions cannot be resolved without a debate on the values which will ultimately drive the health society.

As a consequence of the three expansions the health society carries within it three promises of health: health as an ultimate value, health as a product on the market place or health as a project of empowerment. (Kickbusch, 2002b) F. Fukuyama (2002) in his analysis of the consequences of the biotechnology revolution highlights how it might put into question not only all our assumptions on human nature but also the underpinnings of democracy with its premise that all human beings are created equal. Z. Baumann (1989) in particular has highlighted, that there is an inherent connection between modernity and totalitarianism if the democratic component—the dimension of the citoyen—is neglected. The utopian "total" quality of the health promise of the enlightenment was balanced by the moral obligations of the citoyen as a free political actor. Throughout modernity the involvement of people in their health has offered an extraordinary emancipatory impetus and it is the strength of health promotion as codified in the Ottawa Charter that its vision of health under conditions of modernity is deeply democratic and participatory. It is the role of citizen in health—as most of the theoretical analyses of modernity would agree—that becomes the most critical component of health governance in the 21st century. A theoretical perspective can help us understand why.

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