Health Promotion International, Vol. 26 No. S2
doi:10.1093/heapro/dar071

Healthy public in all policies

EVELYNE DE LEEUW[1]* and CAROLE CLAVIER[2]
[1]*Faculty of Health, Deakin University, Victoria, Australia and* [2]*Montreal Public Health Directorate, Montreal (Quebec), Canada*
**Corresponding author. Email: evelyne.deleeuw@deakin.edu.au*

SUMMARY

The introduction of the notion of 'Healthy Public Policy' in the Ottawa Charter is considered a relevant response to the emerging social-political context of the 1970s and 1980s. It also remains an important, yet volatile, argument for the consideration of policy impact on health. In our analysis, however, those that continued to argue for Healthy Public Policies and those who should develop them have remained naïve about the profound political dimensions of this exercise. Applying insights from the political sciences, we argue that greater levels of connectedness and commitment across civil society, and governance integration between sectors and levels of politicking and action are required for the further success of health integrated policies. The role of communities and the key communicative drivers of the Ottawa Charter (enable, mediate and advocate) need to be strengthened in more astute strategies.

Key words: Healthy public policy; politics; political science; social analysis

INTRODUCTION

'The ultimate end of the State is not dominion, nor restraint by fear, nor the exaction of obedience; on the contrary, its end is to free every man from fear, so that he may live securely'.

Baruch Spinoza, Tractatus Theologico-Philosophicus, 1670

When Nancy Milio and Trevor Hancock, almost simultaneously in the mid-1980s, launched the idea of 'Healthy Public Policy', it necessarily breathed the spirit of many other inventions that had their roots in emancipation movements of the 1960s and 1970s. Those roots included beliefs in the 'makeability' of society, and a rational stages heuristic in public policy development.

In this piece, we will trace the emergence of 'Healthy Public Policy' as it appeared—not for the first time—in the Ottawa Charter, pay tribute to the concept's intellectual parents, provide a brief review of the (effectiveness) of its development and implementation and suggest reasons, both practically and theoretically, why the lofty idea to make health the business of every policymaker may have been doomed.

POLITICS: WHERE HEALTH IS MADE

Health is made outside the health care sector. This obvious idea started to get empirical and theoretical traction in the late 1960s and early 1970s, with work from men like Laframboise (Laframboise, 1973), Blum (Blum, 1974), Waitzkin and Waterman (Waitzkin and Waterman, 1974), Mechanic (Mechanic, 1968) and Navarro (Navarro, 1986). Some men, like Illich (Illich, 1976), even demonstrated that the health care sector was sometimes detrimental to health. Although these men have been potent drivers of change, the impact of their ideas has

been limited by their commitment to the pathogenic epistemology.

Possibly the most powerful, and yet also the most evasive, of the idea that health is not the sole product of the health care sector is the pathogenic epistemology that structures not just health care systems, but also their institutional environment. When in the course of the nineteenth century, the germ theory replaced other notions of the causalities between health and the environment, the search for and identification of micro-biological pathogens shaped entire disciplines and industries, including the strict professionalization of medical training and practice. This 'bio-medical model of health' has been challenged, in the years after the Second World War, by a 'social model of health'. The rise of the complementarity of both models seems to have culminated, at least rhetorically, in the publication in the early twenty-first century of influential works on health equity and the social determinants of health. Yet, as Antonovsky (Antonovsky, 1984) and Kelly and Charlton (Kelly and Charlton, 1995) have shown, the core epistemology of the discourse has not challenged the pathogenic paradigm that governs it: mechanistically and rationally, it remains critical to identify cause and effect, whether in terms or virus activity or toxins affecting cell integrity, or for poverty and climate change impacting on disease patterns. Many would believe that in the latter 'social model of health', it would be important to distinguish between so-called upstream (systems), mid-stream (population) or downstream (behavioural) determinants of health, but Krieger (Krieger, 2008) has convincingly argued that, again, such 'stream' rhetoric only confirms and reinforces the epic search for causalities of disease, and in attempting to mimic the biomedical model of the pathogenic paradigm fails to address the politics of health (rather than disease).

Secondly, the role of the medical establishment and its intimate symbiosis with industry and politics is an issue that merits further scrutiny. Fassin (1996) has shown that, when the collective management of health and disease was first introduced into the realm of governments, physicians and scientists sought to guarantee the autonomy of public health from both medicine and politics. The constitution of a specific corpus and dedicated organizations was considered instrumental in this process. However, the extent of this autonomy is more than questionable even today. Rudolf Virchow—one of the fathers of the germ theory—is often heralded by social science scholars of health as having argued that medicine and politics do go hand in hand ('*Die Politik ist weiter nichts, als Medicin im Grossen*'). Two, slightly more cynical, alternative interpretations of Virchow's statement are possible, too. First, the statement might reflect a simplistic and naive notion of politics being medicine on a grander scale deciding, in triage, 'who gets what', cf. Laswell (Laswell, 1936). But second, and even more insidiously, it would suggest that medical doctors in fact perceive having a legitimate and determining veto (beyond a mere stake) in public policy deliberations. Rarely has this close and hungry connection to power been as visible as blatantly in Chile in 1973 when its Colegio Medico was instrumental in the coup d'etat success of the Pinochet junta (Goldman, 1985). On the other hand, Salvador Allende himself was an eminent pathologist, and the archetypical revolutionary of the left, Che Guevara, was trained to be a dermatologist. More widespread still, mayors or heads of government often grant medical doctors a *de facto* competency to make health policy decisions because of their professional skills (Clavier, 2009). Thus, Ministers of health are often medical doctors, and so are the councillors in charge of health policy in city councils, even though caring for individual patients has little in common with making policy decisions for the public's health. Particularly prominent in the health sector, this tendency to appoint ministers or councillors based on a reputation of competency has worked against the entrenchment of Healthy Public Policy ideas by making health the business of medical doctors at the policy level.

Social movements in the 1960s and 1970s, and in particular the women's movement, described and politicized the haphazard operations of the health care system, and they grounded themselves in more activist and community-based experiences and perspectives (Ehrenreich and English, 1973; Marieskind and Ehrenreich, 1975; Boston Women's Health Book Collective, in Zola, 1991). Although the strong community base of these developments has had its merits, it may also have hindered access to the political system, even when feminists were actively recruited into government

bureaucracies. These 'femocrats' (cf. Williamson, 1999; Sawer, 2007) have been criticized as being co-opted by the status quo, rather than continuing to challenge it.

But they all argued for the need to change health action at the systems level, either with an argument that new kinds of policies needed to be developed or with calls for broad social reform and a redistribution of societal responsibilities.

TOWARD HEALTHY PUBLIC POLICY

The works of these actors paved the way for political intervention. But the idea that health was influenced from outside the health sector still had to be brought into the realm of public policy. The first national policy to formally recognize the contribution of factors beyond the health care sector was of course the Canadian Lalonde Report (Lalonde, 1974). Along with the traditional biomedical determinants of health—human biology, lifestyle, health care services—this report acknowledged the influence of the social and physical environments, emphasizing that they would bring the biggest changes to the health of the population. It nevertheless put much of the responsibility for health on the individuals who should make the right choices for their own good. Then, in the 1980s, the works of two scholars/activists were instrumental in shaping the idea of healthy public policy—that is, how other sector policy could contribute to the health of populations.

Nancy Milio, a scholar with a solid foundation in community nursing, was the first to integrate activism and astute academic analysis in '*Promoting Health Through Public Policy*' (Milio, 1981, reprinted 1985 in Canada). With a massive intellectual effort she compiled the evidence how, and to what extent, sectors such as agriculture, social services and defense influence human health, and how the inclusion of health considerations in other sector policies would contribute significantly to the health of populations. She observed that governments had failed to integrate health as an overarching social policy ambition in public decision making. Her argument was that, regardless of other health efforts (in either the clinical environment or in lifestyle change), public policy across sectors could be seen as having the most profound impact on population health. If there was any truth in often-heard rhetoric that governments were to take care of their constituencies, she maintained, they should build health through public policy. Milio continued to explore such intersectoral policy linkages, using the farm-food-nutrition triad as a compelling case study that demonstrated the feasibility of integrated policy perspectives in food-rich countries such as Norway (Milio, 1990) and in community health (Milio, 1988, 1992).

Around the time that Milio started to transcend her community activism, a young British doctor moved to Canada where he found exciting opportunities to engage in novel, and often futuristic, notions based at the interface of ecological considerations, sustainability, the inability of bureaucracies to respond to (community health) crises and health. Trevor Hancock co-founded the Canadian Greens Party (1983) and contributed significantly to health innovations in the City of Toronto (*1984*). His influential and visionary work is possibly best characterized by his piece '*Possible futures, preferable futures*' (with Clem Bezold, Hancock and Bezold, 1994). In it, the authors write 'Futures thinking is a tool for wiser action that stimulates the imagination, encourages creativity, identifies threats and opportunities, and allows us to relate possible future choices and consequences to our values.' Choosing between possible, plausible, probable and preferable futures, it appears that Hancock consistently has followed the latter part, dreaming large and in a compelling presentation. In an act of fortuitous serendipity, he presented Healthy Public Policy ideas at the City of Toronto 'Beyond Health Care' conference (Hancock, 1985) which celebrated the tenth anniversary of the publication of the Lalonde report. The conference culminated in the formulation of the birth of the 'Healthy City' concept.

The network constellation of the 1980s allowed both Milio and Hancock to take their place on the emerging health promotion stage and embrace new and persuasive arguments over why health should become everyone's business (WHO, 2007; Kickbusch, 2007).

PERSUASIVE, BUT NOT ENOUGH

The ink on the first printing of the Ottawa Charter had not yet dried when one of the

authors of this piece had started investigating the feasibility of Healthy Public Policy development at the national level (De Leeuw, 1989; De Leeuw and Polman, 1995). Very much in the spirit of the times we applied a 'stages heuristic theory' (deLeon, 1999) of the policy development process: Roger Cobb and Charles Elder (Roger Cobb and Charles Elder, 1972) postulated that issues enter the political decision-making agenda from the social discourse through a number of stages in which the perception of the policy issue expands from very narrowly defined specific-interest groups to civil society at large. If this 'issue expansion' process would include a number of (empirically grounded) issue characteristics (for example the issue has to be perceived as being of long-term relevance to society, as having a non-technical nature, have the potential to be conceptualized in different ways, etc.) the chance of policy being adopted would increase. In the second edition of their work (Cobb and Elder, 1983), they acknowledged that apart from the 'romantic' democratic scenario where issues enter politics from society, there are two further possible scenarios: the internal one (where the techno-political-bureaucratic elite frames and establishes policy) and the mobilization one (where government launches issues into society and stimulates and supports mechanisms that would secure issue expansion among publics so as to build policy development pressure).

Applying this framework to efforts in The Netherlands to establish a national Healthy Public Policy called Nota 2000, we found a number of things. Overall, a Dutch Healthy Public Policy in the 1980s and 1990s (and possibly beyond) was completely unfeasible. But retrospectively two issues stand out, one relating to the postulated nature of Healthy Public Policy, and the other related to the validity of Cobb and Elder's theory.

Both Nancy Milio, Trevor Hancock and the aggregate authorship of the Ottawa Charter clearly believed that Healthy Public Policy was an irrefutable necessity for health promotion. The 'evidence' had been established with great assertiveness; Milio included over 1000 references in her Healthy Public Policy work. Hancock spoke with the authority of the Canadian Public Health Association and with superb rhetorical power. No sensible national actor would refute the legitimacy and potency of the argument, and that is precisely what we found in the Dutch study. Thirty-nine national executive stakeholders from professional associations, consumer groups, the research establishment, NGOs, political parties, ministries and departments and advisory councils all acknowledged that Healthy Public Policy was a good (sometimes the term 'lofty' was used) idea and worth pursuing. Twenty three of these groups, however, chose not to engage with tangible resources in the public debate that would, the Ministry of Health, Welfare and Cultural Affairs had hoped, lead to sufficient pressure to have Parliament pass a HPP resolution. On closer analysis, it turned out that these groups, generally representing the clinical domains of the health care system, held possibly up to 80% of the power base required for the maintenance of the status quo. Their position was reinforced by some other stakeholders (the labour unions and some Ministries) that were convinced that health was not their business, but purely the health bureaucracy's. Together, they fought a silent battle of attrition and benevolent dissociation. On the surface, in policy and media rhetoric, they appeared to support a national ambition for a joined-up government for health. But the brutal reality was that 6 out of 10 actors, holding a substantial national power base, never felt compelled to consider the organizational and political benefits associated with embarking on a whole-of-government approach.

The classical Machiavellian analysis would be that there was no reason for the establishment to rock the boat and challenge the status quo; that the Ministry wholly misinterpreted the 'lofty' statements by Civil Society; and that rhetoric without economics can end up anywhere but in policy.

OVERTAKEN LEFT, RIGHT AND CENTRE

By the time the Dutch study was concluded (in 1989) the science-philosophical landscape had changed: post-modernist and social constructivist perspectives had started to take hold of the political and health discourse, particularly in academic circles. The work of Callon (Callon, 1986) and Latour (Latour, 1987) challenged the stages heuristic perspectives, and post-modern political science realized that implementation could happen before problematization; that

(health) governance is much more than government mobilizing legitimacy and resources; that ever-changing networks of actors constantly redefine their operational domains; that arguments are never stable and always up for renegotiation. Cobb and Elders' theory seemed to acknowledge none of these, and was in particular poor at conceding raw power politics and competing policy agendas, especially when they were framed in economic terms.

The Healthy Public Policy agenda was overtaken left, right and centre. Apart from its fairly naïve call to action (and hence limited strategic political analysis) the momentum, in the 1990s and early 2000s, seemed to shift back to health behaviourist perspectives (sometimes labelled 'lifestyle drift'—'*the tendency for policy to start off recognizing the need for action on upstream social determinants of health inequalities only to drift downstream to focus largely on individual lifestyle factors*', Popay *et al*., 2010). Bambra *et al*. (Bambra *et al*., 2011) seem to argue that the unequivocal evidence on social determinants and inequities in health, and the subsequently required policy action, has been generated by academia in an almost pathological disconnect from political discourse and community development issues. The critique that we have voiced elsewhere (De Leeuw *et al*., 2008) of the technocratic solution to this problem—knowledge translation—recognizes that bridging the nexus between research, policy and practice is essentially a political process with many dimensions requiring astute cognizance of governance networks and (often implicit) institutional arrangements. As an example, Fafard (Fafard, 2011) explains the failure of a harm reduction policy in a Canadian city because of its promoters' inadequate understanding of the policy process. The public health promoters of the project relied on classic knowledge transfer techniques developed for small-scale public health practice to convince policymakers to pass legislation, whereas policy change is created through coalition building, mobilizing public opinion, lobbying and influencing political and ideological values. The problem with such an approach, he argues, is that the promoters of the project have treated public policy making as just another singular, targeted health project (taking a classic public health 'interventionist' stance albeit on a larger scale) instead of considering it as a different type of social practice altogether, determined by its own rules and values. Healthy Public Policy may have failed because it has never become part of the social discourse and because we, as health promoters, have failed to understand the policy-making processes presiding over the building of Healthy Public Policy (Bernier and Clavier, 2011; Breton and De Leeuw, 2011).

Finally, the notion that Healthy Public Policy should 'happen' at the national level may never have been tenable. True, some recent experiences with building healthy public policy at the national level are successful in diverse countries such as Thailand, Norway or South Australia (Kickbusch and Buckett, 2010; Rasanathan *et al.*, 2011). However, accounts of these experiences highlight that their success depends on a combination of very specific policy-making conditions: strong political commitment, a benevolent (dis)interest from powerful interest groups, a concern for health equity deeply entrenched in the political structures of the country, a vast mobilization of the public to change things or interdependencies between national and local policy making. Besides, the success of healthy public policy initiatives—such as Scotland's commitment to health impact assessment (Kemm *et al*., 2004)—still has to pass the test of implementation in the long run, which has been identified as one of its major challenges (Koivusalo, 2010).

In our work with local governments, we have seen many indications that the post-modern social discourse fits local conditions exquisitely well. We would in fact postulate that the policy-making processes at the local level have always, better than the national level, allowed for creating the conditions for healthy public in all policy engagement. Popay *et al*. (Popay *et al*., 2010), for instance, have described some of these conditions: adaptive leadership and looser partnership arrangements. Another of these conditions is that policy-making processes at the local level have always been oriented towards a 'global', local development, which is less sector-based than national policy-making processes. The turn towards governance arrangements—at about the same the time that the Ottawa Charter was enacted—again reinforced the possibilities to think of health in all policies at the local level by favouring the participation of public, private and community stakeholders in public policy making (Rhodes, 1997; Le Galès,

2002). Along with Rayner and Howlett (Rayner and Howlett, 2009), we argue that such processes of governance can be conducive to the integration of the policy agendas of several key stakeholders. For instance, negotiations between the city, the local public health authorities, private foundations and community organizations to renew the city's urban planning strategy can be a way of building a shared understanding of (among other things) the importance of urban planning for public health (and vice versa) and integrate health considerations into the urban plan.

Furthermore, we found in a study of the emergence of local public health policies in France and Denmark (Clavier, 2010) that local policy-making processes allowed public health to develop mediating and advocating strategies at the local level. By taking part in governance processes for the elaboration of local public health policies, public health professionals trained to the ideas of the Ottawa Charter earlier in their careers played a crucial mediating role in the transfer of these ideas into local and regional public health policies. Local and regional policy makers did not take up these ideas based solely on the convincing power of the public health professionals but primarily because it fitted their own interests. The strength of the mediation between public health professionals and policy makers was to pinpoint the possibility that cities or regions could use their existing responsibilities for transportation, education or housing as an opportunity to improve the health of their population, thereby increasing public support for their actions or reducing their healthcare expenditure. Though the resulting policies do not completely fit the 'healthy public policy' canon, they nevertheless engage a broad range of policy sectors and stakeholders in a participative, community-based policy effort.

The success of these local conditions, however, depends on the involvement of local politicians: studies of the Healthy Cities movement have shown that their commitment is essential if cities are to take health into account in all their decisions (De Leeuw and Skovgaard, 2005).

Kickbusch in her various works on the health society (for a local policy perspective see, for instance, Warner and Gould, 2008, in a recent edited work) strongly argues that the 'new' health discourse is characterized by a much wider conceptualization of health, and an expansion of the reflexivity of health (Kickbusch, 2007). The idea that health could be regulated through the policies of sectors other than health has given rise to critical studies of this wider conceptualization of health—some being inspired by Foucault's work on biopolitics (Petersen and Lupton, 1996). Foucauldian studies also turned the spotlight on the technologies or mechanisms that public health uses to regulate health, whether through legal constraints or the subjectivation of norms (Rose, 1999; Fassin and Memmi, 2004). This idea of governmentality helps understand the (healthy public) policy development of the past 25 years: we would argue that we have failed to exploit the mechanisms suggested in the Ottawa Charter (notably enable, mediate and advocate; the reorientation of health services; and health skills and community action) and how they should relate to the policy game.

We have failed to get health systems on the side of health promotion. The Health Promoting Hospitals and Health Services movement, in our view, has remained of peripheral importance to global health care developments and policy considerations. We have failed to effectively mobilize communities for health; where consumer organizations form, we have recently demonstrated that their commitment and vigour is quickly co-opted by industry and government to serve institutional rather than community purposes (Löfgren *et al.*, 2011). We therefore might regard efforts to 'mainstream health promotion' (Jackson, 2011) as insidious attempts to counter and limit the rich potential health promotion has, and vigilance is required (Scott-Samuel and Springett, 2007). We would suggest that, therefore, we have botched the potential that the communication strategies embodied in the call to enable, mediate and advocate still hold for effective integral policy development.

CONCLUSION

The Ottawa Charter, and its Healthy Public Policy component, was and remains a landmark visionary document. It clearly and in a few hundred words (a lot less than this paper!), describes the elements of the new public health. What it appeared to have failed to do is to call for systematic, systemic and strategic integration

of all its elements. Either of these may singularly have claimed some successes and failures. But in their synergy, they have resulted in a failure of development of Healthy Public Policies at the national level. We would claim that this is mainly because the public has been absent from the effort, whether as consumers/clients/co-producers in the health care system, activists around social determinants of health and sustainability, governors of their own fate and constituents of political figures, the health promotion community has failed to enable, mediate and advocate for policy and political change, failed to mobilize a health system for such change, and has possibly addressed environments for health in splendid isolation, rather than in its holistic overarching system. It also appears that local politics 'get' these things more easily for reasons of proximity and immediacy. It is then, in conclusion, a challenge to see how the new social media landscape and our increased connectedness may contribute to other degrees of immediacy and proximity at different governance levels so that, indeed, we may see the development of healthy publics in all policies.

REFERENCES

Antonovsky, A. (1984) The sense of coherence as a determinant of health. In Matarazzo, J. D. *et al.*, (eds), *Behavioral Health. A Handbook of Health Enhancement and Disease Prevention*. Wiley, New York, pp. 114–129.

Bambra, C., Smith, K. E., Garthwaite, K., Joyce, K. E. and Hunter, D. J. (2011) A labour of Sisyphus? Public policy and health inequalities research from the Black and Acheson Reports to the Marmot Review. *Journal of Epidemiology and Community Health*, **65**, 399–406.

Bernier, N.F. and Clavier, C. (2011) Public health policy research: making the case for a political science approach. *Health Promotion International*, **26**, 109–116.

Breton, E. and de Leeuw, E. (2011) Theories of the policy process in health promotion research: a review. *Health Promotion International*, **26**, 82–90.

Blum, H. L. (1974) *Planning for Health Development and Application of Social Change Theory*. Human Sciences Press, New York.

Callon, M. (1986) Some elements of a sociology of translation; domestication of the scallops and the fishermen of St Brieuc Bay. In Law, J. (ed.), *Power, Action and Belief. A New Sociology of Knowledge?* Routledge and Kegan Paul, London.

Clavier, C. (2009) Les élus locaux et la santé: des enjeux politiques territoriaux. *Sciences Sociales et Santé*, **27**, 47–74.

Clavier, C. (2010) Bottom-up Policy Convergence. A Sociology of the Reception of Policy Transfer in Public Health Policies in Europe. *Journal of Comparative Policy Analysis: Research and Practice*, **12**, 451–466.

Cobb, R. W. and Elder, C. D. (1972). *Participation in American Politics: The Dynamics of Agenda Building*. Allyn & Bacon, Boston.

Cobb, R. W. and Elder, C. D. (1983). *Participation in American politics: The Dynamics of Agenda Building*. Second edition. Johns Hopkins University Press.

De Leeuw, E. (1989) Health Policy. An exploratory inquiry into the development of policy for the new public health in The Netherlands. Dissertation. University of Limburg, Maastricht, The Netherlands.

De Leeuw, E. and Polman, L. (1995) Health policy and health promotion: a study of prevention developments in the Netherlands. *Prevention in Human Services*, **12**, 133–150.

de Leeuw, E. and Skovgaard, T. (2005) Utility-driven evidence for healthy cities: problems with evidence generation and application. *Social Science & Medicine*, **61**, 1331–1341.

de Leeuw, E., McNess, A., Crisp, B. and Stagnitti, K. (2008) Theoretical reflections on the nexus between research, policy and practice. *Critical Public Health*, **18**, 5–20.

deLeon, P. (1999). The Stages Approach to the Policy Process: What Has it Done? Where is it Going? In Sabatier, P. A. (ed.), *Theories of the Policy Process*. Westview, Boulder, CO, pp. 19–34.

Ehrenreich, B and English, D. (1973) *Witches, Midwives, and Nurses: A History of Women Healers*. Feminist Press, Old Westbury, New York.

Fafard, P. (2011) Science and Social Justice Provide an Inadequate Theory of the Policy Process. *Presentation at the Canadian Public Health Association Conference*, Montreal, 21 June 2011.

Fassin, D. (1996) *L'espace politique de la santé*. Essai de généalogie. PUF, Paris.

Fassin, D. and Memmi, D. (2004) *Le gouvernement des corps*. Éditions de l'École des hautes études en sciences sociales, Paris.

Goldman, B. (1985) Chilean medical college battles doctor participating in torture. *Canadian Medical Association Journal*, **132**, 1414–1416.

Hancock, T. (1985) Beyond health care: from public health policy to healthy public policy. *Canadian Journal of Public Health*, **76**(Suppl. 1), 9–11.

Hancock, T. and Bezold, C. (1994) Possible futures, preferable futures. *The Healthcare Forum Journal*, **37**, 23–29.

Illich, I. (1976) *Medical Nemesis: The Expropriation of Health*. Pantheon, New York.

Jackson, S. (2011) Mainstreaming health promotion. *Global Health Promotion*, **18**, 3–4.

Kelly, M. P. and Charlton, B. (1995) The modern and the postmodern in health promotion. In Bunton, R., Nettleton, S. and Burrows, R. (eds.), *The Sociology of Health Promotion*. Routledge, London.

Kemm, J., Parry, J. and Palmer, S. (2004) *Health Impact Assessment*. Oxford University Press, Oxford.

Kickbusch, I. (2007) Innovation in health policy: responding to the health society. *Gaceta Sanitaria*, **21**, 338–342. ISSN 0213-9111.

Kickbusch, I. and Buckett, K. (2010) *Implementing Health in All Policies: Adelaide 2010*. Department of Health, Government of South Australia, Adelaide.

Koivusalo, M. (2010) The state of Health in All Policies (HiAP) in the European Union: potential and pitfalls.

Journal of Epidemiology and Community Health, **64**, 500–503.
Krieger, N. (2008) Proximal, distal, and the politics of causation: what's level got to do with it? *American Journal of Public Health*, **98**, 221–230.
Laframboise, H. L. (1973) Health policy: breaking the problem down into more manageable segments. *Canadian Medical Association Journal*, **108**, 388–393.
Lalonde, M. (1974). *Nouvelle perspective sur la santé des Canadiens/A New Perspective on the Health of Canadians*. Gouvernement du Canada, Ottawa.
Lasswell, H. D. (1936). *Politics: Who Gets What, When, How*. McGraw-Hill, New York.
Latour, B. (1987) *Science in Action: How to Follow Scientists and Engineers Through Society*. Open University Press, Milton Keynes.
Le Galès, P. (2002) *European Cities: Social Conflicts and Governance*. Oxford University Press, Oxford.
Löfgren, H., de Leeuw, E. and Leahy, M. (eds) (2011) *Democratising Health: Consumer Groups in the Policy Process*. Edward Elgar Publishing, Cheltenham.
Marieskind, H. I. and Ehrenreich, B. (1975) Toward socialist medicine: the women's health movement. *Social Policy*, **6,** 34–42.
Mechanic, D. (1968) *Medical Sociology: A Selective View*. Free Press, New York.
Milio, N. (1981) *Promoting Health through Public Policy*. Davis, Philadelphia.
Milio, N. (1985) *Promoting Health through Public Policy*. Canadian Public Health Association, Ottawa.
Milio, N. (1988) *A Mosaic of Australian Community Health Policy Development*. Australian Government Publishing Service, Canberra.
Milio, N. (1990) *Nutrition Policy for Food-Rich Countries: a Strategic Analysis*. The Johns Hopkins University Press, Baltimore.
Milio, N. (1992), Keeping the promise of community health policy revival under Hawke 1983–85, In Baum, F., Fry, D. and Lennie, I. (Eds.) *Community Health Policy and Practice in Australia*. Pluto Press, Sydney.
Navarro, V. (1986) *Crisis, Health, and Medicine: a Social Critique*. Tavistock, New York.
Petersen, A. and Lupton, D. (1996) *The New Public Health. Health and Self in the Age of Risk*. Sage, London.
Popay, J., Whitehead, M. and Hunter, D. (2010) Injustice is killing people on a large scale—but what is to be done about it? *Journal of Public Health*, **32**, 148–149.
Rasanathan, K., Posayanonda, T., Birmingham, M. and Tangcharoensathien, V. (2011) Innovation and participation for healthy public policy: the first National Health Assembly in Thailand. *Health Expectations*, doi:10.1111/j.1369-7625.2010.00656.x.
Rayner, J. and Howlett, M. (2009) Conclusion: governance arrangements and policy capacity for policy integration. *Policy and Society*, **28**, 165–172.
Rhodes, R. A. W. (1997). *Understanding Governance: Policy Networks, Governance, Reflexivity and Accountability*. Open University Press, Buckingham.
Rose, N. (1999) *Powers of Freedom. Reframing Political thought*. Cambride University Press, Cambridge.
Sawer, M. (2007) Australia: the fall of the femocrat. In Sawer, M., Outshoorn, J. and Kantola, J., (eds) (2007) *Changing State Feminism*. Palgrave Macmillan, Basingstoke, pp. 20–40.
Scott-Samuel, A. and Springett, J. (2007) Hegemony or health promotion? Prospects for reviving England's lost discipline. *Journal of Royal Society Health.*, **127**, 211–214.
Waitzkin, H. and Waterman, B. (1974).*The Exploitation of Illness in Capitalist Society*. Bobbs-Merrill, Indianapolis.
Warner, M. and Gould, N. (2008) Integrating Health in All Policies at the Local Level: Using Network Governance to Create 'Virtual Reorganization by Design'. Chapter 5. In Kickbusch, I. (ed.), (2008) *Policy Innovation for Health*. Springer, New York, pp. 125–164.
Williamson, C. (1999) Reflections on health care consumerism: insights from feminism. *Health Expectations*, **2**, 150–158.
World Health Organization. (2007) *Everybody Business: Strengthening Health Systems to Improve Health Outcomes: WHO's framework for action*. WHO, Geneva.
Zola, I. K. (1991) Bringing our bodies and ourselves back in: Reflections on a past, present, and future 'Medical Sociology'. *Journal of Health Society Behavior*, **32**, 1.