

# Behavior Change or Empowerment: On the Ethics of Health-Promotion Goals (Penultimate version)

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## Introduction

One important ethical issue for health promotion and public health work is to determine what the goals for these practices should be [13]. This paper will, then, try to clarify some of the issues concerning what these goals are thought to be, and what they ought to be. It will specifically discuss two different approaches to health promotion, namely, behavior change and empowerment.<sup>1</sup> Before we look closer at them we need to have a conceptual framework in which we can place these two traditions.

## Background and Framework

Let me first introduce some preliminary distinctions, one between kinds of goals, and the other between kinds of health-promotive (or public-health) work.

### General Public Health Goals

What should the *ultimate* goals of health promotion be, in a public health context? The health and longevity of the population is the obvious answer. However, the answer has to be qualified. We need to state what is meant by health, a question that will be dealt with in a separate section. Furthermore, since health (as will be shown) to a large extent is an instrumental goal (and, thus, primarily has instrumental value), we have to relate it to some other intrinsic or final goal (or value). Some plausible ultimate goals for public health and public policy are equality, happiness, and quality of life. I have earlier argued that health should be a goal for health promotion only in so far as it is quality of life related [77]. The reason is simply that if an increase in health or longevity does not contribute to an

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<sup>1</sup> A previous paper in a similar way discusses and ethically evaluates the different *means* used by these two approaches [83].

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individual's, or population's, quality of life, it is not worth trying to achieve it. Thus, we should only try to promote health if it is expected to lead (directly or indirectly) to increased quality of life, that is, if the specific health increase either constitutes quality of life, or causally contributes to it.<sup>2</sup> Most increases in health do, however, contribute to quality of life, even if sometimes only minutely, and some health increases, mainly in (health-related) well-being, constitute increases in quality of life [80].<sup>3</sup>

But quality-of-life-related health promotion is not all there is to the goals of public health. First of all, most ill health is caused by disease and injury [52; 81-82]. Therefore preventing such states will also be important goals for public health.<sup>4</sup> Second, as will be clear later, since very little is directly done to individuals or populations, health-wise, we also have to consider the 'opportunities' to stay healthy, e.g., promoting those environmental and social factors that contribute to increased or sustained health, especially since public-health work mainly targets the healthy population [20; 23]. Furthermore, the average aggregated health status in a population, and its increase (or decrease), is important, but it is not all that should concern us. It is also of importance how health is distributed in a population [13, p. 41 ff.; 87]. Thus, health inequalities between groups have to be taken into account when evaluating the health status of a population [13, pp. 43-44; 21; 93].

## Kinds of interventions and some contemporary health problems

Interventions can be initiated on various levels in society. There are 'top-down' measures, such as fiscal policy, macro environment changes, health campaigns, or legislation, and most

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<sup>2</sup> There is no room to develop a theory of quality of life here, but a few remarks need to be made. It seems to me that what best explains what makes a life go well for a person (her quality of life) is that her (final) desires are fulfilled. It follows that it is not sufficient that the desires are only *believed* to be fulfilled (an idea that would permit also false beliefs to contribute to a person's quality of life), which is the case in some happiness theories of quality of life. It also seems plausible that the desires that count most (in evaluating the good life) are the ones that are authentic, i.e., that are autonomous and informed. Brülde, who has argued for the above position [12; see also 72], adds a hedonistic dimension to his theory of quality of life. The best life is one where one's (authentic) desires are fulfilled *and* one experiences well-being, and does not suffer. I will assume here that this dimension is not necessary, since to experience well-being, and be free from suffering, are (in most cases) covered by a person's (authentic) desires.

<sup>3</sup> In a public health-context we differentiate between individuals and populations. What might constitute a relevant and important health-promotive activity on the individual level, and a relevant goal, e.g., for a physical therapist, might not constitute such an activity or such a goals on the population level, and vice versa.

<sup>4</sup> For a discussion about the relation between health promotion and disease prevention, see [81-82].

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public health policy is realized in this macro fashion [3; 5, p. 173, ff.; 24]. There are, furthermore, (what I prefer to call) ‘local’ measures, where professionals meet and directly interact with individuals, groups, or communities [83].<sup>5</sup> These projects are often of the kind that address problems that cannot be dealt with top down, at least not fully. Policies always partly fail, despite the (in general) good intentions of politicians, civil servants, and others [6], and there will (most likely) always be marginalized and vulnerable groups that might need special attention, be they drug users, unemployed, overweight, or poor.

Many contemporary health problems (such as cardiovascular disease, cancer, diabetes, STDs, mental illness, injuries, and deaths), as well as ‘risk factors’ (such as smoking, drinking alcohol, eating too energy-rich foods, being physically inactive, and having unsafe sex), are brought about by, or have to do with, the ‘choices’ people make [15, p. 2 ff.].<sup>6</sup> Many of these problems have to do with what is sometimes called “lifestyle” [41]. Therefore some interventions to tackle these problems will have to go via, direct or indirect, influences on people’s choices, behaviors, and actions.

## Aim

The general aim of this paper is to investigate similarities and differences between the behavior-change approach and the empowerment approach, with regard to their immediate, instrumental goals, and in relation to the ultimate goal of health promotion and public-health work, that is, increased or sustained (and equally distributed) quality of life-related health and longevity. The paper also aims to illustrate the moral significance of the differences between the two approaches, and to show that the behavior-change approach has problems that the empowerment approach can handle, and that we therefore, on moral grounds, should prefer empowerment as a goal for health promotion and public health work.

## Procedure

The two approaches, or traditions, will be described, focusing on the explicit (and implicit) goals they try to achieve. There are many different versions of these approaches, so I will have to create two distinct “ideal types” of them [91]. For empowerment, I will use my own

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<sup>5</sup> It is probably better to reserve the notion ‘bottom-up’ for initiatives that are truly born in, and initiated by, the communities themselves (without the help of professionals). ‘Local’ projects will mostly be initiated by professionals, e.g., civil servants, or local politicians.

<sup>6</sup> This primarily goes for the developed countries, even if there are similar tendencies in the developing world [5].

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analysis and definition [78; 80]. Regarding behavior change, I will describe some core ideas of the approach (found in the research literature), so that it becomes a clear and coherent alternative to the empowerment approach. I will also present an ethical evaluation of these goals, or goal structures, that relates to the ultimate goals of health promotion (within public health). The behavior-change approach is scrutinized first, showing some of its shortcomings. After that the empowerment approach is presented, and it is argued that, on the whole, it is to be preferred. Some possible problems with empowerment as a goal are, finally, discussed.

Since health is at the heart of these models, a theory of health will be provided to which the models can be related. The reason for this detour is, first, that health can refer to many different things, which means that we need to make the concept more homogeneous and precise. Second, we saw that health is not necessarily the ultimate goal for health promotion. The theory of health suggested will show us why. Lastly, I will introduce a distinction, namely, that between direct and indirect health changes, mainly to justify the dominant focus of these approaches on instrumental goals, rather than on health itself.

## Theories of Health

There are two distinct aspects of health, namely, ‘manifest’ health, and ‘fundamental’ health, and both will be presented. A few words will also be said about the relation between health and disease.

### Manifest Health

Manifest health refers to two things. A person is healthy 1) if she has acquired the basic abilities and dispositions that her peers have acquired, and 2) if she is in a state of positive well-being, or at least not in a state of suffering [14; 79]. The better her abilities or dispositions, and the greater her well-being, the better her health; and the lower she is in these dimension, the worse her health is [9-10; 79].

*Basic* abilities refer to those abilities and dispositions that we acquire just by living and growing up, such as the ability to walk, stand, think, reason, remember, grab, chew, see, hear, communicate, and the disposition experience emotions [79]. Manifest health, in this sense, also requires that the person has some degree of ‘motivation’ (or ‘will’), and that she has the further ability to acquire more complex (non-health-related) abilities or competencies, such as to the ability or competence to use a computer, play the piano, or drive a car. But, in order to be healthy, the individual should not only have acquired these abilities and dispositions; she

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should also be able to utilize them, here and now [79]. The well-being (or suffering) that is part of health (or illness) consists of moods and sensations, but only those that have their immediate cause within the person,<sup>7</sup> such as calmness, or anxiety (moods), and feeling (physically) fit, or experiencing pain (sensations) [79].<sup>8</sup>

Finally, manifest health is conceptually related to the environment. An environment factor, such as a blizzard, might stop an individual from utilizing her abilities or dispositions. This does not constitute a state of ill manifest health. However, if a person in standard or acceptable circumstances (i.e., in circumstances where most people can ‘function’) cannot utilize her acquired abilities or dispositions, then the person has some degree of reduced manifest health [52; 79].

## Fundamental Health

Fundamental health, the other important aspect of health, refers to the physiological, anatomical, or (deep) psychological structures of the individual [8; 14; 81-82].<sup>9</sup> Fundamental health is defined in relation to manifest health, namely, as those (non-conscious) internal states and processes that support or uphold the manifest health of the individual [81-82]. For example, in order to be able to walk, sit, and stand, we need our muscles and joints to function so that they support walking, sitting, and standing. In order to be able to think clearly or remember we need the various parts (or sub-functions) of the brain to support thinking, i.e., they need to exist, connect to other parts of the brain (in an appropriate way), and work properly [59, p. 60 ff.].<sup>10</sup>

## Disease/Disorder

Very briefly, disease (or disorder) – in the broad sense of the term, including injury and impairment – refers to kinds of (non-conscious) states and processes within the individual that typically reduce manifest health, i.e., reduce ability, well-being, or longevity [11; 14; 18; 52].

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<sup>7</sup> This does not mean that there could not have been an original external cause to the suffering. An accident might have caused a concussion, but the subsequent headache has an immediate internal cause (i.e., the damage caused to the brain), and therefore counts as health related.

<sup>8</sup> Other kinds of well-being, e.g., emotions, have outer sustaining causes (usually mediated by beliefs), such as being happy because of a promotion, or sad because of a personal loss.

<sup>9</sup> This level is more or less what Nordenfelt calls the person’s “second order ability” [52].

<sup>10</sup> Strictly, fundamental health also has to be related to the environment [52].

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Disease (or disorder) is the most common cause of ill manifest health, even though there might be other causes, such as traumas or life crises.<sup>11</sup>

## Direct and Indirect Health Interventions

With the above-mentioned distinctions in mind, we should note several things. First, when we talk about health promotion (within the already healthy population) we are mostly referring to improving or sustaining the *fundamental* health of people, in order for manifest health to be as good as possible in the future [81-82]. Starting to exercise regularly will strengthen the muscles (including the heart), make the joints limber and more flexible, increase lung capacity, etc., and will thereby (over time) improve people's basic abilities, such as the ability to climb stairs, to carry bags, and to move arms in order to clean windows. Thus, manifest health is usually only influenced indirectly through the fundamental health of the individual. Furthermore, such a strengthening of fundamental health will at the same time reduce the risk of diseases, such as osteoporosis, diabetes, or heart disease, which will help sustain future manifest health.

Secondly, in a health-promotion intervention, very little *is done to* individuals, i.e., their fundamental or manifest health are not *directly* influenced or manipulated [51].<sup>12</sup> What is typically done in such interventions is that the *internal* or *external* determinants of health are changed, e.g., through influencing people's beliefs about what constitutes healthy foods (internal), or, through constructing bike-lanes in order to make people exercise more (external).<sup>13</sup>

Both the empowerment and the behavior-change approaches are primarily *indirect* ways of increasing or sustaining health, and, thus, they in general target some instrumental goal (e.g., eating more vegetables), not health directly. There are a number of instrumental goals that might be aimed at in order to try to make people healthier, and as we saw, we can focus on

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<sup>11</sup> The definition needs much more elaboration than there is room for here. Some exceptions have to be made, e.g., for pregnancies (to the extent that they typically reduce health).

<sup>12</sup> Medicine (broadly conceived) is the only kind of practice close enough to people's bodies and minds to be able to change them directly. For example, most *treatment* of disease or illness, such as operating on a knee, or giving pain killers, does directly influence the individual's manifest health, namely, through restoring the knee's function (fundamental health) and the ability to walk (manifest health), and reducing pain (manifest health) [51; 81-82].

<sup>13</sup> A few kinds of population interventions do in fact change the health status of the individual directly, e.g., mass vaccinations, which 'activate' the immune system, or putting fluoride in the drinking water to promote dental health [51; 81-82].

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internal factors, such as attitudes, beliefs, and wants (desires), or knowledge, competences, and skills, as well as external factors, such as norm systems, and social and physical environments, including creating or limiting opportunities for certain actions [3; 5; 33; 42; 56].

## Behavior Change as a Goal for Health Promotion

A general goal for health promotion, and public health, concerning all levels of interventions, is said to be *to change people's behavior* [15, p. 71 ff.; 37, p. 111 ff.], i.e., their health-related behavior. In the book *Theory in a Nutshell. A Guide to Health Promotion Theory* [56], behavior change is the taken-for-granted aim in a number of theories, such as the Health Belief Model, The Theory of Reasoned Action and Planned Behavior, The Transtheoretical Model and Social Cognitive Theory. The authors will, they claim, examine “those models that explain health behavior and health behavior change by focusing on characteristics of the individual” [56, p. xi]. Another author, Mike Kelly, is in full agreement when he claims that these kinds of models provide us with “[r]epresentations of how people think and act and the ways in which this can be changed” [40, p. 141], and he goes on to claim that “changing people's behavior is at the heart of health promotion” [40, p. 141]. Quite a lot of other literature confirms this almost self-evident point, namely, that health-related behavior change is a common goal for health promotion. Some examples are [22; 33] and [3], not to mention the many thousands of scientific papers that claim that behavior change is the topic for their studies, or the aim of their interventions, which is indicated by titles such as “Moving people to behavior change: A staged social cognitive approach to message design” [45], “Using theory to guide changing individual behaviour” [55], and “Understanding and changing health behaviour: From health beliefs to self-regulation” [1], which is also the name of the book where the article is found [54].<sup>14</sup>

But there are other strategies that have behavior change as their goal, e.g., social marketing. There are plenty of examples of this idea in [17]. They claim that “[s]ocial marketers typically try to influence their target audience toward four behavioral changes”, i.e., to accept, reject, modify, or abandon different kinds of behaviors [17, p. 3]. The authors illustrate this view with citations from Kotler and Lee who claim that “social marketing is about influencing behaviors” [in 17, p. 3], as well as from Smith who states that “the genius of modern marketing is [...] the management paradigm that studies, selects, balances, and

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<sup>14</sup> “Behavior change”+“health” yields a great number of entries in Google scholar.

manipulates the 4 Ps [product, price, place, promotion] to achieve behavior change” [in 17, p. 2]. That this description of social marketing goals is the common view is supported in many other sources as well. For example, Nutbeam et al. claim that social marketing “relates to the use of marketing techniques to influence behavior”, adding, however, “for [both] individual and social benefit” [56, p. 43]. Optimally, then, there will be positive effects for both the individual (group) and society (see also [31; 70]).

Health-related behavior change is, however, a rather vague goal. What kinds of changes are envisioned? The specific changes aimed at differ. It can, for example, be smoking cessation, reduction of alcohol intake, reduced drug use, less sexual risk taking, increase of condom use, increase of exercise, reducing overweight and obesity, increased hand washing, or an increase in eating fruits and vegetables. Thus, the target is often for people to change their ‘lifestyles’ [15, p. 41; 27; 37, p. 112 ff.].<sup>15</sup> Not all health-related behavior changes are related to lifestyle (in a more narrow sense of the term), however, but to other kinds of behavior, such as whether or not to get a vaccination, or a mammography, or whether or not to use a crash helmet, or a safety belt.<sup>16</sup> Nor do washing one’s hands, or using a bed-net, seem to belong to a person’s (or group’s) lifestyle. The broader concept, then, seems to be ‘health-related behavior’, of which lifestyle is but one part. Note that lifestyle appears harder to change, since it seems to be more related to self, or group, identity, and to quality of life.

Most of these specific goals are indirect and instrumental, i.e., they do not, as we have seen, directly change the health of individuals, groups, or communities. The desired behavior (or lifestyle) changes are, rather, expected to reduce the risk of *future* disease and ill manifest health, primarily either by strengthening the fundamental health of the individuals, e.g., through exercise, or by reducing a present risk factor for disease, e.g., reducing alcohol intake. The expected change in behavior will go via mental processes. There are several ways to influence behavior change [40, p. 142], for instance, through 1) changed beliefs (having acquired the belief that a glass of red wine a day is good for your health),<sup>17</sup> 2) changed attitudes (becoming more positive to exercise), 3) changed norms (no longer thinking it right

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<sup>15</sup> In a few cases the targets are the behaviors of politicians, civil servants or (other) professionals, e.g., in health advocacy [88].

<sup>16</sup> For some people these kinds of behavior can also be part of a ‘lifestyle’, and, thus, of a person’s identity, e.g., not using a crash helmet because of belonging to a ‘motorcycle culture’ [38].

<sup>17</sup> Note that false beliefs also lead to (in)actions, and that health promoters sometimes use this insight, e.g., when they exaggerate the danger of certain practices, e.g., trying out narcotics, to scare young people from testing such practices [36].

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to smoke in public places), and 4) increased skills, physical (learning to swim), as well as mental (becoming better at understanding one's own needs) (see also [24; 33; 56]). Thus, professionals can have different foci for their attempts to change risky behavior.

### Problems with the Instrumental Goals of the Behavior-Change Approach

Should we be fully satisfied if people changed towards a more healthy behavior? The attainment of reduced smoking, reduced alcohol intake, increased condom use, increased vaccination rates, and more exercise, seems to describe successful interventions, since they lead to better individual, group, and public health. Despite this, there are several difficulties with this approach, namely, it is overly paternalist, and disregards the individual's or group's own perception of what their problems are, and what they want to achieve – something that also increases the risk of failed interventions. It, furthermore, risks leading to (harm through) 'victim blaming' and stigmatization, and to increased inequalities in health. And, finally, it puts focus on the 'wrong' problems, i.e., behavior, instead of the 'causes of the causes'.

First, the approach assumes that professionals know what the problems are that need to be addressed, namely, risky behavior, or 'lifestyle', and, thus, what the goals should be, namely, behavior or lifestyle change, and professionals impose these goals on individuals, groups, or populations. This is paternalist, i.e., to intentionally interfere with a person's liberty and/or autonomy (e.g., "impose limitations on someone, or to require actions by someone"; [4]), without her consent, in order to promote her own good [25], since it ignores the individual's right to 'be heard'. It cannot be taken for granted that the goals chosen are what the people concerned themselves consider to be most relevant or important.<sup>18</sup> Furthermore, when the professional decides upon a goal it is unclear to what extent it contributes to quality of life, i.e., there might be goals that are more important than the ones suggested.

We know, however, that people sometimes choose unwisely, i.e., they might have 'inauthentic' (i.e., uninformed and non-autonomous) goals, goals that do not lead to health, happiness, or quality of life. One might then as a professional be tempted to help the individual set more reasonable goals, at least goals that contribute to health. However, relatively little is gained by achieving such goals, e.g., convincing someone to accept an exercise prescription, if this means that the individual does so unreflectingly and non-

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<sup>18</sup> This is not to deny that there are behaviours that there are good reasons to prohibit (solely for the sake of reducing harm in the individual herself), either because the infringement on the person's liberty is slight, as with having to wear a seat-belt, and/or because the harm from the behavior is great, as with autonomy-reducing behaviours such as using heavy drugs.

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autonomously, since it (more or less) neglects the importance of strengthening the general ability for control and autonomy. We should also realize that people might (autonomously) want to sacrifice or risk some of their health for important and fulfilling pursuits – pursuits that contribute to their quality of life, e.g., someone working as a graffiti artist voluntarily incurring the risk of inhaling unhealthy fumes from the spray-paint bottles.

In any case, it might be wise to involve people in choosing the targets of interventions that concern them, since these interventions are then more likely to succeed (for more arguments, see [83]). In projects that have predetermined, ‘narrow’ behavior-change goals (set by the professionals) there is the risk of failure, as is seen in many major top-down interventions [3; 5; 42; 67; 74; 76]. When people’s own concerns are not addressed, they are less likely to experience that the intervention is for or about them. Smoking might be the least problem for a low educated, unemployed, or homeless, and depressed individual. On the contrary, smoking might be one of the few comforts in the situation she is in [3, p. 474]. Quite a few of those behaviors professionals want to reduce give people pleasure, relief, or comfort.

Leonard Syme describes an illustrative case of a failed behavior-change project [75]. His research team received a large research grant for trying to reduce smoking in Richmond, California. The project, conceived of as a “community project”, was considered especially well-designed by the NCI (National Cancer Institute) who sponsored it, and the design was later used in a major nationwide intervention (the COMMIT study). Nevertheless, Syme’s and his colleagues’ ambitious five-year project failed to make any difference whatsoever in the smoking population [75]. The same fate befell the other twenty projects built upon the same strategy and with the same narrow goal, smoking cessation [75]. Later it became clear to Syme and his colleagues what had gone wrong. Richmond was a poor neighborhood, with a high unemployment rate, high crime and drug use rates, and few health services. It was, furthermore, polluted by the nearby oil refineries. In hindsight, Syme concludes: considering these much more serious and important problems, it was very naïve for the researchers to target smoking [75]. Later, humbled by these experiences, Syme and his colleagues began working with communities instead, collaborating with them around initiating more suitable health projects, i.e., with more suitable goals [75].

Another important problem with the behavior-change approach to goals is that it increases the risk of ‘victim blaming’, as well as that of stigmatization [29, pp. 73-75; 35; 37, pp. 115-117; 44; 65]. When we focus on behavior, ascribe rationality and autonomy to individuals, and, furthermore, assume that individuals are (or ought to be) well informed, we imply that people themselves are to blame for their problems. If those with the ‘risk behavior’ do not

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adopt the alternative behaviors recommended, they might be deemed fully responsible for the resulting problems. They received the information, and they (appear to) choose not to use it. They should perhaps then also bear the burdens of this neglect.

However, it is not as simple as this. Many other reasons can be given for this lack of change of behavior, e.g., poor health literacy (information is contextual, and cannot be understood by everyone), lack of possibility or opportunity, e.g., few green areas, few bike lanes, absence of stores with a reasonable assortment of foods, lack of job opportunities, and cultural norms and habits [3, p. 474]. These are not factors that the person or group has much control over, and therefore it is unjust to blame them for their risky behavior. There are plenty of other factors correlated with such behavior that show that it is unlikely for people themselves, in any straightforward way, to choose them. Risk behavior is correlated with class, education, social status/capital, gender, age, occupational status, norms, housing area, and other living conditions, etc. [2; 15; 20-21; 37; 46; 47; 92].

The focus on ‘risk behavior’ might, furthermore, lead to stigmatization of the condition. This, for example, happened with HIV [86]. But there is a similar risk with other behaviorally conceived problems, such as obesity and smoking [44; 68; 71]. As with blaming the victim, conceiving the problem as one of behavior, and not seeing the problem in a broader context, puts focus on the individual, or group, in question, increasing the risk that they become exposed and vulnerable. Concerning overweight and obesity, for example, the fact that we live in an “obesogenic environment” [60], i.e., one in which we have easy access to inexpensive foods rich in calories, but few ‘natural’ possibilities to burn calories, is at least as important as individual ‘choices’.

Closely related to these problems of victim blaming and stigmatization is the fact that focusing on behavior risks moving the attention away from more serious problems, i.e., from the underlying causes of the (behavioral) problems (‘the causes of the causes’), and questions of social justice, to behavior or lifestyle problems [5, p. 77; 16; 20; 21; 46; 47]. Few of the social psychological (and other) models and theories mentioned (having behavior change on their agenda) include, or discuss much, the greater social, economic, and environmental factors influencing behavior. What the most vulnerable and marginalized people need is social justice and social change, such as better schools, better education, better housing, health insurances, jobs, more equal pay, and better working conditions, and in some countries food,

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housing, safe water, better sanitations, and primary health-care [2; 3, p. 472, ff.; 5, p. 56 ff.; 16; 21].<sup>19</sup>

Note, finally, another problem that partly has to do with goals, and partly with strategies [83]. Even if the professionals only provide ‘neutral’ (i.e., not manipulative) health information, e.g., through media campaigns, and succeed in changing some people’s health-related behavior, we run into another risk, that of increasing health inequalities. This phenomenon is sometimes referred to as the “knowledge gap” [35, p. 549], since the evidence shows that the more well-educated (the ‘upper’ socio-economic classes) are more likely than the less well-educated (the ‘lower’ socio-economic classes) to adopt healthy behaviors that they learn or hear about [3, p. 475; 26, p. 70 ff.], e.g., to exercise more, drink one glass of red wine a day, drink green tea, eat dark chocolate (rather than other sweets), or eat more (oily) fish, vegetables and fruits. That is, certain messages to change behavior or life-style appeal more to, or are more easily ‘decoded’, and adopted, and can be afforded, by some groups than others. A behavior-change campaign having these goals might, then, paradoxically, increase the average health of a population, and in that sense be a success, but at the same time increase the inequalities in health [13; 20; 35; 93].

Thus, a great deal can be said against behavior or lifestyle change as the primary goal for health promotion and public health, despite its rather self-evident character.

## Empowerment: Two Definitions

There are (at least) two distinct and useful definitions of ‘empowerment’. The term can be defined both as a *state* (and a goal) to be achieved, and as a *process* (or a means) to achieve this state (and these goals) [80]. These two definitions should (as indicated) be congruent. One of them is important here, namely, that of empowerment as a state of individuals, groups, and communities. There are several similar definitions of empowerment as a state [42; 58; 73; 84; 85], but the present paper will take a previously suggested definition for granted. Empowerment as a process is primarily focused on *how* to achieve empowerment change, and will therefore not be discussed in this paper. Suffice it to say that empowerment as a process is about professionals letting the person, group, or community ‘facilitated’ have or acquire as much control over the change process as possible [30; 42; 62-63; 80; 84; 89].

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<sup>19</sup> This means that we also need other theories, other than those narrowly focused on behavior, to guide us – political, social, environmental, organizational, and economic theories – in order to understand social reality, and in order to achieve alternative goals, such as empowerment.

### Empowerment as a State, and as a Goal to be Achieved

Empowerment will here be defined in the following way: To be empowered is to have control over the determinants of one's quality of life. The more control one has over these determinants, the more empowered one is, and the less control one has, the less empowered one is [78; 80]. Empowerment is a state of an individual, group, or community – a 'dynamic state' that can change over time, sometimes quickly, e.g., in an environmental disaster, and sometimes slowly, as when someone acquires occupational competence through an education. In general, however, it is a rather stable state, especially within relatively affluent welfare societies. Most people in these kinds of societies have a fair degree of empowerment, but some have less of it.

Quality of life is chosen as the most important factor to control, since it is what is most valuable to people, and not, for example, health. However, health is one of the determinants of quality of life, so most increases in health will be empowering. Other factors that are likely to contribute positively to the control of quality of life, and thus constitute, or contribute to, empowerment, are knowledge of various kinds (e.g., raised consciousness, generic competence, and occupational skills), autonomy, confidence and self-esteem, and opportunity and freedom [78; 80]. Thus, an increase in any of these factors is likely to be an increase in control of a person's, group's, or community's quality of life,<sup>20</sup> depending partly on the existing degree of these factors and on the situation at hand. Different professions will deal with different aspects of empowerment, e.g., teachers with (some kinds of) knowledge, therapists with self-esteem and self-knowledge, health promoters with health, and politicians with opportunities.

### Ethical Aspects of Working Towards Empowerment as a State

In the following section I will show that the empowerment approach to goals is not afflicted with the problems associated with the behavior-change model. After that, some possible problems with the approach will be discussed and resolved.

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<sup>20</sup> Note that a group's quality of life is the aggregated (authentic) desire-fulfilment of the members of the group. The desires might differ, but in certain collective actions they are likely to merge, e.g., when a group fights for social recognition.

### The Importance of Having Control over Health and Quality of Life

The problems we have seen with the behavior-change model can usually be handled by the empowerment approach. It is not paternalist (in any problematic way), especially not in local interventions, since the professional does not decide which *specific* goals should be targeted in the interventions; it does not lead to the risk of ‘victim blaming’, and neither does it risk stigmatization, since it does not focus on behavior and lifestyle; it focuses more on broader social and economic issues; and it does not risk increasing health inequalities, since it often targets the less well-to-do.

Paternalism, as already noted, is not necessarily something to be avoided, and it should be clear that in a (rather innocuous) sense empowerment (as a goal) can also be paternalist, since its agenda is for people to become more empowered (without asking for their consent). But this primarily goes for top-down interventions.<sup>21</sup> When it comes to local empowerment interventions, they are very different from those of the behavior-change approach, since professionals do not at all impose *specific* behavior-change goals on individuals, or groups, such as to exercise more, use bed-nets, or drink less alcohol.<sup>22</sup> Rather, empowerment is about people gaining more general control over their (quality-of-life-related) health, making them less in need of paternalist interventions. Empowerment as a goal (and as a means), in local interventions, is even ‘anti-paternalist’, since it rarely, if ever, “requires actions” or “imposes limitations” on individuals, or groups [4], nor, in general, ignores people’s right to autonomy. Furthermore, promoting the *ability* for autonomy (the ‘opposite’ of paternalism) is a central aspect of empowerment (as a goal), as will be even more clear in a moment.

Furthermore, having the empowerment of individuals, or groups, as a goal for local interventions, reduces the risk of victim blaming, and stigmatization, since no specific (behavior) problem is assumed. You are usually not blamed, or stigmatized, for having low control over those determinants of your (quality-of-life-related) health that are targeted for an intervention. As for top-down interventions, empowering the population, or large segments of

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<sup>21</sup> In certain kinds of (paternalist) top-down interventions it seems acceptable to impose restrictions on people, for their own sake, e.g., mandatory schooling, prohibiting drug use, or requiring (through taxation) that people deposit money in (their own) pension funds. The best argument for such interventions is that they promote future autonomy, or empowerment.

<sup>22</sup> Note that we are dealing with two kinds of ‘groups’ or ‘communities’, one geographical, i.e., people living in the same area (e.g., block., village, town, county, or country), and one where the individuals involved share a certain ‘property’, i.e., share the same kind of ‘problem’ (e.g., being unemployed, illiterate, or obese). The two might, of course, go together, such as living in a village where everyone is poor, or illiterate.

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the population, e.g., increasing educational opportunities for unemployed people, or making recreational areas more available and safe for the elderly, they do not lead to these kinds of problems. Thus, not attributing some specific problem to the individual, or group, more or less eliminates the risk of ‘victim blaming’ and stigmatization.

Unlike behavior-change projects (of all kinds), which primarily focus on specific behaviors, or life-styles, empowerment projects in general focus on broader issues. Rather than try to change behavior, top-down empowerment projects often target the ‘causes of the causes’, i.e., those social or economic factors that contribute to the more specific problems. As we have already noted, most risk behaviors are found in low social-economic groups [57]. This indicates that what people need is to get more access to empowering factors, such as education, jobs, better work environments, better housing, better transportation, and recreational areas [2]. These are factors that, if attained, influence health and longevity positively. They might even lead to reduced risk-taking behavior. But with these kinds of intervention, reduced risk behaviors will be the unintended consequence of increased control.

Furthermore, the empowerment approach to goals does not risk increasing inequalities, since it often focuses on the inequalities themselves. Thus, it is the other way around. Top-down empowerment projects often target vulnerable groups or communities, by, e.g., providing low-cost child care for the less affluent mothers who want and need to work, making the job market more accessible for immigrants, increasing availability of recreational facilities in deprived areas, or expanding the possibilities for poor people to access higher educations. Local empowerment projects are usually even more targeted on vulnerable groups, usually focusing on issues that the group, or community, themselves find important [83], e.g., on getting access to basic health care, family planning, or language training (for newly arrived refugees and immigrants). The empowerment approach has historically been closely related to the agenda to equalize opportunity and control in the population, primarily focusing on marginalized and vulnerable groups [28; 69], associated as it has been to civil rights movements of various kinds [28, pp. 39-41].

I claimed earlier that empowerment goals, just as those of behavior change, are instrumental. Note, however, that some changes that constitute increased empowerment *also* constitute increased quality of life, i.e., they have final as well as instrumental value, e.g., increases in autonomy and confidence, or having a well-paid, as well as meaningful and stimulating, job [77-78]. The major difference in relation to behavior change as a goal, is that the empowerment goals are more basic, or generic, including e.g., consciousness raising, skills development, democratic decision-making skills, autonomy, and increased self- (or

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group-) confidence and self- (or group-) esteem, but also increased opportunities, and empowerment goals are therefore more important for achieving more extensive life changes. An increase in general confidence will most likely be of greater benefit, with a multitude of effects on the person's (or group's) life, than being able to lose weight (even if this achievement might also boost confidence in those belonging to the group). Finally, it is more likely that the achievement of these goals will have positive effects on quality of life, not only on health, since (in local interventions) they to a large extent focus on the individual's, group's, or community's ability to consciously and critically reflect upon choices, and revise them if necessary.

### The Importance of Autonomy as an Ability

A crucial aspect of empowerment is that of the *ability* for autonomy (or self-determination),<sup>23</sup> since autonomy refers to the individual's, group's, or community's ability to be self-governing, i.e., to decide over her (their) own life (lives). Autonomy is deeply linked to what it is to be a human being, or a person, and it is a central concern for liberalism [49] as well as for existentialism [66]. It is, furthermore, one of three requirements for personhood, and dignity, argues Griffin. The other two are opportunity (or "minimal provision") and liberty [34, pp. 32-33].<sup>24</sup> Having the ability for autonomy (as well as the opportunity), i.e., to be able to deliberately and successfully form realistic 'life plans', has deep importance for people, even if this might sometimes lead to autonomously 'surrendering' yourself to other greater goods, e.g., your community, your family, or your god.<sup>25</sup>

We have seen that to be empowered (in this context) is to have control over the determinants of quality-of-life-related health. The ability for autonomy is therefore crucial for this control, since it constitutes the ability to deliberate and to formulate and choose goals to pursue.<sup>26</sup> It is, thus, hard, if not impossible, to have control over the determinants of quality-of-life-related health without having a reasonable degree of autonomy. For example, choosing

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<sup>23</sup> This, obviously, is not the same as the right to autonomy, and increasing the ability for autonomy is compatible with some restrictions of individual liberty (exercise of autonomy). See footnote 18.

<sup>24</sup> Not only individuals, but groups, and communities, need autonomy, opportunity, and liberty, even if this is not specifically for their 'personhood'!

<sup>25</sup> Note that all choices, also autonomous ones, are 'contextual', i.e., they (including their fulfillment) are limited by physical, mental, and social constraints. Within these constraints we can, however, be more or less autonomous, and the general claim is that the greater the ability for self-determination, the better.

<sup>26</sup> It is, of course, conceivable that someone else knows better what belongs to our quality of life, but this is less likely than if the (relatively autonomous) person herself (or group itself) were to choose.

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something as important as your future profession is difficult if you lack knowledge about possibilities, if you lack self-confidence, and if you are uncertain about ‘what you want’. In a sense, then, autonomy also has instrumental value. Acting autonomously probably leads to better outcomes, since when people pursue their own chosen goals they are more likely to succeed, than when the goals are imposed on them (Cf. [75]).

To conclude, it is important that we help facilitate the *ability* to choose (wisely). Things other than autonomy are, as we have seen, also needed in order to be empowered, but I hope to have established the primacy (individually and collectively) of autonomy, or self-determination, as a goal for health promotion (and public health work).

## Possible Problems with the Empowerment Approach

It might be hard to find anything problematic about the goal of helping people gain more control over their lives. Still, there are some questions that can be raised against empowerment as a goal. One worrying aspect seems to be that facilitating some people to get more control over their lives, might involve reducing other people’s power over their lives. This seems to assume that empowerment is a zero-sum game [15; 48]. Secondly, is the goal not too wide, focused as it is on changes other than health-related behavior, especially if we frame the goals within a public health context [7]? Thirdly, it appears to be a problem that empowered people, including groups and communities, might autonomously choose to live in ways that are detrimental to their health.

## Empowerment Might Lead to Power over Others

David Buchanan has several concerns with the empowerment approach [15, p. 79 ff.]. One is that it is too much focused on power, and forgets a number of other important goals, e.g., “caring, or compassion, or dignity, or love, morality, respect, harmony, [and] responsibility” [15, p. 81]. He is certainly right in emphasizing these values, but it seems to me that many of them are already indirectly supported by an empowerment approach. The humanistic existential roots of this approach are an indicator of that. Carl Rogers, e.g., claims that the “fully functioning person”, a person that appears to be rather empowered (at least from within), is both ‘social’ and constructive [62].<sup>27</sup>

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<sup>27</sup> The means used in empowerment projects are also a testimony to that, e.g., that treating people as autonomous individuals or groups will induce them to become more engaged and take responsibility, and this is expected to lead to greater dignity (as identity) of the individuals involved [15; 53]. And the dialogical, collaborative quality of empowerment projects fosters other values, such as mutuality, respect, compassion, and morality [30; 62].

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However, the main concern is Buchanan's rhetorical question, namely, does increased empowerment not always lead to 'power over' other people – "at a minimum", to some people having "to pay more taxes" [15, p. 80]? Buchanan recognizes that there is a difference between 'power to' and 'power over', but he holds that 'power to' is bound to lead to 'power over' in projects where people come together to improve their situation and living conditions, such as rallying for "better housing, better education, better transportation, food, childcare, etc." [15, p. 80].

Empowerment is a form of 'power to', as it is (as we have already seen) about having control over the determinants of one's (good) life. There are several things to take notice of. First, 'power to' is more or less equivalent to *ability* or capacity [50; 64; 94]. Second, ability and capacity are *dispositional* terms [50; 52, p. 41 ff.; 94]. Thus, strengthening a person's (group's) ability (power to) is to give her (them) tools that can be utilized if the person (group) chooses to utilize them (assuming that there are opportunities to do so). Finally, power is best characterized as an *intentional* ability [50; 52; 94]. To unintentionally influence other people is not, then, to exercise power.

'Power over' (other people) is taken to be the ethically most problematic form of power (to), so let me briefly mention three common uses of the term. First, it might mean that a person (or group) gets another person (or group) to do something that she (they) *would not otherwise do* [19]. Second, it might mean that a person (or group) gets another person (or group) to do something that she (they) *does (do) not want to do* [90]. And, finally, it might mean that a person (or group) gets another person (or group) to (consciously or unconsciously) do something that it is *not in her (their) own interest to do* [43].<sup>28</sup> Note that none of these three versions of 'power over' are *necessarily* morally problematic (even if they might be), since there might be legitimate reasons for exerting 'power over'. However, nothing so far said excludes the possibility that empowerment might include getting more control over other people.

A few major points will be made against Buchanan's critique. First, it seems to me that Buchanan trivializes the notion of 'power to'. There are plenty of important ways to strengthen people's empowerment ('power to'), without this affecting other people negatively, in the sense that they have to do things they would not otherwise do (or do not

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<sup>28</sup> This is a simplification, since 'power over' ought also to cover, such things as intentionally induced experiences, e.g., threats, and the intentional creation or limitation of opportunities, such as withholding someone's passport or money.

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want to do, or that it is not in their interest to do). One might facilitate increases in people's autonomy (self-determination), self-esteem or confidence, knowledge (including self-knowledge and consciousness raising), competence or skills, health, or opportunity. None of these increases in empowerment need involve exerting power over other people. Rather, other people might even gain from their community fellows' increases in empowerment, since they might become more creative, more productive, or more altruistic. Empowerment (power to), then, is no zero-sum game.

However, what if someone (through being empowered) gains a benefit at the expense of someone else? Say, for example, that a group of unemployed people, who have been given the opportunity to develop their professional skills (and, thus, to become more empowered), get jobs that other people would have obtained were it not for the group's opportunity to acquire these skills. Is this not a case of power over? It is not. It is just an unfortunate unintended consequence. First, there is no intention on the part of the individuals applying for the jobs, nor is there one on the part of the professionals creating the opportunity, that other people should not get the jobs in question. And in a capitalist society there necessarily has to be some unemployment, for the economy to 'function' (Marx, in [32, pp. 106-108]). So, we should not accuse the individuals, nor the facilitators, of exercising 'power over' those who did not get the jobs. What it does show, however, is that helping individuals, groups, or communities might be futile (on the whole), when the social, economic, and political system limits the options available. In cases such as the one described above, more jobs, or other opportunities (i.e., social justice; [2; 16]), are needed, not primarily individual, or group, empowerment.

Second, as to Buchanan's idea that some people might have to pay more taxes in order for some other people to get empowered, this might be true, but again it cannot count as 'power over', since this is not the intention with the empowerment project.<sup>29 30</sup> But even if this were so, there are moral arguments that can justify such an increase of tax. We might, for example, have reasons to rectify social injustices, e.g., compensate for inequalities in opportunity [2; 20; 61]. To take an example: if poor, landless peasants succeed in pressuring the government to create land reforms so that land is redistributed to them, this will count as 'power over' (the

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<sup>29</sup> Unless this is a very specific tax-financed project, making people pay local tax for it. But this is 'power over' coming from the politicians, not from those involved in the concrete empowerment project.

<sup>30</sup> The most problematic ethical aspect of the exercise of 'power over' is making people do what is not in their own interest [43]. But it is not obvious that having to pay taxes for empowerment projects is against (all) taxpayers' interests, at least not if the projects are successful. Nor should we assume that people in general do not want to pay taxes.

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landowners). But this need not be a moral problem, if, for example, the uneven distribution of land was unjust to start with. To create social justice and reduce inequities are, thus, legitimate reasons for exerting ‘power over’, something also Buchanan agrees with [16]. Note, once again, that an empowered person is more likely to be productive, take care of herself, help others, and not harm other people [30; 62-63]. So any empowerment project that succeeds is (in the end) likely to lessen, rather than increase, tax burdens.<sup>31</sup>

### Empowerment, Why Not (Just) Health?

We are in the field of public health and health promotion. Why bother about empowerment? Why not just go for health increases in the population? Working towards health-related behavior change seems more straightforward than working towards empowerment [7].

True, since we are discussing this within a health-promotion, or a public-health, context, health should, as was stated in the beginning, be the overall aim, also for empowerment work. Thus, the empowerment goals focused on should, in this context, be those that are the most relevant for the health of the individual (or group, or community, members). But note the following: to become healthy is to become empowered, since health (as ability) is one important factor with which control over life is established. Furthermore, (increased) autonomy, self-confidence and self-esteem (empowering factors) *are parts* of manifest mental health, and not just beneficial determinants for future health [79].

But what, primarily, speaks in favor of empowerment as a goal is, as we already saw, that its effects are much broader, and that its effects are likely to be more long-lasting. An empowered person (or group, or community, member), research shows, is a person (member) who can take better care of herself, including her health [15; 42; 46; 47]. The more empowered an individual is in general, the more likely it is that she stays healthy. Thus, in empowering an individual, a group, or a community, even if the focus is not specifically on health, we will most likely get health ‘as a bonus’. This is supported by what we know about ‘the causes of the causes’, e.g., about the causes behind risks and risk behavior [46; 47]. Those with higher status, better socio-economic situations, better jobs, better educations, more money or other forms of capital (social or cultural), are (in general) those who have the most control over their lives, who are the ones least exposed to risk factors, and who have less risk behavior, and they (on average), therefore, have better present and future health, and live

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<sup>31</sup> In most other respects I find Buchanan’s book highly important and inspiring. Most of what he wants to achieve clearly falls under what I would call the empowerment approach.

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longer [16; 20; 39; 46; 47]. Thus, increasing the empowerment (i.e., control) of low socio-economic, low-educated, vulnerable, or marginalized individuals, groups, or communities, is the best strategy for increasing (equitable) health. Finally, through this general goal, empowerment, we conceptually tie our health-promotive work to what is most valuable for people, namely, their quality of life.

### Does Autonomous Choice (Always) Lead to Better Health?

What if the empowered and autonomous individuals or groups (after all) choose to pursue goals that on the whole are considered detrimental to their health? If this is the case, we would have to question empowerment as a goal for *health promotion* and *public health*.<sup>32</sup> I have tried to make it plausible that empowered people in fact take care of their health, but there might still be groups where empowerment leads to a situation where we can question the outcomes concerning health.

Some (autonomous) choices that people make can be risky, such as mountain climbing, racing, horse riding, and playing football. We usually have no trouble respecting them, and should respect most of them, as long as they do not harm other people [49], or create undue burdens on society. We also have the ‘bohemian objection’,<sup>33</sup> namely, that, through history, many artists (of all kinds) chose to live lives that were detrimental to their health, but that let them develop their artistic creativity. Even if we should be wary of creating or upholding myths, it is clear that many artists are still willing to sacrifice a ‘comfortable life’, as well as their health, and sometimes even their lives, for their art. Thus, health is not, as we have already concluded, the most important value in life, and people should be allowed to take some risks in order to pursue (at least authentic) quality-of-life goals.<sup>34</sup>

So, empowered people might on occasion make (autonomous) unhealthy choices, in order to reach authentic quality-of-life goals, but in general, as we concluded in previous sections, empowered people are good at taking care of their health.

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<sup>32</sup> But perhaps not for other kinds of social interventions, since (control over) quality of life (on the whole) is more important than (control over) health (even if they are causally interrelated).

<sup>33</sup> I have the term from Luca Chiapperino (personal communication April 2013).

<sup>34</sup> Note that in many cases people should also be allowed to pursue inauthentic goals. However, society should create social foundations for authenticity, as well as those for health, empowerment, and quality of life.

## Conclusion

In this paper I have discussed two approaches to the goals of health promotion and public health. With regard to the goals discussed, i.e., behavior change and empowerment, I have argued that the empowerment approach, on the whole, is superior to the behavior-change approach. Both, of course, try to achieve health increases in individuals and in populations. Many of the more specific behavior-change targets, such as smoking cessation, weight loss, increased condom use, or getting vaccinated, might be important, but they do not seem as important for health as other goals, such as targeting the empowerment of the individual, group, or community. The advantage of empowerment is that it strengthens the ‘whole’ individual, group, or community, her/their autonomy, skills, and general control, in achieving better and healthier lives. Behavior changes might sometimes also lead to the development of the ability for autonomy and control, but, if they do, this is usually a ‘secondary effect’, such as feeling strengthened by the fact that one has lost weight, started to exercise, or stopped gambling.

Moreover, even when risk behaviors are not voluntary or autonomous, and concerned people themselves would like to change their risky behavior, the solution should not necessarily be behavior change (in a narrow sense), but the attainment of more autonomy and empowerment. Targeting behavior change seldom addresses the most important issues for people, such as powerlessness, lack of control, or lack of hope. What is needed for populations not so susceptible to the goals envisaged in behavior-change projects, is the attainment of other (more empowering) instrumental goals, such as increased real opportunities in life.

Finally, we must realize that for some people, health is secondary to (other) quality-of-life goals, i.e., some goals are so valuable to them that they risk their health in order to pursue them. This idea is not compatible with the assumptions of the behavior-change approach.

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## Conflict of interest

The author declares no conflict of interest.

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