Session 61.2

Promoting Health, Healthy Public Policy and Social Investment

Chair: P. Fafard

Behavior Change or Empowerment: On the Goals of Health-Promotion

Preliminary version

Published as: Tengland, P-A (2013). Behavior Change or Empowerment: On the Ethics of Health-Promotion Goals. *Health Care Analysis*. Online first. DOI 10.1007/s10728-013-0265-0

Per-Anders Tengland

per-anders.tengland@mah.se

Health and Society

Malmö University

205 06, Malmö, Sweden

Introduction

One important ethical issue for public health work and health promotion is to try to determine what the goals for these practices should be (Brülde 2011).[1] 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. Before we look closer at them we need to have a framework in which we can place, and to which we can relate, 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 (in a public health context) be? The health and longevity of the population is the obvious answer. However, the answer needs to be qualified. First of all we need to state what we mean by health. This question will be dealt with in a separate section. Secondly, since health (as will be shown) is to a large extent an instrumental goal (and, thus, primarily has instrumental value), we have to relate it so 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 (Tengland 2006). The simple reason is that if an increase in health or longevity does not contribute to an 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 quality of life. 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[2] (Tengland 2008).[3]

[1] A previous paper in a similar way discusses and ethically evaluates the different *means* used by these two approaches (Tengland 2012).

[2] Concerning health-related abilities, an increase in the ability for autonomy, at least, seems to constitute an increase in quality of life.

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 (Nordenfelt 1995; Tengland 2010a-b). Therefore preventing disease and injury will also be important goals for public health.[4] Second, as will be clear later, since very little is directly done to individuals or populations, health-wise, we must consider the "opportunity" for health, e.g. promote those environmental and social factors that contribute to health, especially since public health work mainly targets the healthy population (Daniels 2008; Dawson 2011). 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 (Verweij and Dawson 2007; Brülde 2011, p. 41 ff.). Health inequalities between groups have to be taken into account when evaluating the health status of a population (Wilson 2011; Daniels 2011; Brülde 2011, pp. 43-44).

Contemporary health problems and kinds of interventions

Many, if not most, contemporary health problems, such as cardiovascular disease, cancer, diabetes, STDs, accidents, mental illness, suicide, violence, homicide, etc., as well as risk factors, such as smoking, drinking alcohol, eating energy-rich foods, being physically inactive, etc., are brought about by, or have to do with, the "choices people make" (Buchanan 2000, p. 4). Some of these choices are "forced" upon people, such as sedentary occupations, others are more voluntary, such as binge drinking in week-ends. Many of these problems have to do with what is sometimes called "lifestyle" (Lalonde 1974). This means that some interventions to tackle these problems will have to go via, direct or indirect, influences on people's choices, behaviors, and actions.

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 public health policy is realized in this macro fashion (Downie et al. 1996; Beaglehole and Bonita 2004, p. 173, ff.; Baum 2008). There are, furthermore (what I prefer to call) "local" measures, where professionals meet and directly interact with individuals, groups or

[3] 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 on the population level, and vice versa.

[4] For discussion about the relation between health promotion and disease prevention, see Tengland 2010a-b.

communities (Tengland 2012).[5] These projects are often of the kind that they 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 (Berglund 2008), and there will (most likely) always be marginalized and vulnerable groups that might need special attention, be they drug users, homeless, unemployed, or obese.

Aim

The general aim of this paper is to investigate what the similarities and differences are between the behavior-change model and the empowerment model, concerning their immediate (instrumental) goals or aims, and, in relation to the ultimate goal of health promotion (and public health work) – i.e. increased or sustained (and equally distributed) quality of life-related health and longevity – morally evaluate the strengths and weaknesses of these two goal models, and, finally, argue that we should prefer empowerment to behavior change.

Procedure

The general procedure used is to first describe the two approaches, or traditions, and the explicit (and the 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 (Ringer 1997). For empowerment, I will use my own analysis (Tengland 2007a, 2008). 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. Secondly, there follows an ethical evaluation of these goals, or goal structures, an evaluation that is related to the ultimate goals of health promotion (and public health).

The behavior-change model is first scrutinized, showing some of its faults. After that the empowerment model is presented, and it is argued that, on the whole, it is to prefer. Finally, some possible problems with empowerment as a goal are 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 importance with this detour is, first, that health can refer to many different things, which means that we need to make the concept more homogeneous and

[5] 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.

precise. Second, we saw that health is not necessarily the ultimate goal for health promotion. A plausible theory of health will show us why. After the section on health, I will introduce a distinction, 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 aspects of health, namely "manifest" health, and "fundamental" health. 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 if she has acquired the basic abilities and dispositions that her peers have acquired, and if she is in a state of positive well-being, or at least not in a state of suffering (Brülde and Tengland 2003; Tengland 2007b). 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 (Brülde 2000a-b; Tengland 2007b).

A few further distinctions: *basic* abilities refer to those abilities and dispositions that we acquire just by living and growing up, such as to walk, stand, think, reason, remember, grab, chew, see, hear, communicate, and experience emotions (Tengland 2007b). Manifest health, in this sense, also requires that the person has some degree of "motivation" (or "will"), and that she has the ability to acquire more complex (non-health-related) abilities or competencies, such as using a computer, playing the piano, or driving a car. But, the individual should not only have acquired these abilities and dispositions. In order to be healthy she should also be able to utilize them, here and now (ibid.). 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, such as calmness, or anxiety (moods), and feeling (physically) fit, or experiencing pain (sensations) (Tengland 2007).[6]

Finally, manifest health is conceptually related to the environment. An environmental factor might stop an individual from utilizing her abilities or dispositions. This does not constitute a state of ill health. However, if a person in standard or acceptable circumstances (i.e. in circumstances where most people can "function") cannot utilize her acquired abilities

[6] 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.

or dispositions, then the person has some degree of reduced health (Nordenfelt 1995; Tengland 2007b).

Fundamental health

Fundamental health, the other important aspect of health, refers to the physiological, anatomical, or (deep) psychological structures of the individual (Brülde 1998; Brülde and Tengland 2003; Tengland 2010a-b).[7] Fundamental health is defined in relation to manifest health, as those (non-conscious) internal states and processes that support or uphold the manifest health of the individual (Tengland 2010a-b).[8] 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. that they exist, connect to other parts of the brain in an appropriate way, and work properly (Pestana 1998, p. 60 ff.).

Disease/Disorder

Very briefly, disease/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 health, i.e. it reduces ability, well-being, or longevity (Culver and Gert 1982; Nordenfelt 1995; Brülde and Tengland 2003; Brülde 2003). Disease is the most common cause of manifest ill health. But there might be other causes of ill health, such as traumas or life crises.[9]

Direct and indirect health interventions

With these 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 (Tengland 2010a-b). 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 improve people's basic abilities, such as to climb stairs, carry bags, and move arms in order to clean windows. Thus, manifest health is usually only

[7] This level is more or less what Nordenfelt calls the person's "second order ability" (1995).

[8] Strictly, fundamental health also has to be related to the environment (Nordenfelt 1995).

[9] 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).

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 hearth 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 (Nordenfelt 1991). [10] What is typically done in such interventions is that the *internal* or *external* determinants of health are changed, for example through influencing people's beliefs about what constitutes healthy foods (internal), or, through constructing bike-lanes in order to make people exercise more (external).[11]

Both the empowerment and 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 targeted in order to try to make people healthier, and as we saw, we can target internal factors, such as attitudes, beliefs, and wants (desires), or knowledge, competence, and skills, as well as external factors, such as norm systems, and social and physical environments, including creating or limiting opportunities for certain actions (Beaglehole and Bonita 2004; Glanz et al. 2008; Baum 2008; Laverack 2009; Nutbeam et al. 2010).

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* (Buchanan 2000 p. 71 ff.; Holland 2007, p. 111 ff.). In this context it mostly concerns health-related change. In the book *Theory in a Nutshell. A Guide to Health Promotion Theory* (Nutbeam et al. 2010), 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

[10] Only a rather narrow "medical" approach can focus on health itself, since 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 painkillers, does directly influence the individual's manifest health, namely through restoring the knee function (fundamental health) and the ability to walk (manifest health), and reducing pain (manifest health) (Nordenfelt 1991; Tengland 2010a-b).

[11] A few kinds of population interventions do in fact change the health status of the individual directly, e.g. mass vaccinations that "activate" the immune system, or putting fluoride in the drinking water to promote tooth health (Nordenfelt 1991; Tengland 2010a-b).

behavior change by focusing on characteristics of the individual" (Nutbeam et al. 2010, p. xi). 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" (Kelly 2006, p. 141), and he goes on to claim that "changing people's behavior is at the heart of health promotion" (Ibid., p. 141). Quite a lot of other literature confirms this almost self-evident point, i.e. that health-related behavior change is a common goal for health promotion (for example Glanz et al. 2008, Davies and Macdowall 2006, and Baum 2008), 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" (Maiback and Cotton 1995), "Using theory to guide changing individual behaviour" (Nutbeam 2006), and "Understanding and changing health behaviour: From health beliefs to self-regulation" (Abraham and Sheeran 2000), which is also the name of the book where the article is found (Norman et al. 2000).[12]

But there are other methods that have the same goals, for example Social Marketing. There are plenty of examples of this idea in Cheng et al. (2011). 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 (Cheng et al. 2011, p. 3). They illustrate this view with citations from Kotler and Lee who claim that "social marketing is about influencing behaviors" (in Ibid., p. 3), as well as from Smith who states that "the genius of modern marketing is…the management paradigm that studies, selects, balances, and manipulates the 4 Ps [product, price, place, promotion] to achieve behavior change" (in Ibid., p. 2). That this is the common view is supported in a lot of other sources as well; for example, Nutbeam et al. claim that social marketing "relates to the use of marketing techniques to influence behavior" (2010, p. 43), "for [both] individual and social benefit", however (Ibid., p. 43). Optimally, then, there will be positive effects for both the individual (group) and society (see also Storey et al. 2008; Frensh et al. 2009).

Health-related behavior change is, however, a rather vague goal. What kinds of changes are envisioned? The specific changes targeted differ. It may, for example, be smoking cessation, reduction of alcohol intake, or of 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 the consuption of fruits and vegetables. Thus, the aim is often for

[12] "Behavior change"+"health" produces 281.000 entries in Google scholar.

people to change their "lifestyles" (Buchanan 2000, p. 41; Holland 2007, p. 112 ff.; Earle and O'Donnell 2007).[13] Note, however, that some health-related behavior changes are not related to lifestyle (in a more narrow sense of the term), 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.[14] Nor do washing one's hands, or using a bed-net, seem to belong to a person's lifestyle. The broader concept, then, seems to be "health-related behavior", of which lifestyle is but one part. Note that a person's lifestyle appears harder to change, since it seems to be more related to a person's self-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 or groups. The desired behavior (or lifestyle) changes are, rather, expected to reduce the future risk of disease or injury, primarily either by strengthening the fundamental health of the individuals, or of preventing disease or injury, and therefore help sustain future manifest health. The expected change in behavior will go via internal mental processes. There are several ways to influence behavior change (Kelly 2006, 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),[15] 2) changed attitudes (becoming more positive to exercise), 3) changed norms (no longer thinking it right 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 Downie et al 1996; Glanz et al. 2008; Nutbeam et al. 2010). Thus, professionals can have different foci for their strategies in attempting to change risky behavior.

Problems with the instrumental goals of the behavior change model

Should we be fully satisfied if people change their behavior 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 problems

[13] In a few cases the targets are the behaviors of politicians, civil servants or (other) professionals, e.g. as in health advocacy (Wallack 1994).

[14] For some people these kinds of behavior can also be part of a "lifestyle", and, thus, of a person's identity, for example not using a crash helmet because of belonging to a "motorcycle culture" (Jones and Bayer 2007).

[15] Note that false beliefs also lead to (in-)actions, and that health promotors sometimes use this insight, for instance when they exaggerate the danger of certain practices (e.g. try narcotics) to scare young people from trying them (Hastings, Stead and Webb 2004).

with this approach. It is overly paternalistic, and disregards the individual's or group's own perception of what they want to achieve – something that also increases the risk that the intervention fails. Furthermore, it 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. behaviour instead of the "causes of the causes".

First, the approach (to goals) 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 those goals on individuals, groups or populations. This is paternalistic (i.e. "to impose limitations on someone or to require actions by someone for his or her own good"; Bayer et al. 2007, p. 86), at least once certain actions are taken to achieve these goals.[16] But it cannot be taken for granted that these goals are what the people concerned themselves consider to be most relevant or important. Neither do they in any obvious way harm other people (cf. Mill's harm principle; Mill 1859), even if the long-term effects of the behavior might lead to increased health-care costs and premature death.[17] 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 targets that are more important than the ones suggested. Thus, if people were to choose goals they might look different.

We know, however, that people sometimes choose unwisely, i.e. they might have "inauthentic" goals (i.e. uninformed and non-autonomous), 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 those that contribute to health. However, relatively little is gained by achieving such goals, if this means that the individual unreflectingly and non-autonomously has accepted them, since this does not in general strengthen the ability for 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, for example someone working as a graffiti artist who risks inhaling unhealthy fumes from the spray-paint bottles.

[16] Note that these behavior-change goals are not strictly paternalistic unless they are combined with measures that are coercive ("impose limitations" or "require action") in some sense. Note also that paternalistic actions always have "predetermined" goals, often concerning behavior change, set by professionals or politicians.

[17] This is not to deny that there are behaviours that there are good reasons to prohibit (solely for the sake of reducing harm to 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.

In any case, it might be wise to involve people in choosing the targets of some interventions, since they might also be more likely to succeed if people are involved in the interventions (for more arguments, see Tengland 2012). 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 (Syme 1996; SBU 1997; Beaglehole and Bonita 2004; Baum 2008; Syme and Ritterman 2009; Laverack 2009). 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 perhaps depressed, individual. On the contrary, smoking might be one of the few comforts in the situation she is in (Baum 2008, p. 474). Quite a few of those behaviors we want to reduce give people pleasure, relief, or comfort, and may even be part of their quality of life.

Syme describes an illustrating case of a failed behavior-change project (2004). 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 (ibid.). The same fate befell the other twenty projects built upon the same strategy and with the same narrow goal, smoking cessation (ibid.). Later it became clear to Syme and his colleagues what had gone wrong. Richmond was a poor neighborhood, with high numbers of unemployment, high crime and drug use rates, and few health services. It was, furthermore, polluted by the nearby oil refineries. In hindsight, Syme concludes that considering these much more serious and important problems, it was very naïve for the researchers to target smoking (Syme 2004). 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 (ibid.).

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 (Ryan 1971; Fitzpatrick 2001 pp. 73-75; Guttman and Salmon 2004; Holland 2007, pp. 115-117; Loss and Nagel 2010). 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 adopt the alternative behaviors recommended, we might deem them 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 (Baum 2007, p. 474). These factors are not the kind 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 that people themselves, in any straightforward way, choose them. Risk behavior is correlated with class, education, social status/capital, gender, age, occupational status, norms, housing area, and other living conditions, etc. (Wickler 1987; Marmot and Wilkinson 1999; Buchanan 2000; Marmot 2004; Barry 2005; Holland 2007; Daniels 2008, 2011).

The focus on "risk behavior" might, furthermore, lead to stigmatization of the condition. This, for example, happened with HIV (Valdiserri 2002). But there is a similar risk with other behaviorally conceived problems, such as obesity and smoking (Loss and Nagel 2008; Shaw et al. 2012; Stuber et al. 2009). 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", i.e. one in which we have easy access to cheap foods rich in calories, but few "natural" possibilities to burn calories, is at least as important as the individual's "choices" (Powell et al. 2010).

Closely related to these problems of victim blaming and stigmatization is that focusing on behavior change 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 (Marmot and Wilkinson 1999; Marmot 2004; Beaglehole and Bonita 2004, p. 77; Buchanan 2008; Daniels 2008, 2011). Few of the social psychological (and other) models and theories mentioned (having behavior change on their agenda) include, or discuss much, the greater social 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, housing, safe water,

and better sanitations (Barry 2005; Beaglehole and Bonita 2004, p. 56 ff.; Baum 2008, p. 472, ff.; Buchanan 2008; Daniels 2011).[18]

Note, finally, another problem that partly has to do with goals, and partly with strategies (Tengland 2012). Even if the professionals only provide "neutral" health information (i.e. that is not manipulative, or coercive), 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" (Gutman and Salmon 2004, 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 (Baum 2008, p. 475; Earle et al. 2007, 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 some groups than others, or are more easily "decoded" and adopted by (and affordable to) some groups. A behavior-change campaign 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 and inequities in health (Gutman and Salmon 2004; Daniels 2008; Brülde 2011).

Thus, quite a lot 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 as both a state (and a goal) to be achieved, and as a *process* (or a means) to achieve this state (and these goals) (Tengland 2008). These two definitions should (as indicated) be congruent. One of these conceptions are important here, namely that of empowerment as a state of individuals, groups, and communities. There are several similar definitions of empowerment as a state (Swift and Levin 1987; Perkins and Zimmerman 1995; Tones and Green 2004; Thompson 2007; Laverack 2009), but the present paper will take a previously suggested definition for granted. The second, related, empowerment idea will not be used in this paper, since its focus is primarily on how to achieve empowerment change. Suffice it to

[18] 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 to achieve alternative goals, such as empowerment.

say that empowerment as a "process" is about the professional letting the person or group "facilitated" have or acquire as much control over the change process as possible (Freire 1972; Rogers 1961, 1977; Wallerstein and Bernstein 1988; Thompson 2007; Tengland 2008; Laverack 2009).

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, and where quality of life is (tentatively) defined in terms of authentic desire fulfillment (Sumner 1996; Brülde 2006). The more control one has over these determinants, the more empowered one is, and the less control one has, the less empowered one is (Tengland 2007a, 2008). Empowerment is a state of an individual, group, or community – a "dynamic state" that can change over time, sometimes quickly, such as with an environmental disaster, and 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. However, health is one of the determinants of quality of life, so most increases in health will be empowering. Others 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. self-knowledge, raised consciousness, generic competence, and occupational skills), health, autonomy, self-confidence and self-esteem, and opportunity and freedom (Tengland 2007a, 2008). Thus, an increase in any of these factors is likely to be an increase in control of one's quality of life, 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

We saw that there were some problems with the health-related goals envisaged by the behavior-change approach. In the following section I will try to show that the empowerment approach to goals is not afflicted by these kinds of problems. Finally, some possible problems with the approach will be discussed and resolved.

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. The approach to goals is not paternalistic (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. It should be clear that in a (rather innocuous) sense empowerment (as a goal) can also be paternalistic, since its agenda is for people to become more empowered. But this primarily goes for top-down interventions. 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, such as to exercise more, or to drink less alcohol. Rather, empowerment is about gaining more general control over health and life, making people less in need of paternalistic interventions. Rather, empowerment as a goal (and as a means), in local interventions, is anti-paternalist, since it rarely, if ever, "requires actions" or "imposes limitations" on individuals or groups. 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 victim blaming, and stigmatization, since no specific (behavior) problem is taken for granted. You are usually not blamed, or stigmatized, for having low control over those determinants of your health and life that are targeted for an intervention. As for top-down interventions, empowering the population, or large segments of the population, e.g. increasing educational opportunities for unemployed people, or making recreational areas more available and safe for the elderly, 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 behaviour change projects, which primarily focus on specific behaviors, or life-styles, top-down empowerment projects in general focus on broader issues. Rather than try to change behavior, 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 (Pellmer and Wramner

2009.). 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 (Barry 2005). 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 unintended consequences 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, 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 education. Local empowerment projects are usually even more targeted on vulnerable groups, for example, on peer-education regarding safe sex, or providing language training for newly arrived refugees and immigrants. The empowerment approach should be, and historically has been, closely related to the agenda to equalize opportunity and control in the population, primarily to increase the empowerment of the marginalized and vulnerable groups (Starrin 1997; Eklund 1999), associated as it has been to "civil rights" movements of various kinds (Eklund 1999).

It was claimed that not only behavior changes are instrumental goals, but also empowerment goals. This is not entirely true, since some changes that constitute increased empowerment also constitute increases in quality of life, for example increases in autonomy and self-confidence, or access to a meaningful and attractive education. The major difference in relation to behavior change as a goal, is that the empowerment goals are of another kind. They are more basic, or generic, for example including consciousness raising, skills development, democratic decision-making skills, autonomy, and increased self-confidence and self-esteem, but also including increased opportunities, and they are therefore more important for achieving more extensive life changes. An increase in general self-confidence will most likely be of greater benefit, with a multitude of effects on the person's life, than being able to lose weight (even if this achievement might also boost self-confidence). Thus, finally, it is more likely that the achievement of these goals have positive effects on quality of life, not only on health, since they to a large extent focus on the individual's "second-order" 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 individual *ability* for autonomy.[19] This is the most important aspect of having empowerment, since autonomy refers to the individual's (or group's) ability to be self-governing, i.e. deciding over her (their) own life (lives). Autonomy is deeply linked to what it is to be a human being, or a person (Kant 2004, Griffin 2008). Self-determination is a central concern for existentialism (Sartre 1956) as well as for liberalism (Mill 1859). Autonomy is one of three requirements for personhood, and dignity, argues Griffin. The other two are opportunity (or "minimal provision") and liberty (2008, pp. 32-33). Having the ability for autonomy (as well as the opportunity), i.e. to be able to deliberately and successfully form a realistic life plan, 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.[20]

We have seen that to be empowered is have to have control over the determinants of health and quality of life. The ability for autonomy is therefore crucial for this control, since it constitutes the ability to formulate and choose life goals. It is, thus, hard, if not impossible, to have control over the determinants of one's health-related quality of life without being (reasonably) autonomous. In a sense, then, autonomy also has instrumental value. Furthermore, being in control of possible choices also makes it more likely that the "right goals" are pursued. This, as we saw, 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. Syme 2004).

To conclude, it is important that we help facilitate the *ability* to choose (wisely). Things other than autonomy are, of course, also needed in order to be empowered, for example knowledge, health, freedom and opportunity (Tengland 2008), but I hope to have established the primacy of autonomy as a goal for health promotion.

[19] This, obviously, is not the same as the right to autonomy, and increasing the ability for autonomy is compatible with restrictions of individual liberty (exercise of autonomy), for example, if the gain from such an infringement is considerable in terms of future empowerment, autonomy, or quality of life, and the infringement in itself is "reasonable" (or "moderate"), e.g. using seat-belts, or crash-helmets.

[20] 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 autonomy, the better.

Possible problems with the empowerment model

It might be hard to find anything problematic with the goal of helping people gain more control over their lives. Still, we find 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 the power of other individuals over their lives. This seems to assume that empowerment is a zero-sum game (Mayo and Craig 1995; Buchanan 2000). Secondly, is not the goal too wide, focused as it is on changes other than health-related behavior, especially if we frame the goals within a public health context (Braunack-Mayer and Louise 2008)? Thirdly, it appears to be a problem that empowered people might autonomously choose to live in ways that are detrimental to their health.

Empowerment might lead to power over others

Buchanan has several concerns with the empowerment model (2000, p. 79 ff.). One is that it is too focused on power, and forgets a number of other important goals, for example "caring, or compassion, or dignity, or love, morality, respect, harmony, [and] responsibility" (ibid., 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 is an indicator of that. Carl Rogers, for example, claims that the "fully functioning person", a person that appears to be rather empowered (at least from within), is both "social" and constructive (Rogers 1961).[21]

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" (Buchanan 2000, 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." (ibid, 80).

Empowerment is a form of "power to". As already seen, it is about having control over the determinants of one's (good) life. There are several things to take notice of. First, "power to"

[21] The means used in empowerment projects are also a testimony to that, e.g. that treating people as autonomous individuals 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 (Buchanan 2000; Nordenfelt 2004). And the dialogical, collaborative quality of empowerment projects will foster other values, such as mutuality, respect, compassion, and morality (Rogers 1961; Freire 1972).

is more or less equivalent to *ability* or capacity (Russell 1986; Morriss 2002; Wrong 2004). Second, ability and capacity are *dispositional* terms (Nordenfelt 1987, p. 41 ff.; Morriss 2002; Wrong 2004). Thus, strengthening a person's ability (power to) is to giver her tools that can be utilized if the person chooses to utilize them (assuming that there are opportunities to do so). Finally, power is best characterized as an *intentional* ability (Nordenfelt 1995; Morriss 2002; Wrong 2004). 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 gets another person to do something that she *would not otherwise do* (Dahl 1982). Second, it might mean that a person gets another person to do something that she *does not want to do* (Weber 1978). And, finally, it might mean that a person gets another person to (consciously or unconsciously) do something that it is *not in her own interest to do* (Lukes 2005).[22] 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 want to do, or it is not in their interest to do). We might facilitate an increase in their autonomy, self-esteem or self-confidence, knowledge (including self-knowledge), competence or skills, health, or external freedom (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. This gain might be especially noticeable for family members, e.g. children. 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 an "empowered person", who had been given an opportunity to develop her professional skills, gets a job that some other person would have

[22] This is a simplification, since "power over" also ought to cover, at least, intentionally created experiences, and the intentional creation or limitation of opportunities, e.g. scaring someone, or withholding her passport or money, and not only determine her "doings".

had, were it not for the 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 individual applying for the job, nor is there one on the part of the professional creating the opportunity, that someone else should not get the job in question. And in a capitalist society there necessarily has to be some unemployment, for the economy to "function" (Marx, in Fulcher, pp. 106-8.). So, we should not accuse the individual, nor the facilitator, of exercising "power over" those who did not get that job. 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; Buchanan 2008), 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 this cannot count as "power over", since this is not the intention of the empowerment project.[23] [24] But even if this were so, there are moral arguments that can justify such an (intentional) increase of tax. We might, for example, have reasons to rectify social injustices, e.g. compensate for inequalities in opportunity (Rawls 1971; Barry 2005; Daniels 2008). Or, to take another 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 "land lords"). 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 Buchanan also agrees with (2008). Note, once again, that an empowered person is more likely to be productive, take care of herself, help others, and not harm other people (Rogers 1961; Freire 1972). So any empowerment project that succeeds is (in the end) likely to lessen, rather than increase, tax burdens.[25]

[23] 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.

[24] The most problematic ethical aspect of the exercise of "power over" is making people do what is not in their own interest (Lukes 2005). 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.

[25] In most other respects I find Buchanan's book to be highly important and inspiring. Most of what he wants to achieve clearly falls under what I would call the empowerment approach.

Why empowerment, and not (just) health?

We are in the field of public health and health promotions. Why bother about empowerment? Why not just go for health increases in the population? Working towards health-related behavior change seems more straight-forward than working towards empowerment (Braunack-Mayer and Louise 2008).

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 we expect to be the most relevant for the health of the individual. 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 (Tengland 2007b).

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, research shows, is a person who can better take care of herself, including her health (Marmot and Wilkinson 1999; Buchanan 2000; Marmot 2004; Laverack 2009). The more empowered an individual is in general, the most likely it is that she stays healthy. Thus, in empowering an individual or a group, 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, for example about the causes behind risks and risk behavior. Those with higher status, better socio-economic situations, better jobs, better education, more money or other forms of capital (social or cultural), are (in general) those who have the most control over their lives, the ones least exposed to risk factors, and with less risk behavior, and they (on average), therefore, have better present and future health, and live longer (Karasek and Theorell 1990; Marmot and Wilkinson 1999; Marmot 2004; Daniels 2008; Buchanan 2008). Thus, increasing the empowerment (i.e. control) of low socio-economic, low-educated, vulnerable or marginalized individuals or groups is the best strategy for increasing (equitable) health, even if health is not always the primary target. 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 (after all) choose to achieve goals that on the whole are considered detrimental to their health? If this is the case, we would have to question empowerment as a goals for *health promotion* and *public health.*[26] 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. I will discuss one example.

In 2003, after years of work, advocacy and lobbying, the organization New Zealand Prostitutes Collective managed to legalize prostitution in New Zealand. The victory led to a much better work situation for sex workers, e.g. better working conditions, reduced risk of abuse, and of STDs, and therefore better health (Laverack and Whipple 2010). Thus, from a health promotion perspective this can be seen as a success story. However, the conclusion might have to be nuanced. First, even if the health situation became better, it might not be as good as it would have been, had the sex workers instead found other kinds of work. Some research has, for example, shown that these sex workers develop worse mental health, as a result of their work (See Ross et al. 2013, pp. 4-5). And even if they use condoms they are more likely than other people to become ill, for example through infections, but also through "repetitive strain injury" (Ross et al. 2010, p. 6).

Second, we are interested in quality-of-life-related health. So, a question remains. Did the improvement in their work situation also increase their quality of life? Probably to some extent. But even if we find that some women (and men) would choose this kind of occupation as their primary choice, they are probably rather few. It is reasonable to assume that all, or most, sex workers prefer legalization of prostitution, but they would most likely not choose prostitution before other kinds of work, given that they were relatively autonomous and had the opportunity. My suggestion is that the more empowered the individual is the less likely it is that he or she becomes a sex worker. The reason why we might conclude that the sex workers in New Zealand are better off today is that they were in a vulnerable situation before the legal reform. Were they to start over, and be able to choose their life course, autonomously, and had been given the opportunities, most of them would rather have become doctors, lawyers, artists, midwives, teachers, architects, carpenters, nurses, police officers, journalists, scientists, etc. Thus, their quality-of-life-related health might have increased somewhat, but not as much as if they had changed to (certain) other professions.[27]

[26] But perhaps not for other kinds of social interventions, since (control over) quality of life is more important than (control over) health (even if they are causally interrelated).

[27] We have to acknowledge, though, that some people would rather be well-paid sex workers than ill-paid waitresses (etc.). However, this highlights another relevant problem, that some professions' wages are unfairly low. We should expect any profession's pay to be decent (i.e. possible to live comfortably on).

But other (autonomous) choices that people make can also be risky, such as mountain climbing, racing, horse riding, and playing football. We usually have no problems respecting them, and should respect most of them, as long as they do not harm other people (Mill 1992; Powers et al. 2012), or create undue burdens on society. Thus, health is not, as we have already concluded, the most important value in life, and we should be allowed to take some risks in order to pursue quality-of-life goals.

So the answer to the question in the title of this section is that 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, the empowered person will be one who is fairly good at taking care of her health.

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 model, on the whole, is superior to the behavior-change model. Both models, 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, etc., might be important, but they do not seem as important for health as other goals, such as targeting the empowerment of the individual, or group. The real advantage for empowerment is that it strengthens the "whole" individual or group, her/their autonomy, skills, and general control, in achieving better health. Behavior changes might lead to the development of the ability for autonomy and control, but, if they do, this is usually a byproduct of other kinds of behavior change, such as feeling strengthened by the fact that one has lost weight, has started to exercise, or stopped gambling.

Autonomy (as an ability) or (general) control are almost never explicitly stated as goals in the literature describing the behavior-change approach, and the word "autonomy" (as ability) is mostly absent in the indexes of such books (Davies and Macdowall 2006; Earle et al. 2007; Glanz et al. 2008; Nutbeam et al. 2010). Unlike the behavior-change model, developing autonomy, and in general strengthening the individual's or group's ability for action and control, are at the heart of the empowerment model. Strengthening the empowerment of individuals or groups will (most likely) lead to positive changes, but what changes they lead to cannot be known (with certainty) beforehand. Some might be health-related, others not, but in general empowerment is good for the health, even if only indirectly.

Moreover, even when risk behaviors are not voluntary or autonomous, and the individual would like to change behavior, the solution should not necessarily be behavior change (in this narrow sense), but the attainment of more autonomy and empowerment. To "only" change a person's behavior seldom addresses the most important issues, such as powerlessness, lack of control, or lack of hope. And what is needed for the population that is 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, e.g. access to better education, or to better work or living conditions.

Furthermore, we must realize that for some individuals or groups, health is secondary to (other) quality-of-life goals, i.e. some activities or projects are so valuable to people that they will sacrifice their health (and sometimes even their lives) for them. This is not compatible with the assumptions of the behavior-change approach.

References:

Abraham, C. and Sheeran, P. (2000). Understanding and Changing Health Behavior: From Health Beliefs to Self-Regulation, In P. Norman, C. Abraham, and M. Connor (Eds.) *Understanding and Changing Health Behavior: From Health Beliefs to Self-Regulation*. Amsterdam: Harwood Academic Publishers, pp. xx-yy.

Barry, B. (2005). *Why Social Justice Matters*. Cambridge: Polity.

Baum, F. (2008). *The New Public Health* (3rd ed.). Oxford: Oxford UP.

Bayer, R., Gostin, L.O., Jennings, B. and Steinbock, B. (eds.) (2007). *Public Health Ethics. Theory, Policy, and Practice*. Oxford: Oxford UP.

Beaglehole, R. and Bonita, R. (2004). Public Health at the Crossroads. Cambridge: Cambridge UP.

Berglund, S. (2008). *Competing Everyday Discourses: The Construction of Heterosexual Risk-Taking Behavior among Adolescents in Nicaragua*. Malmö: Malmö högskola, Hälsa och samhälle, 250.

Braunack-Mayer, A. and Louise, J. (2008). The Ethics of Community Empowerment: tensions in health promotion theory and practice. *IUHPE – Promotion & Education*, 15(3), 5-8.

Brülde, B. (1998). *Vad är hälsa? Några reflektioner kring hälsobegreppet*. [What is Health? Some Reflections about the Concept of Health] Göteborg: Filosofiska institutionen.

Brülde, B. (2000a). "On How to Define the Concept of Health: A Loose Comparative Approach". *Medicine, Health Care and Philosophy* **3:** 305-308, 2000.

Brülde, B. (2000b). "More on the looser comparative approach to defining 'health': A reply to Nordenfelt's reply". *Medicine, Health Care and Philosophy* **3:** 313-315, 2000.

Brülde, B. (2003). *The Concept of Mental Disorder*. Philosophical Communications, Web Series, No. 29. Dept. of Philosophy, Gothenburg University.

Brülde, B (2006). Happiness theories of the good life. *Journal of Happiness Studies*, Vol. 8, No 1, 2007: 15-49.

Brülde, B. (2011). Health, disease, and the goals of public health. In A. Dawson (ed.) *Public Health Ethics*, Cambridge: Cambridge UP, pp. 20-47.

Brülde, B. and P.-A., Tengland (2003). *Hälsa och Sjukdom: En begreppslig utredning* [Health and Illness: A Conceptual Investigation]. Lund: Studentlitteratur.

Buchanan, D. (2000). *An Ethic for Health Promotion*. Oxford: Oxford UP.

Buchanan, D. (2008). Autonomy, Paternalism, and Justice: Ethical Priorities in Public Health. *American Journal of Public Health*, 98:15-21.

Cheng, H., Kotler, P., and Lee, N.R., (eds.) (2011). *Social marketing for public health : global trends and success stories*. Sudbury, Mass: Jones and Bartlett.

Culver, C.M. and Gert, B. (1982). *Philosophy in Medicine*. Oxford: Oxford UP.

Dahl, R. (1982). Power as the Control of Behavior, In S. Lukes (ed.) *Power*. Oxford: Blackwell.

Daniels, N. (2008). *Just Health. Meeting Healthy Needs Fairly*. Cambridge. Cambridge UP.

Daniels, N. (2011). Equity and population health: toward a broader bioethics agenda. In Dawson, A. (ed.) *Public health ethics,* Cambridge: Cambridge UP, pp. 191-210.

Davies, M. and MacDowall, W. (eds.) (2006). *Health Promotion Theory*. Maidenhead: Open University Press.

Downie, R. S., Tannahill, C. and Tannahill, A. (1996). *Health promotion: Models and values*. Oxford: Oxford UP.

Earle, S., Lloyd, C.E., Sidell, M., and Spurr, S. (eds.) (2007). *Theory and research in promoting public health*. London: Sage.

Earle, S. and O'Donnell, T. (2007). The factors that influence health. In S. Earle, C.E. Lloyd, M. Sidell, and S. Spurr (eds.) *Theory and research in promoting public health*. London: Sage, pp. 67-100.

Eklund, L. (1999) *From Citizen Participation Towards Community Empowerment*. Academic Dissertation: University of Tampere, Tampere.

Fitzpatrick, M. (2001). The tyranny of health: doctors and the regulation of lifestyle. London: Routledge.

Freire, P. (1972). Pedagogik för förtryckta [Pedagogy of the oppressed]. Stockholm: Gummessons.

French, J. Blair-Stevens, C., McVey, D., and Merritt, R. (2009). *Social Marketing and Public Health: Theory and practice*. Oxford: Oxford UP.

Fulcher, J. (2004). *Capitalism: A very short introduction*. Oxford: Oxford UP.

Glanz, K., Rimer, B.K., and Viswanath, K. (eds.) (2008, 4th revised ed.). *Health Behavior and Health Education: Theory, Research, and Practice*. San Francisco: Jossey-Bass.

Guttman, , N. and Salmon, C.T. (2004). Guilt, Fear, Stigma and Knolwedge Gaps: Ethical Issues in Public Health Communication Interventions. *Bioethics*, 18(6), 531-552.

Hastings, G, Stead, M. and Webb. J. (2004. Fear Appeals in Social Marketing: Strategic and Ethical Reasons for Concern. *Psychology and Marketing*. 21(11), 961-986.

Holland, S. (2007). *Public Health Ethics*. Cambridge: Polity.

Kant, I. (2004 [1788]). Kritik av det praktiska förnuftet [*Kritik der praktischen Vernunft*]. Stockholm: Thales.

Karasek, R. & Theorell, T. (1990). *Healty Work*. USA: Basic Books.

Kelly, M. (2006). Applications of models of behavior change. In M. Davies and W. Macdowall (eds.) *Health Promotion Theory*. Maidenhead: Open University Press.

Lalond, M. (1974). A New Perspective on the Health of Canadians : A Working Document. Ottawa http://www.hc-sc.gc.ca/hcs-sss/pubs/system-regime/1974-lalonde/index-eng.php [Accessed 2011-12-16]

Laverack, G. (2009, 2nd ed). *Public Health, Power and Empowerment*. Basingstoke: Palgrave MacMillan.

Laverack G och Whipple A (2010) The sirens' song of empowerment: a case study of health promotion and the New Zealand Prostitutes Collective. *Global Health Promotion* 17(1): s. 33-38.

Lukes, S. (2005, 2nd revised ed.). *Power: A Radical View*. Oxford: Oxford UP.

Loss, J. and Nagel, E. (2010). Social Marketing – Verführung zum gesundheitsbewussten Verhalten? [Social Marketing – Seduction with the Aim of Healthy Behavior] *Gesundheitswesen*, 72: 54–62.

Marmot, M. and Wilkinson, R. (1999). *The Social Determinants of Health*. Oxford. Oxford UP.

Marmot, M. (2004). The Status Syndrome. How your social standing directly affects your health. London: Bloomsbury Publishing.

Maibach, E. W. and Cotton, D. (1995). Moving People to Behavior Change: A Staged Social Cognitive Approach to Message Design. In E. Maibach and R.L., Parrott (eds.) *Designing Health Messages: Approaches from Community Theory and Public Health Practice*, London: Sage, 41-64.

Mill, J. S. (1859). *On liberty and Utilitarianism*. London: Everyman's Library, 1992.

Mayo, M. and Craig, G. (1995). Community participation and empowerment: the human face of structural adjustment or tools for democratic transformation? In G. Craig, and M. Mayo (eds.) *Community Empowerment: A Reader in Participation and Development (Experiences of Grassroots Development)*. Zed books Ltd.

Morriss, P. (2002, 2nd revised ed.). *Power: A philosophical analysis*. New York: St. Martin's Press.

Jones, M.M. and Bayer, R. (2007). Paternalism and Its Discontents: Motorcylce Helmet Laws, Libertarian Values, and Public Health. *Am J Public Health*. February, 97(2), 208-217.

Nikku, N. (1997). *Informative Paternalism Case studies in the ethics of promoting and predicting health*. Linköping Studies in Arts and Science 155.

Nordenfelt, L. (1991). *Towards a theory of health promotion: a logical analysis*. Linköping university: Health service studies, 1100-6021 ; 5.

Nordenfelt, L. (1995, 2nd revised ed.). *On the Nature of Health: An Action-Theoretic Approach*, Dordrecht: Kluwer.

Nordenfelt, L. (2004). The Varieties of Dignity. *Health Care Analysis*, 12(2), 69-81.

Norman, P., Abraham, C., and Connor, M. (Eds.) 2000. *Understanding and Changing Health Behavior: From Health Beliefs to Self-Regulation*. Amsterdam: Harwood Academic Publishers.

Nutbeam, D. (2006). Using theory to guide changing individual behavior. In M. Davies and W. Macdowall (eds.) *Health Promotion Theory*. Maidenhead: Open University Press.

Nutbeam, D., Harris, E., and Wise, M. (2010, 3rd ed.). *Theory in a Nutshell: A Practical Guide to Health Promotion Theories*. North Ryde: McGraw-Hill.

Pellmer, K. and Wramner, B. (2009). *Grundläggande folkhälsovetenskap* [*Basic Public Health*]. Stockholm: Liber.

Perkins, D.D. and Zimmerman, M.C. (1995). Empowerment Theory, Research, and Application. American Journal of Community Psychology, Vol. 23, No 5, PP. 569-579.

Pestana, M (1998). *Moral Virtue or Mental Health*. New York: Peter Lang Press.

Powell, P., Spears, K. and Rebori, M (2010). What is an Obesogenic Environment? Fact Sheet-10-11. Reno: University of Nevada Cooperative Extension.

Rawls, J. (1971). *A Theory of Justice*. Oxford: Oxford UP.

Rogers, C. (1961). *On Becoming a Person*. Boston: Houghton Mifflin.

Rogers, C. (1977). *Carl Rogers on Personal Power*. New York: Delacorte.

Ross, M.W., Crisp, B.R, Månssons, S.-A. and Hawkes S. (2012). Occupational health and safety among commercial sex workers. *Scand J Work Environ Health,* Mar;38(2):105-19.

Russell, B. (1986). The Forms of Power. In Lukes (ed.) *Power*. Oxford. Blackwell.

Ryan, W. (1976). *Blaming the Victim*. New York: Vintage books.

Sartre, J.-P. (1956). *Being and nothingness*. New York: Philosophical Library.

SBU (1997). Att förebygga sjukdom i hjärta och kärl genom befolkningsinriktade program – en systematisk litteraturöversikt [To prevent cardiovascular disease through public

programs – a systamatic literature review]. Stockholm: SBU (Statens beredning för utvärdering av medicinsk metodik [The government drafting committee for evaluations of methods in medicine]).

Shaw, A., Ritchie, D. Amos, A., Mills, L., O'Donnell, R., Semple, S., Turner, S. and Wilson, I (2012). SMOKING AND STIGMA A Review of the literature. http://www.refreshproject.org.uk/wp-content/uploads/2012/02/REFRESH-Smoking-and-Stigma.April20124.pdf [Accessed February 21, 2013]

Starrin, B, (1997) Empowerment som tankemodell [Empowerment as a model for thought]. In E. Forsberg & B. Starrin (Eds.), *Frigörande kraft – Empowerment som modell i skola, omsorg och arbetsliv*. Stockholm: Gothia.

Storey, J.D., Saffitz, G.B., and Rimón, J.G. (2008). Social Marketing. In K. Glanz, B.K. Rimer, K. and Viswanath (eds.) *Health Behavior and Health Education: Theory, Research, and Practice*. San Francisco: Jossey-Bass., pp. 436-464.

Stuber, J., Galea, S., and Link, B.G. (2009). Stigma and Smoking. The Consequences of Our Good Intentions. *Social Service Review* (December), 585-609.

Syme, S.L. (1996). To prevent disease. We need a new approach. In Blane, D. and Brunner, E. and Wilkinson, R.G. (eds.). *Health and Social Organisation*. London: Routledge.

Syme, S.L. (2004). Social Determinants of Health: The Community as an Empowered Partner. *Preventing Chronic Disease,* 1(1):1-5.

Syme, S.L. and Ritterman, M.L. (2009). The Importance of Community Development for Health and Well-Being. *Community Development: Investment Review*, 5(3), 1-13. Federal Reserve Bank of San Francisco. http://www.frbsf.org/publications/community/review/vol5_issue3/syme_ritterman.pdf [Accessed July 24 2012]

Sumner, L.W. (1996). *Welfare, Happiness and Ethics*. Oxford: Clarendon press.

Swift, C., & Levin, G. (1987) Empowerment: An Emerging Mental Health Technology. *Journal of Primary Prevention*, 8 (1&2), Fall/Winter.

Tengland, P.-A. (2006). The Goals of Health Work: Quality of Life, Health and Welfare, in *Philosophy, Medicine and Health Care* 9: 155-167.

Tengland, P.-A. (2007a). Empowerment: A Goal or a Means for Health Promotion? *Medicine, Health Care and Philosophy*, 10:2, 197-207.

Tengland, P.-A. (2007b). A two-dimensional theory of health. *Theoretical Medicine and Bioethics*, 28: 257-284.

Tengland, P.-A. (2008). Empowerment: A Conceptual Discussion. *Health Care Analysis* 16: 77-96.

Tengland, P.-A. (2010). Health Promotion and Disease prevention: Logically Different Conceptions? *Health Care Analysis*: 18:4, 323-341.

Tengland, P.-A. (2011). Empowerment och etik i folkhälsoarbete [Empowerment and Ethics in Public Health Work], in B. Brülde (ed.) *Folkhälsoarbetets etik* [The Ethics of Public Health Work]. Lund: Studentlitteratur, 227-259.

Tengland, P-A. (2012). Behavior Change or Empowerment: On the Ethics of Health-Promotion Strategies. *Public Health Ethics*, Vol. 5 , No. 2, 140-153.

Thompson, N. (2007). *Power and Empowerment*. Lyme Regis: Russell House.

Tones, K. and Green, J. (2004). *Health Promotion. Planning and Strategies*. London: Sage.

Valdiserri, R.O. (2002). HIV/AIDS Stigma: An Impediment to Public Health. *Am J Public Health*. 2002 March; 92(3): 341–342.

Verweij, M. and Dawson, A. (2007). The meaning of 'public' in public health. In Dawson, A. and Verweij, M. (eds.) *Ethics, prevention and public health*. Oxford: Oxford UP, 13-29.

Wallack, L. (1994). *Media Advocacy and Public Health : Power for Prevention*. London: Sage.

Wallerstein, N., and Bernstein, E. (1988). Empowerment Education: Freire's Ideas Adapted to Health Education. *Health Education Quarterly*, Vol. 15(4): 379-394.

Weber M. (1978). *Economy and Society*. Berkeley: California university press.

Wikler, D. (2007). Who Should Be Blamed for Being Sick? In Bayer et al. (eds.), *Public Health Ethics*. Cambridge: Cambridge UP.

Wilkinson, R. G. and Picket, K. (2010). *The Spirit Level. Why equality is better for everyone*. London: Penguin.

Wrong, D. (2004). *Power: Its Forms, Bases and Uses*. New Brunswick: Transaction.