What could a feminist perspective on power bring into Public Health?
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This special issue on feminism in Public health contains several articles, which in somewhat different ways deal with the gendered nature of power and its connection to health. This is important, as the notion of power is not visible in traditional medical research – on the contrary an analysis of power is often regarded as unscientific. In Scandinavian, as in contrast to many other countries, public health is developed within the medical discipline and is heavily influenced by the medical paradigm. In other countries, including Australia, Public health is developed within social science, which opens the view for broader perspectives, for example in relation to power. In Australian public health a power perspective has been developed, with regard to class and ethnicity, while analysis of gendered power is still - to a great extent –absent. In this editorial we will, from the articles in this issue, discuss what a feminist perspective on power could bring to public health. We will argue that a feminism informed by a Foucauldian perspective can provide a far more comprehensive understanding of power and its effects on the health status of populations. There is a need to differentiate several ways, in which power can be understood and used in different approaches to public health. Three models of power can be usefully differentiated.

1. **Power as an individual attribute.**
   Here the capacities of individuals are seen as either allowing or retarding a person to take up a healthy lifestyle. Life-style is often regarded as a voluntary choice, which people make about their behaviour, especially about their exercise and their consumption of food, alcohol and tobacco.
   Some approaches to health promotion work from this model where they offer individual interventions to increase people’s knowledge, self-confidence, living skills, behaviours or attitudes in order to enhance health. Blaxter has among others pointed out that harmful life circumstances, such as poverty and lack of social support, are more important influences on public health than individual life-style habits (1). In our special issue we do not have any focus on life-styles. On the contrary, the health related meaning of the construction of gender in different life circumstances such as sexualised violence, waged work, unemployment, domestic work and reproductive health are in focus.

   Within discussions of the power of individuals to effect their health status, the concept of empowerment is often evoked. Ironically this concept initially emerged from writing of the Third World feminist movement about the importance of community action where it is a term which represents new notions of power, based on collective responsibility, shared power and democratisation (2). Empowerment has come to be used in self help and some health promotion as something that can be achieved by individualism in contrast to the community approach based on social change and redistribution of power. The individual approach is commonly used in clinical practice and is compatible with the bio-medical model of illness. The article by Kirst Malterud and Hanne Hollnagel propose that a resource approach through empowering dialogues in general practice challenges medicine’s contribution to gendered practices. The woman’s answer changed the doctor’s perception of her as a passive and resigned sufferer to an active and strong subject who utilizes numerous strategies in order to gain health and to remain healthy. The authors propose potential links between health resources, salutogenesis and empowerment, as opposed to pathogenesis, risk factors and medicalization.

2. **Power as structurally and socially distributed**
   In this model the capacity for people to achieve and maintain health is considered not to result from their personal attributes but to be related to social structures, which systematically
advantage some groups over others. Socio-economic status is the structural factor, which has been most widely accepted as influencing the health of populations (3). Because the patterns of health and illness within populations can best be understood through these structural factors, this structuralist paradigm has predominated in theories of public health in many countries where public health has developed within social science. There appear to be two versions of structuralist approach.

A. Economic structuralism
This version places socio-economic status as the central determinant of health status with the implication that poverty itself is the major barrier to wellbeing. It would seem from Johanne Sundby’s article that the measurement of the burden of disease, as developed by the World Bank, implicitly takes this position with its assumption that death in the ‘productive’ years is more catastrophic than death of old or young individuals. The middle years are valued so highly because of the assumption that productive employment is the major protection against poverty and therefore ill health and dependence. Poverty is known to be the factor, which world-wide is most closely associated with health status. Poverty is itself related to other structuring factors, including employment status, age, levels of education, region (whether from industrialised or developing world) ethnicity, and importantly for this issue gender (4).

More sophisticated analyses of the impact of class have shown that it is not only the absolute level of wealth, which determines the health of the population but that the amount of differentiation between the rich and the poor in a country is also important (5). The health of the population as a whole is better where there is less disparity between the highest and the lowest income. It seems that relative equality has a health enhancing effect. This is an important finding when considering the various axes of power that operate to rank some more highly than others according to gender, region, education, age and so on.

B. Pluralist Structuralism
Another version of structuralist theory recognises that other stratifying factors (including gender, region, age, etc) are important determinants of health of populations along with class or socio-economic status. It is also acknowledged that these factors interact to produce a diversity of health effects within subsections of the population. For example the differential infant mortality of boys and girls in China is clearly the outcome of the operation of gender hierarchy although the practice of infanticide itself is largely economically determined within a particular cultural context.

This pluralist model of structural determinism still operates with a model of power as an oppressive force, which affects the health in a negative direction. Often the multiple axes of power are shown to cause multiple disadvantages for sub-sections of the population and advantages for others. This model of power is widely utilised to identify special needs groups and shape public health policies such as The National Women’s Health Policy in Australia, as described in the article by Karen Willis. It is also used elsewhere in this volume, for example in the articles about rehabilitation, women’s network and sexualised violence.

3. A post structuralist model of power
The influence of Foucauldian post modernist thought has brought with it a re-definition of power as not necessarily oppressive nor imposed from above by a privileged group upon a subordinate and disadvantaged group. Instead power is conceptualised as productive by which is meant that it generates change, that are likely to have positive as well as negative effects (6). Importantly, the effects of change are neither predictable nor uniform. Power in
Foucault’s terms is seen as interplay of forces operating at the level of everyday exchanges in all relationships, exercised from ‘the bottom up’ as well as from above. Exchanges are however not equal; they are the sites at which a multitude of hierarchies is played out at a micro level. This understanding of power is built on the recognition that the discursive realm (of language, ideas and conceptual frameworks) shapes all exercises of power. Power understood in this way is inextricably linked to knowledge claims, to the credibility of the suggestion or perspective being presented. This credibility is in turn both dependent on and reproductive of hierarchies, which relate to gender class and culture. Truth claims based on rational scientific evidence are therefore valued above intuition or folk knowledges. Characteristics associated with masculinity (action, reason, self sufficiency, productivity, politics, leadership, competitiveness and the public realm) are valued over those associated with femininity (nurturance, collaboration, expressiveness, dependence, emotionality and the domestic realm) (7). Similarly associations with what is thought to be ‘civilised’ by a particular culture are valued over what are considered ‘wild’ or untamed. In capitalist contexts factors associated with production and accumulation are valued whereas in a subsistence economy factors associated with conservation and frugality would be privileged.

In application to public health this foucauldian understanding of power as a process, is helpful in understanding the multiple and conflicting positions in which people are placed and these explain the difficulties that they have in acting to enhance their health. The importance of opposing gendered discourses in relation to diabetic management of food become obvious in Julie Hepworth’s article. The foucauldian perspective also helps our understanding of the dynamics of the clinical exchange which privilege ‘expert’ knowledge over patient’s perspectives. In the article about menstruation written by Elina Oinas for example, the author demonstrates that formal information about menstruation was preferred over that from friends and family. Here we see the privileging of expert knowledge, but also at work in this example is the simultaneous desire to maintain ‘appropriate’ levels of talk and intimacy across generations so that these educated young women disavow information from older women in favour of that from strangers.

A post-modern understanding of power is harder to apply to population groups as a whole because it is dependent on understanding the multiple and conflicting meanings that people bring to an interaction. It is, however, an approach that helps understanding the apparently contradictory positioning of individuals and groups, which results in them appearing to act in irrational or harmful ways. Nowhere is this more evident than in understanding the dynamics at work in domestic violence, as exemplified in this special issue. Here discourses of romance can be called upon to sustain a relationship despite violence, discourses of male dominance can sustain men’s self image despite the harm they inflict on the women they love. Sexual jealousy and possessiveness are closely entwined with passion and infatuation to allow a reframing of abuse as affection. Discourses about the necessity of a ‘father figure’ for children’s wellbeing can operate to justify maintaining a relationship despite the man’s violence. Finally the valuing of a ‘private life’ free from public scrutiny and intervention is implicated in the problem of violence by men against women in intimate relationships. Whilst none of these are rational, adequate or much less acceptable explanations for violence against women they are all part of the discursive context in which this public health problem is located and which make it such an intractable issue.

A further contribution of post-modern approaches have been to theorise the way in which the body is itself a discursive site (or ”text”) onto which, and through which, meaning is made.
Despite its emphasis on language and the discursive realm, post modern feminists have been foremost amongst theorists of the body who aim to trace the intersections between the material and discursive realm by exploring the ways in which gender relations are inscribed in bodily practices and ideas. Elina Oina’s article on menstruation offers an exploration of the way in which denial of the body operates within contemporary meanings of menstruation for young middle-class Finnish women.

**Interactions between the different models of power**

Like all categories, these three differentiations of power are somewhat loose and in one article you may have aspects of two or all of the models. In Kirsti Malterud’s and Hanne Hollnagel’s article individual empowerment challenges the notion of expert knowledge by pointing out that the value of the interaction might have been in teaching the doctor something. The article by Christina Ahlgren and Anne Hammarström uses both a pluralist structuralist and a foucauldian model of power. The gender order in the rehabilitation system acts as an oppressive force, which diminishes the women’s chances of returning to work after a work-related disorder. The foucauldian model can be illustrated by the gendered expectations in the consultation. These expectations were not imposed on the women or on the men but taken up by them. For example the women had an expectation about their rehabilitation, which was not a demanding attitude, and which could be seen as part of the discourse about women’s shared responsibility for domestic and waged work that women should not be in the work force in the way that men do. Another example is sexualised violence. As suggested in this volume this public health issue cannot be understood without a power analysis based on both a structural model and a foucauldian model of power.

**Conclusion**

The issues raised in this editorial indicates that public health research must embrace the advances made in the understanding of gender and other power dynamics, which influence the social distribution of health and illness among the population. Furthermore, it is crucial to recognise that social research (including that in health) is part of the social fabric – not separable from – the processes of power. Thus, a power perspective in public health can bring a more comprehensive and subtle understanding of the multiple and contradictory elements of gender and other relations of power that impact on health status of populations.

**References**


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