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Off the couch and on the move: Global public health and the medicalisation of nature

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Abstract

In May 2004 the World Health Organization (WHO) officially launched the '*Global Strategy on Diet, Physical Activity and Health*'. Lying at its heart is the recognition that many of the risk factors associated with non-communicable diseases, particularly poor diet and physical inactivity, have begun to move beyond the confines of the West. It was this apparent shift in the epidemiological boundaries of such diseases, along with fears over the so-called 'double burden' that they presented to some nations, that finally prompted the WHO to develop such a far reaching strategy. This paper adds to the on-going debate surrounding this important issue by drawing on the concepts of medicalisation, governmentality and the spatiality of scientific knowledge to explore one particular element of it: namely, the identification of nature as a setting for the promotion of physical activity. We adopt this perspective because we are concerned to understand the ways in which the knowledge and practice of the 'new' public health travels. As our analysis reveals, in many Western nations the natural environment has emerged as an important 'transactional zone' where the governmental imperative for the production of fit and active bodies coalesces with the individual desire to be healthy. However, while it is apparent that this physical activity discourse increasingly operates throughout the globe, there is less evidence of an equivalent discourse that promotes the health-related benefits of nature. We argue that this is significant because it helps us to recognise that contemporary public health discourse has a distinct geography.

Keywords: Public health; Mobility; Nature; Governmentality; Medicalisation; Spatiality of knowledge

Introduction

> The time is right for health promoters to take a close look at the evidence of the impacts nature has on the health of individuals and communities. Why? Because we may actually be able to achieve more appropriate and sustainable conditions that support health than if we only address interventions that focus on a particular health issue… (St Leger, p. 174).

The above quotation is taken from an editorial, published in the journal *Health Promotion International*. As implied, the editorial sought to encourage health promotion experts to re-examine the scientific evidence surrounding the links between the natural environment and health. In an earlier article, another advocate of nature's health-related benefits presented a similar argument when he suggested that environmental, and by association public, health needs to move beyond its current

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focus on toxicity: "If people have regular contact with flowers or trees, do they report greater well-being, better sleep, fewer headaches, reduced joint pain? Do inner city children who attend a rural summer camp have better health during the next semester at school than their friends who spent the summer in the city?" (Frumkin, 2001, p. 238).

For many geographers, the idea that nature should be thought about in this way will come as little surprise. In his highly influential paper on therapeutic landscapes, Gesler (1992, p. 736) identified some of the ways in which health and wellbeing have come to be associated with the natural environment; "whether this entails materials such as medicinal plants, the fresh air and pure water of the countryside, or magnificent scenery". The response to Gesler's initial account has been an extensive examination of the relationship between landscape or place and health (see Williams, 1998). A key feature of this literature is its recognition that the connection between therapeutic landscapes and human health is a relational one. As Conradson (2005) suggests, an interest in the relational dynamics of therapeutic landscapes has been present in geographical research on gardening (Milligan, Gatrell, & Bingley, 2004), walking (Palka, 1999), and exercise and play (Kearns & Collins, 2000).

While such studies vary both in the approaches they adopt and the scales at which they operate, they often take as their starting point the idea that contact with nature "affords a range of personal, social and health benefits" (Milligan et al., 2004, p. 1785). The purpose of this paper is to reflect a little more critically on this belief because we are interested to explore how this discourse relating to nature and health has been captured by the 'new' public health. In order to do so, we refer to literatures that sit outside of the therapeutic landscapes tradition; namely, those relating to medicalisation, governmentality and the spatiality of knowledge. We begin with the former because, as Nye (2003, p. 117) indicates, medicalisation is not only understood in terms of the "nefarious collaboration of experts and state authority" imposing their will from above. Rather, it is also thought of in less pejorative terms, as a "process whereby medical and health precepts have been embodied in individuals who assume this responsibility for themselves".

Central to this interpretation is the notion of "governable space" (Rose, 1999, p. 31*ff*.). Here, regulated freedom, as a form of neo-liberal rule, is seen to operate through the alignment of governmental objectives with personal life-projects. This process is argued to occur within certain spaces, or particular micro-locales, "where authorities of all types exercise their powers over the conduct of others" (Rose, 1999, p. 36). We suggest in this paper that the natural environment has emerged in contemporary public health discourse as such a micro-locale. As we go on to demonstrate, this is in part related to the intuitively held belief that health and nature are intricately linked; what Arnold (1996) terms the 'environmentalist paradigm'. However, it is also closely associated with the production of active rather than sedentary bodies within related physical activity debates. Following this, we turn our attention to a discourse that promotes nature as a setting within which the governmental and personal desires for good health can be translated into embodied practice.

There is, however, one further issue that we seek to address. In the preface to the World Health Report, 2002, the then director-general of the World Health Organization (WHO), Dr. Gro-Harlem Brundtland, stated that "the world is living dangerously, either because it has little choice or it is making the wrong choices" (WHO, 2002a, p. 4). Made in light of epidemiological evidence suggesting that a global "risk transition" is currently underway, this statement identifies unhealthy patterns of food consumption and physical inactivity as two of the major risk factors for premature death. Such a threat is not new to many countries in the West. Indeed, until recently chronic or non-communicable diseases were referred to as 'diseases of affluence' and were seen to reflect problems associated with the 'Western lifestyle' (McKeown, 1988; Trowell & Burkitt, 1981). The response of the WHO to this 'crisis' was to establish a *Global Strategy on Diet, Physical Activity and Health* (see WHO, 2004).

Officially launched in May 2004, the Global Strategy was described by Brundtland's replacement, Dr. Lee Jong-Wook, as a "landmark achievement in global public health policy" (WHO, 2004). In many regards, the Director-General's triumphant remarks do not appear too far off the mark. While only in its infancy, the strategy is already extremely wide-ranging and has been endorsed by most national governments, especially those in the West. There is, however, one aspect of the discourse surrounding the strategy that is of particular interest; that is, the belief that risk behaviours