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Socially Sustainable Degrowth as a Social-Ecological Transformation

Degrowth and health: local action should be linked to global policies and governance for health

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Abstract Volume and increase of spending in the health sector contribute to economic growth, but do not consistently relate with better health. Instead, unsatisfactory health trends, health systems' inefficiencies, and high costs are linked to the globalization of a growth society dominated by neoliberal economic ideas and policies of privatization, deregulation, and liberalization. A degrowth approach, understood as frame that connects diverse ideas, concepts, and proposals alternative to growth as a societal objective, can contribute to better health and a more efficient use of health systems. However, action for change of individual and collective behaviors alone is not enough to influence social determinants and counteract powerful and harmful market forces. The quality and characteristics of health policies need to be rethought, and public policies in all sectors should be formulated taking into consideration their impact on health. A paradigmatic shift toward a more caring, equitable, and sustainable degrowth society will require supportive policies at national level and citizens' engagement at community level. Nevertheless, due to global interdependence and the unavoidable interactions between global forces and national systems, a deep rethinking of global health governance and its reformulation into global governance for health are essential. To support degrowth and health, a strong alliance between committed national and global leaderships, above all the World Health Organization, and a well-informed, transnationally interconnected, worldwide active civil society is essential to include and defend health objectives and priorities in all policies and at all levels, including through the regulation of global market forces.

Keywords Degrowth · Health · Globalization · Global governance · Civic action · World Health Organization

Introduction

The health care industry is one of the world's largest and fastest growing industries and it substantially contributes to global economic growth. Indeed, in both OECD and low-income countries, health expenditure rose faster than income for many years (Savedoff et al. 2012) and represented around 10 % of gross domestic product (GDP) of most developed nations before slowing markedly or falling in real terms in 2010 as a consequence of the economic crisis (OECD 2013).

General correlation exists between health care spending and life expectancy; however, it has been shown that above annual expenditure of approximately US $75 per capita, that relationship is not predictable. Germany spends over twelve times as much in health care per capita as Costa Rica, with virtually no difference in life expectancy (Birn et al. 2009); even in OECD countries, robust differences in health-spending efficiency are recorded (Barthold et al. 2014). Improvement in health outcomes depends critically on how the money is spent and population access to needed health care depends on political action to pool financing and establish mechanisms to spend efficiently and equitably (Savedoff et al. 2012). On the other hand, societal determinants external to the health sector substantially influence health conditions.

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Most authors would agree that good health is a productive asset that significantly influences economic growth (CMH 2001). Instead, as the WHO Commission on Social Determinants of Health pointed out, economic growth in itself—i.e., the increase of GDP—without appropriate social policies and equitable distribution across the population brings no benefit to health. The global spread of commercialization and commodification of almost any area of social life associated with the economic growth dogma, generated inequality, negative impacts on health, and deep health inequities (CSDH 2008). In turn, beyond a certain level of per capita GDP, inequality in income distribution rather than growth is strongly correlated to ill health and distress (Wilkinson and Pickett 2009).

Both the laws of thermodynamics and ecologic sciences show that the consumption imperative associated with unlimited economic growth is not compatible with the finite space and resources of the planet, leading to environmental disruption, inevitably linked with negative impact on human health (Greenham and Ryan-Collins 2013). The need to invert this trend is increasingly felt in the public health community and alternative approaches have been proposed focusing for example on health systems' sustainability (Pencheon 2013) or introducing "ecological public health" (Lang and Rayner 2012).

As an alternative model to the growth society, 'degrowth' was launched just over a decade ago as a societal project of voluntary equitable downscaling of production and consumption that increases human well-being and enhances ecological conditions at the local and global level in the short and long term (Demaria et al. 2013). The increasingly challenging objective of social justice, i.e., the 'equitable redistribution of wealth within and across the Global North and South, as well as between present and future generations' and its democratizing nature have been highlighted as additional characteristics of the process that should lead to a post-growth society counteracting the omnipresence of market-based relations in society in search for alternative world representations (Demaria et al. 2013). In other words, degrowth should not be understood as a growth society with a decreasing GDP, but as a starting point for a paradigmatic change in the inspiring values of human society (Latouche 2010). In this paper, degrowth is understood as a wider frame that connects diverse ideas, concepts, and proposals which share first and foremost the critique of economic growth as a social objective (Kallis et al. 2014).

The concept of degrowth and its relationships to well-being and social capital formation has been explored, both from a theoretical point of view or by qualitative description of the real case of degrowth practices (Andreoni and Galmarini, 2013). However, although health is arguably the most essential condition of human well-being and a healthy population an essential component of social capital, peer-reviewed literature specifically addressing the relation between degrowth and health is limited to a few studies (Borowy 2012, 2013). Even blogs only sporadically offer a specific insight about the relation between degrowth and health and in isolated cases discuss the future of health systems in a degrowth world (Bednarz and Beavis 2012). The relation between degrowth and health has also been debated in international degrowth conferences, attempting to define the 'new paradigm' (Aillon 2014), or referring to degrowth in relation to health care and medical practice (Aillon et al. 2012), but lacking a global governance perspective.

Some authors have highlighted the need for a global focus on growth in well-being instead of consumption, and the need for global financial and trade Institutions (such as the World Bank, the International Monetary Fund, and the World Trade Organization) to be adjusted to promote widespread increases in human well-being, rather than economic growth (Rogers et al. 2012). However, in the context of the degrowth-related debate, no studies refer to the role of global health institutions, namely the World Health Organization (WHO) and the need for their reform and democratization.

Based on the above considerations, this paper makes a first attempt to fill the gap. The argument of this paper is twofold.

First, due to powerful global market forces pushing in the opposite direction, change of individual behaviors, and community action for local change and sustainability will be of limited impact on population's health if not supported by adequate policies, beyond national domains. Effective implementation of global governance and regulatory frameworks *for* health, i.e., including global governance processes outside the health sector that can affect health (Ottersen et al. 2014), are needed in building a degrowth society.

Second, in the transition toward a degrowth society, effective global governance *for* health will require transnational social movements to coalesce in pushing the prioritization of health and equity goals in policy making in all sectors and at all levels.

In the following sections, the paper first examines the negative influences of the globalization of the dominant societal model, i.e., an individualistic, deregulated 'growth society' with minimal public intervention (McGregor 2001), on health needs, demand, and access to care. The possible alternative represented by degrowth, its relationship with health and the main related challenges are then explored. In a following section, the role of global health governance in controlling market forces is presented. Two case studies related to the experience with the food and tobacco industry, are used to highlight on the one side, the

need for public regulation to contrast corporate practices inducing unhealthy life styles; and on the other side, the relevance of coordinated civic action in support of those public policies. The findings are then discussed, followed by general concluding remarks advocating for a new model of G-local Governance *for* health as a fundamental step in the transition to a post-growth society.

Globalization and health

The scientific debate about globalization, economic growth, and health is a longstanding one.

In a paper that elicited much discussion over 10 years ago, Richard Feachem (2001) argued that 'globalization is good for your health'. In Feachem's opinion, globalization—understood as openness to trade, to ideas, to investment, to people, and to culture—was bringing a variety of social and political benefits, especially to oppressed peoples (Feachem 2001). Another study, published the same year, by Chen and Berlinguer (2001) acknowledged the possibility that globalization—described as a multidimensional integration of the world economy, politics, culture, and human affairs—was offering new opportunities for human progress. However, they stressed that if left unattended, the forces of globalization could worsen inequities in the social determinants of health and unequal access to health care. They advocated a renewed focus on the role of global institutions and, specifically a strengthened normative role of WHO for supporting equity-oriented health policies (Chen and Berlinguer 2001).

Since these two papers, driven by the neoliberal push for unregulated markets, worldwide economic integration spreads market relations into ever more areas of social life. The liberalization of trade regimes and deregulation processes facilitated the intensified commodification and commercialization of vital social determinants of health, severely impacting on peoples' life conditions and health (CSDH 2008).

Trade liberalization affects health through a variety of mechanisms, such as changes in lifestyles; environmental degradation; reduced human security; sequestration of public wealth; privatization, and commercialization of health care.

The worldwide increase in chronic diseases, with a heavier impact for poorer countries which face an epidemiological transition with a double burden of disease, i.e., infectious and non-communicable, is largely related to over-consumption and the adoption of unhealthy lifestyles. Extremely aggressive global marketing strategies are put in place by industry to push for increased consumption of their products. Among others, the food industry has direct responsibilities in the current obesity pandemics and the growing burden and high mortality deriving from related chronic diseases (Swinburn et al. 2011). These are equally associated with the tobacco and alcohol industry, which take special advantage of potential for growth in developing countries and especially push for increased consumption among already vulnerable population groups (Huynen et al. 2005).

The steady increase in chronic diseases is equally related to environmental degradation originated through uncontrolled economic growth thriving on sustained consumption and waste. Environmental contaminants may also produce irreversible epigenetic changes that genetically induce new diseases in the offspring, adding disease burden on future generations (Burgio and Migliore 2014; The Lancet 2013). Long-term negative health outcomes can also be foreseen as a consequence of climate change (Anstey 2013).

Privatization and trade of water reduced water security and increased incidence of water-related diseases (Huynen et al. 2005). Neoliberal economic reforms also exacerbated food insecurity in poorer countries by eliminating social safety nets, increasing poverty and inequality, reducing domestic food production, and depressing export earnings (Gonzalez 2004). Transnational corporations' practices are in themselves determinants of health (Freudenberg and Galea 2008), but their influence goes well beyond industries with a direct impact on health (such as pharmaceuticals, food and beverages, tobacco, or alcohol), including additional pathways such as sequestration of public wealth (tax avoidance strategies and use of tax heavens), and labor markets (for example, through the delocalization of production to areas with poor labor rights and working conditions) (McNamara 2014).

Vested interests with profits as the bottom line, within increasingly corporatized frameworks, contributed to the uplift of health care costs and often to the loss of health care systems' link with local health needs (Benatar 2013). In the 1980s, the 'Washington Consensus' financial institutions imposed macroeconomic Structural Adjustment Programs to indebted countries, producing the dismantlement of relatively equitable health systems that were substituted by inefficient and costly, unregulated commercialized health systems (Labonté and Schrecker 2007; McGregor 2001). Neoliberalism also is at the roots of the remarkable shift in the global development assistance architecture observed over the last 15 years, with the establishment of new aid mechanisms and global public–private partnerships (GPPPs) targeted to the control of specific diseases. GPPPs allowed private interest to become more embedded within the public sphere and to influence global and national health policy making (Ruckert and Labonté 2014). Pursuing economic growth, health tourism has been promoted, without caring for the consequences in terms of access to health services for national residents

(Labonté 2010). Neoliberal recipes have been imposed also in more advanced economies, particularly in response to financial crisis, with cuts on public health and social expenditure pushing wide strata of population into poverty (Kondilis et al. 2013), increasing the vulnerability and health needs of the population, while reducing access to care (WHO 2014a). To increase their sales, drug companies have also adopted 'Disease mongering' strategies (i.e., distorting the prevalence and/or severity of a condition, redefining risk factors as diseases, inflating mild or self-limiting symptomatic states, and pathologizing normal human variation) with additional increase of health expenditure (Doran and Henry 2008). Also global research priorities have been linked to the anticipation of commercial returns, rather than to needs and burden of diseases (Labonté and Schrecker 2007). As a consequence, only 10 % of the global spending on health research is devoted to conditions that account for 90 % of the global burden of disease (Global Forum for Health Research 2004). Between 2000 and 2011, only 1 % of newly approved chemical entities were for poverty-associated neglected diseases (Pedrique et al. 2013). The unavailability of a vaccine to combat the recent and ongoing Ebola epidemic provides additional tangible evidence.

Degrowth and health

Although he never explicitly referred to degrowth, Ivan Illich is often considered a founding father of degrowth concepts. He foresaw and denounced the 'rising irreparable damage [that] accompanies industrial expansion in all sectors', and in his seminal work *Medical Nemesis* (Illich 1976) he identified and classified well ahead of his time the health hazards of the 'medicalization of society'. His notion of conviviality and its health enhancement anticipated much of the degrowth discourse and are remarkably in tune with current views on the influence of the social environment on health (Bunker 2003). Nevertheless, due to his rather limited focus on iatrogenesis associated with modern industrialized medicine, Illich was criticized on one side for lacking a wider critique of the social and economic system, and from the other for a vision that was judged as over-simplistic and giving insufficient credit to some indubitable achievements of medicine (Scott-Samuel 2003). Indeed, a more comprehensive analysis of the relations between health and degrowth must extend beyond medicine and health care systems, taking into account environmental and social determinants of health and considering how degrowth may contribute to better health through a positive impact on those.

Instead, medical doctors engaged in 'degrowth medicine', seem to concentrate their action for change on medical practice, with almost no reference to public policies and interventions related to environmental and social determinants. 'To put the patient and his needs at the centre of the system' (Aillon et al. 2012) is the main objective, to be accomplished through the adoption of appropriate behaviors—that in principle do not substantially differ from any sound and ethical medical practice—such as: prevention and 'promotion of a real psycho-physical and social well-being' through the adoption of 'degrowth' lifestyles; refraining from laboratory tests and pharmacological treatment whenever possible and appropriate, protecting patients from multinational pharmaceutical companies' disease mongering; privileging an holistic approach to the patient and 'quality of life' over 'quantity of life'; and fostering interpersonal relations (Aillon et al. 2012). In synthesis, those proposals do not reject modern medicine and technological progress, but recommend a conscious and cautious use of resources. Such an approach could in itself contribute to reduce expenditure. Indeed, overuse of health services contributes importantly to the high costs and inefficiencies of health care systems, besides posing in many cases (i.e., overuse of drugs and imaging) significant risks to the safety and health of individual patients and the overall population (Nassery et al. 2014). It must also be noted that creating awareness about over- and misuse of services through improved interpersonal relations between health workers and their patients, advocated by degrowth doctors (Aillon et al. 2012), would undoubtedly have an added value considering that overuse of services such as antibiotics, labor inductions, and cesarean sections have a strong patient demand component, and interventions to improve shared decision making with patients demonstrated effectiveness in reducing use of antibiotics (Chan et al. 2013). Overuse (and misuse) intimately link values, personal and societal, with scientific evidence of outcomes and risks associated with an intervention (Chan et al. 2013), thus any study reinforcing that evidence could considerably contribute to affirm a degrowth medicine approach.

For their more holistic approach also the practice of certain types of non-conventional medicine (such as homeopathy, acupuncture, anthroposophic, and other natural medicines) are also often associated with 'degrowth medicine'. Indeed, patients choosing non-conventional medicines are often more prone to healthier and more ecologically sustainable lifestyles in line with those alternative health care approaches (Karlik et al. 2014).

The studies that try to estimate the possible impact of degrowth-oriented policies on health are practically limited to Borowy's (2013) analysis of the experience of Cuba in the 1990s during the so-called Special Period following the fall of the communist bloc. The country experienced almost a decade of negative economic growth due to declining production and consumption rates and had to adapt

to shrinking resources and to local and labor-intensive production modes. Despite the disastrous conditions in which it had to develop and, unlike other crises of comparable scale, that period brought about lifestyle changes (including reduced sedentariness and healthier nutrition) with tangible health benefits. This was made possible also thanks to a strong sense of priority put on health, social cohesion, and government control over central aspects of socio-economic life, although allowing for some private initiative and problem solving (Borowy 2013).

In an equitable society as the one degrowth promoters envisage, ensuring adequate universal access to health care becomes imperative. However, by definition, the answer cannot be found in increasing health expenditure, rather in 'doing better with less' (Benatar 2013). On the one side, this may be achieved by reducing the burden of disease, thus demand on health services, through a stronger focus on preventive measures, healthy public policies for the control of social determinants, the promotion of healthy lifestyles, and the control of medical consumerism (Spady 2012). On the other side, the efficiency of health systems may be increased, both through a more conscious and cautious use of technological resources and by modifying the way health care is provided, including through alternative structures and functions that will largely depend on local demands and local resources to respond to those demands. Health care quality and efficiency may be undoubtedly enhanced through a better use of communities' own resources, strengths, and social networks.

For example, a possible response to the increased burden that aging and the rise in chronic degenerative diseases pose on health services, is found in a modified living model facilitating to any possible extent the participation of the disabled and the elderly as an active component of the community. Extended families, living communities, cohousing experiences all show the possibility of intergenerational experiences of sharing of care and related competences as an alternative to hospitalization and institutionalization of the elderly and people that have otherwise lost a certain degree of their autonomy (Robert 2012). In a degrowth perspective, Bednarz and Beavis (2012) consider Illich's 'localization' based on self-organization, self-reliance, self-limitation, and self-rule as the way forward for a degrowth society. Those authors also argue that the structure of health services must be redesigned in terms of less complexity and fewer available resources to operate institutions. In open contrast with what is argued in this paper, Bednarz and Beavis (2012) also categorically exclude that institutions such as WHO could play a role in the transition, due to their being dominated by neoliberal agendas and to their uncertain destiny in a degrowth world.

Instead one can agree with Bednarz and Spady (2010) when they highlight that education of health workers plays a substantial role in the building of sustainable health systems. With few exceptions, today medical schools follow a standard curriculum that continues to emphasize resource-intensive treatment over less resource-consumptive and preventive health care. This approach also dominates the medical research agenda. Thus, Bednarz and Spady (2010) argue that medical schools should undergo deep reform incorporating 'supply-side sustainability' and consider advocating for a sustainable society as a matter of public health and social responsibility, as a strategic imperative.

Global health governance and market forces

With the rise of the neoliberal model, the influence of the corporate sector on WHO also increased.

According to its 1948 Constitution WHO is mandated to act as the directing and coordinating authority on international health work with the objective to achieve the attainment by all peoples of the highest possible level of health. Nevertheless, WHO's 'accommodation to neoliberal dogma and practice'—mainly under Director General Gro Harlem Brundtland—contributed to WHO's loss of social relevance (Navarro 2006).

The remarkable upsurge and multiplicity of new private actors and public–private ventures further weakened WHO's role, increasing the inefficiency of the global health system, inducing an unsustainable fragmentation at country level, and confusion in global health governance. For example, the Global fund to fight HIV/Aids, Tuberculosis, and Malaria, a global public–private partnership, is second only to the United States of America as a channel of development assistance for health (DAH) resources (IHME 2014). In addition, WHO has become overdependent from often highly conditional contributions from governmental and single private donors, such as the Bill & Melinda Gates Foundation, which is the first contributor to WHO's extra-budgetary funds, which constitute about 78 % of the organization's total spending (WHO 2014b). Chow (2010) highlighted that WHO is no longer setting the agenda of global health, while policies impacting on health are increasingly decided in fora traditionally lying outside the domain of the health sector, which are scarcely influenced by health concerns.

Trade and investment treaties, for example, increasingly limit the policy space for public regulatory interventions, including those to protect public health. International trade agreements may indeed prevent countries from implementing health protective regulation which—as pricing and access measures—are likely to be considered as trade-restrictive under those agreements. The highly structured, formalized, and demanding trade governance system

prevails on the weaker global health governance domain (Labonté 2010).

In addition, corporate sector's tactics to avoid regulation are well known, including front groups, lobbies, promises of self-regulation, lawsuits, and industry-funded research that confuses the evidence (Chan 2013). Despite the normative power and regulatory capacity deriving from article 19 and 21 of its Constitution (WHO 2006), to contrast the production and marketing of harmful products and services WHO always relayed on non-binding recommendations, promoting industry's self-regulation and Corporate Social Responsibility (CSR), as in the case of WHO's Global Strategy on Diet, Physical Activity and Health (DPAHS) (WHO 2004). A notable exception was the Framework Convention on Tobacco Control (FCTCT), an international treaty developed under the leadership of WHO.

The argument of this paper is that a transition toward degrowth needs to take into account the global regulation of market forces, which to be successful must transnationally engage civil society. To that purpose, the FCTC and the DPAHS are used below as case studies to analyze on one side the weakness of simply relying on the social responsibility and self-regulation of the relevant corporate sectors, i.e., the tobacco and the food industry, respectively, and on the other the involvement of civil society as an element of success.

Case 1: The Framework Convention on Tobacco Control (FCTC)

The launch of the WHO Framework Convention on Tobacco Control (FCTC) in 2003, which entered into effect as international law in 2005, established a milestone in the history of corporate accountability and public health. This initiative openly challenged the tobacco industry. To avoid very probable interference during the negotiations, WHO decided to keep the tobacco industry out of the process, nevertheless the opportunity was offered to the industry to present its opinion in public hearings (Diethelm 2013).

Already before the adoption of the initiative for FCTC by the World Health Assembly in 1999, international tobacco corporations Philip Morris/Altria, British American Tobacco and Japan Tobacco International sought to weaken and bury the treaty. This was pursued staging events to divert attention from the public health issues raised by tobacco use, attempting to reduce budgets for the scientific and policy activities carried out by WHO, putting other UN agencies against WHO, seeking to convince developing countries that WHO's tobacco control program was a 'First World' agenda carried out at the expense of the developing world, distorting the results of important scientific studies on tobacco, and discrediting WHO as an institution. Evidence was gathered by an Expert Committee established by WHO. The Committee found that the tobacco industry regarded the WHO as one of their leading enemies, and that the industry had a planned strategy to "contain, neutralize, reorient" WHO's tobacco control initiatives (Zeltner et al. 2000).

Tobacco industry considered the treaty to be an unprecedented challenge to the industry's freedom to continue doing business. Among others, WHO was accused of 'creating an additional layer of bureaucracy and regulation in a policy area where national governments are competent to act.' Although the tobacco transnationals had developed a common industry-wide approach to resisting government legislation and regulation, they were opposed to WHO formulating an international response to an international problem (Saloojee and Dagli 2000). Under the pressure of tobacco lobbies, the United States worked to derail the treaty, trying to water down much of the document (Nikogosian 2010).

On the other side, the global tobacco treaty process showed the potential of an alliance with civil society and public health advocates. NGOs provided technical assistance to government delegates, monitored and exposed tobacco industry abuses such as interference in public health policy, generated direct pressure on tobacco transnational industry including through boycott tactics targeting tobacco relates industries.

The developing world, led by a block of 46 African nations and supported by NGOs, united to push for positions that would prevent the spread of tobacco addiction, disease, and death. This alliance made the success of FCTC, which has become one of the most widely and rapidly ratified treaties in the history of the United Nations (Nikogosian 2010). Thanks also to the FCTC, tobacco global consumption progressively decreased over the last years (Diethelm 2013).

Case 2: The Global Strategy on Diet, Physical Activity and Health (DPAHS)

In May 2004, under a May 2002 mandate from Member States, the WHO launched the Global Strategy on Diet, Physical Activity and Health (DPAHS) calling on governments, private industry, and consumer groups to take action against marketing messages that promote unhealthy dietary practices (Hawkes 2007).

In the preparatory work, in setting nutrients intake goals for preventing diet-related chronic diseases, the WHO's experts committee recommended that free sugars should be $<10\ \%$ of daily energy intake. That recommendation provoked the violent protest of the sugar industry and its associations, who 'wrote angry and threatening letters' to the Director General at the WHO, and asked the US Government not to pay its contribution to the WHO should

the recommendation stay (Norum 2005). Under pressure from the domestic food lobby, the US Government argued against stronger regulation, citing the importance of individual responsibility for lifestyle choices (Lee 2006). The industry also threatened developing countries that if that recommendation was endorsed this could seriously influence their financial status. The Executive Board of WHO was equally lobbied. Agricultural and trade policy, not health, was brought at the forefront of the discussion. The approved DPAHS contained a rather bland recommendation to limit the intake of free sugars (Norum 2005).

In the case of the fight against obesity and other non-communicable diseases, instead of pursuing alliance with clearly public interest positioned civil society organizations, WHO adopted the so-called 'multistakeholder approach', i.e., allowing very diverse and often conflicting actors, such as the food industry and Public Interest NGOs (PINGOs) to take part to the debate supposedly as peers, notwithstanding evident disparity among them in terms of means and power of influence. Supporters of this approach argue that involvement of industry would elicit its social responsibility and facilitate its adoption of healthy practices (Di Girolamo and Fabbri 2013).

From a global perspective, the result has been that following DPAHS there has been more talk about regulation than action to implement regulations (Hawkes 2007). Answering to the pressure for a more responsible marketing of unhealthy food and to avoid government regulation, food industry very quickly made various national, regional and global pledges and established its own codes of conduct (Swinburn et al. 2011), but there is evidence of the ineffectiveness of existing self-regulation schemes (Ronit and Jensen 2014).

Despite strong advocacy by public health and consumer groups for legal restrictions on food marketing to children, few governments introduced statutory regulation. The result is that most regulation in place today is still self-regulation and companies have continued to proactively market their products and lobbied against any proposals to legally restrict food marketing to children (Hawkes 2007). For example, while claiming the introduction healthier low-energy options in response to consumers' pressure in rich markets, soft drink companies, such as The Coca-Cola Company and PepsiCo Inc., who together control 34 % of the global soft drink market, simply move their marketing and sales of unhealthy drinks to more malleable markets (Kleiman et al. 2012).

Despite evidence that the large increase in obesity is due to marketing (Zimmerman 2011), industry frames obesity as a consequence of individual poor lifestyle choices, claiming that lack of physical activity rather than increased food consumption is the dominant cause of obesity (Jenkin et al. 2011). In 2010, WHO recommended the protection of children from the marketing of unhealthy foods and beverages. Anticipating public regulation, some companies adopted and publicized their cautious marketing toward children under 12 years of age (i.e., not advertising in a media whose audience is composed for more than 35 % by children under twelve), claiming their socially responsible marketing. This is for example the case of The Coca-Cola Company in Mexico who heavily retargeted its advertising toward parents: 'parents and tutors have the right to decide what children should drink. That is why our bottles contain something more than a beverage. They contain responsibility' (advertising on daily newspaper La Jornada on 20.8.2012). In addition, surreptitiously addressing an adult public the Company uses children dressed as superheroes to promote the beverage, in spots appealing to parents' childhood memories (Cavillo Unna 2012).

Discussion

To address the challenge of a world system spinning out of control, to meet essential life needs and ensuring safety from preventable economic, and other social and environmental threats to health, a call emerges for a paradigmatic shift toward a more caring, equitable, and sustainable society. Such a re-appraisal of the currently dominant value system and economic model will also require the modification of power and governance structures (Benatar 2013).

In the transition, full implementation of existing global regulatory instruments may be needed. The case studies proposed in this paper suggest that a regulatory approach is possible, but needs strong multilevel alliances, as it is further discussed below.

Degrowth offers the opportunity for the confluence of a multiplicity of diverse streams of ecological and social thoughts, and political action looking for an alternative to economic growth as the objective in political agendas. It challenges the consensus on growth in the public debate and in the social imaginary, gives visibility to the contradictions and the conflicts of growth society at different scales and implies societal transformation (Demaria et al. 2013). The alternative that degrowth proposes is described as centered around the reproductive economy of care, and the reclaiming of commons embodied in new forms of living and producing, such as eco-communities and cooperatives, and "supported by new government institutions" (Kallis et al. 2014).

Nevertheless, starting with Illich, 'localization' and lifestyle changes seem to inspire the dominant perspective of degrowth supporters, in some case explicitly excluding a possible role of global institutions (Bednarz and Beavis 2012).

However, due to global interconnectedness and interdependence between global, national and local levels, it

appears rather improbable that post-growth alternatives to the current economic system can be built solely on the promotion of change in individual behaviors and on initiatives at community level, without concomitant supportive policies at national and global level.

Whether the transition to a post-growth governance will be done incrementally and in an orderly way, or chaotically in response to significant ecological crisis cannot be foreseen, nor can be predicted the global governance model of the post-growth society. However, whatever type and form of governance emerges, it will require normative legitimation to be sustained and a new form of social contract will be needed as its foundation (Jennings 2012).

At least in the case of global health governance the existing mandated multilateral organization, i.e., the World Health Organization, could play an important role in that transition, but will need adjustment and reform. The existing international governance structure has become widely insufficient among others to effectively deal with the power and influence of transnational market forces. In the words of Margaret Chan, the Director General of the World Health Organization (WHO) those forces exert a 'formidable opposition' to international efforts for public health, with market power readily translating into political power (Chan 2013). The pervasive and aggressive marketing strategies of Transnational Companies (TNCs) are at the very roots of today's hyper-consumerism. Paradoxically, TNCs' arguments seem to coincide—with opposite goals—with a degrowth approach that puts emphasis exclusively on individual lifestyle choices. Indeed, TNCs place the responsibility for harm to health on individuals, and portray government regulatory actions as interference in personal liberties and free choice (Chan 2013). At community level, many people in the developed world are already voluntarily choosing more sober lifestyles and organizing local exchange and consumers' networks that recur to local producers for their food, clothing, and other needs (Victor 2010). However, it is improbable that these experiences alone may have a significant impact of the current dominant socio-economic model. The mass psychological impact of modern advertising, media, and virtual manipulators on the cultural conditions in which people live should not be underestimated. Change also requires policy response, nevertheless this is currently 'too narrowly corralled within the language of corporate social responsibility, partnerships, and so-called shared value' (Lang and Rayner 2012).

It is widely acknowledged that most cost-effective interventions are those aiming at reversing the socio-economic drivers. In first instance, this requires public regulation. Less effective interventions include health promotion programs acting both on environments and individual behavior (Swinburn et al. 2011).

Choosing to avoid public regulation, global and national policy makers also avoid the clash with powerful lobbies, in the assumption that companies' CSR will prevail over their economic interest. However, as the two case studies in this paper have shown, this is doubtfully the case. The experience of using voluntary codes of conduct with the food industry has been disappointing. Companies' persistent disregard of the code of conduct for breast-milk substitutes confirms the weakness of that assumption (Chopra and Darnton-Hill 2004). All voluntary self-regulatory initiatives have to ultimately improve financial performance of the firm. Reportedly, in the words of the famous free marketer Milton Friedman, the only social responsibility of industry is to make a profit for its owners (Friedman 1970).

Free market proponents argue that individuals should have the right to choose what they consume without interference from a 'nanny state', suggesting that lifestyle choices are made in a vacuum. Instead, lifestyle choices are often the direct result of corporate decisions and induced through marketing strategies. However, corporations, like individuals, make decisions constrained by the social and economic context, thus identifying policies that foster corporations to choose health should be a public health priority (Freudenberg and Galea 2008).

Experience tells that even when left out of the room, private interests conflicting with those of public health make their way into the decision-making process through heavy lobbying and complicity of like-minded governments. Whenever possible, business seeks to establish its own rules (self-regulation) eventually claiming its CSR. Where this is not possible, it seeks to influence public regulation, through for example the United Nations, or promoting co-regulation (Buse and Lee 2005).

Clearly those influences lay often outside the control of public health authorities and comprehensive solutions will require defending and proactively affirm public health priorities in all policy-making settings. Regulatory processes oriented by public health goals are possible. The FCTC lead by WHO, is possibly the best example of how that agency can exercise its mandate for health through internationally binding instruments. International non-binding 'soft law' can also contribute to limiting the marketing of unhealthy products and services, as in the case of WHO's DPAHS, but it would be naïve to believe that results can be achieved solely relying on industry's CSR.

Undoubtedly, the use of internationally binding instruments or conventions like those achieved with the FCTC in tobacco control for counteracting the marketing of other harmful products that may not yet be perceived as dangerous as tobacco (as is the case of soft drinks) may result much more challenging. Nevertheless, the importance of international instruments in bringing about changes in national behavior should not be under-rated. Potential

international standards might cover issues such as restrictions of marketing, advertising and availability of unhealthy products, standard packaging and labeling of food products, or potential price or tax measures to reduce the demand for unhealthy products. The public attention and awareness generated by the discussion and formulation of such standards may condition corporate conduct without being politically unacceptable and even generate enough political capital for national legislation (Chopra and Darnton-Hill 2004).

As the FCTC and the DPHAS experiences have also shown, success is also linked to strong leadership of WHO, a clear identification of conflicting interests, and the choice of allies. Civil society organizations (CSOs) play an essential role in upholding public health protections and mobilizing public opinion to regulate the behavior of powerful states and corporate interest, and WHO can take advantage of strong alliances with those civil society movements that defend the public interest and identify global health as a common good (Lee et al. 2009). This specification is not trivial, in fact differentiating between business interest NGOs (BINGOs) and public interest NGOs (PINGOs) is not as easy as it may seem as NGOs can be linked to economic interests through several and very diverse ways (through its members, its governing bodies, financial support, partnerships, and many others). The current process of reform that WHO is undergoing could already represent an opportunity to clarify its relations with the private sector and take strong side for the public interest according to its original mandate (Verzivolli 2013). In what many indefinitely call civil society, a wide diversity of actors coexist, often in competition among themselves, with very different values, objectives, and approaches. Civil society includes 'the good, the bad, and the ugly', the 'civil' and the 'uncivil' actors with some forces within it being agents of change and others striving for the preservation of the status quo (D'Alisa et al. 2013). Thus, 'democratized' WHO should clearly spell out the values, principles, inclusion and exclusion criteria that benefit public health outcomes (van de Pas and van Schaik 2014). In this sense, serious concerns have been expressed about WHO's attempt at its 67th World Health Assembly in May 2014, to bring actors with conflicting interests under a single "Framework on engagement of non-state actors" (Richter 2014).

In a degrowth perspective, a strong alliance between WHO and a wider movement of CSOs bringing together scientists, practitioners, and activists who embody degrowth ideas in new material spaces, growing in a movement capable of building alliances with other similar cultural stories and movements (Kallis 2011), may represent a strategic step also to promote healthy policies in other domains. The prototypic alliance between WHO and the International Baby Food Action Network (IBFAN) in the early 1980s in support of the International Code of Marketing of Breast-Milk Substitutes represents a successful example of such an approach. Initiatives, such as the Democratizing Global Health Coalition, launched in 2010 by a worldwide network of civil society organizations offers a more recent example of such a transnational alliance (Delhi Statement 2010).

Indeed, rather than circumscribing the debate in the traditional, and currently rather confused sector domain of Global Health Governance, to substantially influence health relevant policy instruments both internally and externally to the health sector, higher emphasis should be put on Global Governance *for* health. This has two implications: on one side confirms the need, more than ever, to strengthen the normative role 'that WHO can play in line with its primary Constitutional function as "directing and coordinating authority on international health work" '(WHO 2011), as advocated by Chen and Berlinguer a decade ago (Chen and Berlinguer 2001) and reaffirmed as 'an overarching objective of reform' in the current adjustment process that the Organization is undergoing (WHO 2011). On the other hand, a *for* health governance approach requires WHO to be more proactive and timely in representing health interests in other fora, such as in trade or environmental negotiations, at regional and global level, where businesses have privileged access to policy makers and dominate the formulation of negotiating positions exerting heavy influence on the trade agenda (Lee et al. 2009). At least in principle, WHO is the only international institution capable to intervene imposing a clear indictment of products, practices, and processes that are proven to be hazardous to health, and could do so through international binding agreements. The adoption of a legally binding global health treaty—a framework convention on global health grounded in the right to health, with WHO at the center of the convention regime has been proposed by a global coalition of civil society and academics—the Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI) (Gostin et al. 2013). However, a new framework convention to indict at least those substances and products that WHO itself has already recognized as hazardous to health, could represent a valuable first step (Westra 2012).

The challenge is surely clear to WHO's leadership. Referring to the 'globalization of unhealthy lifestyles' the WHO's Director General has clearly stated that it 'is a political issue. It is a trade issue. And it is an issue for foreign affairs'. She also denounced that today the promotion of healthy lifestyles faces opposition from tough market forces and 'go against the business interests of powerful economic operators' (Chan 2013).

To face the challenge, WHO will need to count on a wide support of its membership, but as the FCTC case has

shown, success is highly dependent on wider alliances with sectors of civil society actively engaged with the promotion of the right to health and the Common Good at both the global and community level.

Conclusion

To truly attain health for all, a paradigmatic shift is required. Health as a complete state of physical, mental, and social well-being should be reaffirmed not only as a fundamental human right and asset of good life, but as a political priority, and policies at all levels should be reoriented accordingly.

Claiming the social dimension of health becomes vital in a degrowth perspective. Such a paradigm shift necessarily needs a substantial reorientation of policies at national level in addition to citizens' engagement at community level. Local and national action in turn, cannot prescind today from the complexity of the globalized world and the need to control transnational forces influencing our everyday life and finally our health, through institutions and policies able to do so.

While local practices are an essential starting point in developing healthy, equitable, caring, and ecologically sustainable society, those experiences may have to face enormous challenges, and eventually fail for the strenuous and well-organized opposition from global market forces.

Thus, local experiences of social transformation along the diverse ideas, concepts and proposals that have been included in the degrowth framework (Kallis et al. 2014), will need to go hand in hand with worldwide action for healthy global policies, i.e., regulatory interventions aiming at correcting socio-economic determinants of health, eventually establishing wide alliances among organizations which share a common understanding about the increasing risks linked to the current growth society. The contribution of health professionals in creating the necessary awareness among the communities they serve can be of great relevance. Professionals and researchers who are concerned with population's health have the additional duty and ethical responsibility to provide evidence and advocate for those policies, conveying the sense of urgency that the foreseeable consequences of maintaining the current unsustainable model require.

In turn, to succeed, the connection between global institutions, namely WHO, and a 'civil' society movement capable of interlinking local degrowth-related experiences on a global scale, will have to be pushed and probably literally reinvented through dynamics and mechanisms that will undoubtedly require further investigation and analysis.

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