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This chapter summarizes the development of public health systems and thinking from ancient times to today. It identifies some of the critical events that have significantly influenced this development, some current issues and some of the challenges that could shape its evolution. It concludes by exploring the congruence of the concepts of health and wellbeing.

Introduction

The word ‘health’ is derived from the Old English *hæl* meaning wholeness, of being whole, sound or well with overtones of holy, sacred and healing.

Public health has been defined in many ways (p. 12) but its two distinctive characteristics are that it deals with the prevention of disease/illness, rather than cure or healing; and that its focus is populations rather than individuals. The population in question can be as small as a handful of people or as large as all the inhabitants of several continents – as for instance, in the case of pandemics.

The evolution of public health thinking and practice

Before 1840: of plagues and empiricism

Public health is a modern concept, although it has roots in antiquity. From the beginnings of human civilization, it was recognized that polluted water and lack of proper waste disposal spread vector-borne diseases.

Around ten thousand years ago, when people began to move from being nomadic hunter-gatherers to living a more settled farming lifestyle, the risks to
health changed. Increased contact with people and animals and their waste products generated new problems. But, while the nature of both disease and good health was little understood, some ancient civilizations evolved rituals in which cleanliness and a healthy lifestyle were central. Usually religious in origin, some of these behaviours were also effective public health measures. In ancient Babylon, for example, religious teaching forbade drinking wells being dug near cemeteries and rubbish dumps. Cleanliness was also associated with religion in ancient Egypt, where an emphasis on washing had obvious public health benefits. The Chinese developed the practice of variolation (inoculation) following a smallpox epidemic around 1000 BC.

The ancient Greeks understood some of the links between lifestyle, the environment and health. Advice on diet, exercise and cleanliness is found in the works of Hippocrates (On Airs, Waters and Places). Inevitably, these Greek ideas influenced the Romans. While the ancient Greeks instituted some central control of public health, as had the rulers in ancient China and India, this greatly increased under the Romans, who believed that cleanliness would lead to good health and that prevention of illness was as important as its cure. From empirical observations, they made links between causes of disease and methods of prevention, as a consequence of which they developed a sophisticated system of public health infrastructure throughout the Roman Empire. Such observations led them to believe that ill health could be associated with, amongst other things, bad air, bad water, swamps, sewage, debris and lack of personal cleanliness. Their response was to provide clean water through aqueducts, to remove the bulk of sewage through the building of sewers and to develop a system of public toilets throughout their towns and cities. Personal hygiene was encouraged through the building of public baths.

The decline of the Roman Empire was accompanied by the loss of much of the public health infrastructure. However, in the Near East parts of the rising Islamic Empire developed health care services and public health schemes. Baghdad opened its first hospital in 800 AD and, by the year 1000 AD, had sixty of them. A number of cities also had public baths and sewage systems. In some ways, it is difficult to conceive of a more public health-friendly religion than Islam, which strongly advocates healthy behaviour. The Quran and the hadith (teachings and sayings of the Prophet Muhammad) offer numerous directives about maintaining health at community, family and individual levels.

From the eleventh century, growing international trade stimulated urbanization in western Europe, with a resulting rise in the prevalence of communicable diseases. Leprosy was especially widespread and laws enforcing the isolation of sufferers were passed throughout the medieval period. Such powers were expanded in the wake of the Black Death and the subsequent waves of plague that recurred over several centuries. The development of the practice of quarantine in this period also helped to mitigate the effects of other infectious diseases.

With the decline in the toll of the plague in the eighteenth century there was less need for strict public health measures. At the same time, an interest in the
underlying health of populations developed. Counting and valuing – characteristics of trading nations with growing empires – were now applied to populations. Censuses, disease statistics, birth rates and bills of mortality marked the earliest beginnings of epidemiology: the science of public health (Porter, 1999).

By the late 1700s, Britain was evolving into the first industrialized nation – a revolution that created public health challenges of a type still faced today as industrialization spreads around the world. Although this new age brought medical advances, it occurred within a social climate of laissez faire, where little thought was given to ensuring that people were healthy, clean or well-housed. However, the cholera pandemic that devastated Europe between 1829 and 1851 stimulated government action leading to measures such as regulating the location of cemeteries which were based on the then current miasmatic theory of disease. Other public health interventions included latrinization; the building of sewers; the regular collection of garbage, followed by incineration or disposal in a landfill site; the provision of clean water and the draining of standing water to prevent mosquitoes breeding.

1840 to 1980: from microbes to lifestyle

Reports by social reformers such as Edwin Chadwick revealed the extent of the public health crisis in Britain. He drafted the revisions of the Poor Laws and was subsequently the administrator for the Poor Law Commissioners. It was the failure of the workhouse system, however, that led Chadwick to public health. His Report on the Sanitary Condition of the Labouring Population of Great Britain, published in 1842, argued that the primary cause of pauperism and misery was not poverty or rampant capitalism, but filth. To him, the water queue, the dung heap and the cesspool were the causes of moral decline, fever and death. His arguments were a counterpoint to the more radical visions of William Cobbett (Cole, 1924); the Chartists; and Friederich Engels (Henderson, 1976), as expressed in The Condition of the Working Class in England, published in 1844, and in the Communist Manifesto of 1848. Work, wages and food were rejected as remedies for pauperism in favour of water and sewerage systems. The notion that poverty itself was the cause of illness was, for Chadwick, unthinkable (Hamlin, 1998).

Public pressure for health reform, combined with Chadwick’s advocacy on sanitation, prompted the government to pass its first Public Health Act in 1848 which, over the following decades, stimulated the growth of public health bureaucracies armed with increasingly strong powers. A German physician, Johann Peter Frank, had at this time developed the concept of Medical Police (Medizinische Polizei), comprising a state administered system of health inspectors with powers to quarantine, disinfect and cleanse with the aim of promoting population growth, a healthy labour force and fit military recruits (Lesky, 1976). This policing model was a major influence during the nineteenth century in Britain as elsewhere, to which the development of the key role of the Medical Officer of Health bears witness.

The impact of these developments in sanitation was, however, extremely limited: by the start of the twentieth century, slum housing was still a prominent
feature of many cities, and the poor physical condition of Boer War recruits bore witness to the deprivations endured by large sections of the population.

In 1700, there were only seven towns outside London with a population greater than 10,000 (Clark and Slack, 1976) but, with the influx of workers and their families into the rapidly industrialized towns during the 1800s, this number increased significantly, leading to overwhelming problems of overpopulation. Ashton and Seymour (1988) describe the findings of Dr Duncan, Liverpool’s first Medical Officer of Health, who wrote of one third of the population of Liverpool living in the cellars of back-to-back houses with earth floors, no ventilation or sanitation, and as many as 16 people in one room. The infrastructure of these communities had not been built to withstand such a population explosion and, in the early nineteenth century, ‘the problems of environmental degradation, disease and human misery reached massive proportions and were in evidence across large tracts of Britain’ (Webster, 1990).

To provide professional leadership for sanitary reform, local authorities appointed Medical Officers of Health, medical practitioners with appropriate training in the then new science of public health. Over time, local authorities gained new roles and, by the 1930s, the Medical Officer of Health’s empire had grown to include environmental health, district nursing, community midwifery, health visiting, school health, maternal and child health, mental health, welfare and the former Poor Law hospitals. At the height of local authorities’ power and independence, Medical Officers of Health were important people with considerable influence within organizations.

The modern study of the social determinants of health can be said to have begun with the writings of Rudolph Virchow (Koch, 1882) and Friedrich Engels (Henderson, 1976), and the creation of social medicine during the mid-nineteenth century. Virchow and Engels not only made the explicit link between living conditions and health, but also explored the political and economic structures that create inequalities in the living conditions that lead to health inequalities.

The scientific underpinning of public health – epidemiology – was established by John Snow’s identification of a polluted public water well as the source of a cholera outbreak in Golden Square, London in 1854 (Snow, 1855).

As the prevalence of infectious diseases in the developed world decreased during the twentieth century, public health began to place greater focus on chronic diseases such as cancer and heart disease.

A key development of the 1920s was the publication of the Dawson Report: ‘Interim Report on the Future Provision of Medical and Allied Services of the Consultative Council on Medical and Allied Services’ (MOH, 1920). Lord Dawson was ‘convinced that preventive and curative medicine cannot be separated on any sound principle, and in any scheme of medical services must be brought together in close coordination’ (MOH, 1920: 6). He proposed that health care in a given district should be based upon ‘Primary Health Centres’, which he termed ‘institutions equipped for services of curative and preventive medicine to be conducted by the general practitioners of that district’ (MOH, 1920: 6). These centres were to be supported by secondary health centres and
teaching hospitals, which would deal with difficult cases requiring special treatments and/or expert diagnosis. This pattern of provision provided the framework on which the National Health Service (NHS) was constructed in 1948.

A particularly prescient focus of the Dawson Report was on the value of physical culture as a vital necessity to the health of the nation (MOH, 1920: 30).

Not long after the publication of the Dawson Report, but probably not influenced by it, the Peckham Experiment was initiated (Barlow, 1988). This was a study into the nature of health. It lasted from 1926 to 1950 and was conducted by Drs George Scott Williamson and Innes Hope Pierce, both of whom refused to divide souls from bodies or to divide bodies into sets of distinct medical specialities.

Healthy Living Centres are a recent derivative of the long-defunct Peckham Experiment. These are based on the recognition that determinants of poor health in deprived areas include economic, social and environmental factors that are outside the influence of conventional health services. Several more recent projects have also been based on a holistic approach to health and a commitment to partnership with patients. For example, the Bromley by Bow Centre links health, education, arts and the environment. Activities include a community education programme, a food cooperative, complementary therapies and exercise classes. In Bristol, Knowle West Health Park is planned to include a new health centre, family centre, dance studio, community café, jogging track and community gardens.

The dramatic increase in average life span during the twentieth century is widely attributed to public health achievements, such as vaccination programmes and the control of infectious diseases, effective safety policies (such as motor vehicle and occupational safety), improved family planning, the chlorination of drinking water, smoke-free measures and programmes designed to decrease chronic disease. In the aftermath of the Second World War, the further expansion of government involvement in health culminated with the emergence of the welfare state. In Britain, this was characterized by the introduction of financial and medical assistance from the cradle to the grave, the most significant component of which was the launch of a National Health Service in 1948.

At the same time, the World Health Organization (WHO), created in 1946, developed its landmark definition of health as ‘a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity’. This definition, which remains unchanged, has been much criticized for its lack of practical application. It also lacks internal coherence in envisaging wellbeing in both subjective terms (mental wellbeing) and objective terms (physical and social wellbeing). Conceptually, however, it marked the first explicit equating of health with wellbeing in modern times.

Public health initiatives have now moved beyond national boundaries with the WHO launch of extensive international campaigns – often combining health education with practical activities such as vaccination. Under its auspices, the global eradication of smallpox was achieved in the 1980s and the global eradication of poliomyelitis is currently well-advanced.
The Lalonde Report (1974), *A New Perspective on the Health of Canadians*, is considered to be the first modern government document in the Western world to acknowledge that our emphasis upon a biomedical health care system is wrong, and that we need to look beyond the traditional health care (sick care) system, if we wish to improve the health of the public. It proposed a new health field concept with four major determinants of health: human biology, environment, lifestyle and health care organization. The report emphasized individuals’ roles in changing their behaviours to improve their health, and was groundbreaking in identifying health inequalities as a major issue.

In the UK, 1974 was a watershed in public health that saw the transfer of many public health functions and their associated personnel from local government to the NHS (Draper *et al*., 1976). This resulted in a loss of confidence within the public health community that was apparent from the lack of progress in developing the public health agenda over the next twenty years. This was only partially countered by the implementation of the recommendations of the Acheson Report of 1988.

The establishment of the Faculty of Community Medicine as a faculty within the Royal Colleges of Physicians of the UK in 1972 reinforced the medical domination of the public health function which impeded the involvement of other disciplines so important to developing the so called wider determinants agenda by at least two decades.

Two notable publications of the 1970s were Ivan Illich’s *Medical Nemesis* (1975) and Thomas McKeown’s *The Role of Medicine: Dream, Mirage or Nemesis* (1976), both of which promoted the view that improvements in health in the nineteenth and twentieth centuries had little to do with medical interventions, and more to do with social conditions and the actions of individuals and society.

The Declaration of Alma-Ata, adopted at the WHO International Conference on Primary Health Care in Kazakhstan in 1978, expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world. It was the first international declaration underlining the importance of primary health care. The primary health care approach has, since then, been accepted by member countries of the WHO as the key to achieving the goal of ‘Health for All’. The first section of the declaration reaffirms the WHO definition of health, and seeks to include the social and economic sectors within the scope of attaining health through *intersectoral collaboration*; it also reaffirms health as a human right.

The Healthy Cities project was established by the WHO in 1985 as a test bed for Health for All and, in the UK, achieved some success in promoting intersectoral collaboration between local authorities, health authorities, voluntary agencies and even the private sector. Liverpool was the site of one particularly active Healthy City project, and the county of Norfolk uniquely applied the same concept in a large rural county in the 1990s with some success (Norwich Health Authority, 1990). The programme continues today with about 8000 cities worldwide now engaged, Cardiff being amongst the most recent signatories.
Since 1980: from inequalities in health to social determinants

Inequalities in health
Inequalities in health have been noted since the time of Hippocrates: Chadwick, in his Report on the Sanitary Condition of the Labouring Population of Great Britain (1842), documented the wide discrepancy in longevity between occupational groups in different parts of England. However, seeing such groups as more than just an interesting finding of descriptive epidemiology is a recent phenomenon: I received my public health training in 1970/71 in Edinburgh without any reference whatsoever to this issue.

Sir John Brotherston, in his 1975 Galton Lecture, identified various occupations as a cause for concern, which was echoed the following year in the Labour government’s landmark document ‘Prevention and Health: Everybody’s Business’ (DHSS, 1976). In this lecture, Sir John Brotherston identified inequalities in health as a cause for concern.

In August 1980, the UK Department of Health and Social Security published the Report of the Working Group on Inequalities in Health, also known as the Black Report. It demonstrated in great detail the extent to which ill health and death were unequally distributed among the population of Britain, and suggested that these inequalities had been widening rather than diminishing since the establishment of the NHS in 1948. The Report concluded that these inequalities were not mainly attributable to failings in the NHS but, rather, to social inequalities influencing health (such as income, education, housing, diet, employment and conditions of work). In consequence, the Report recommended a wide strategy of social policy measures to combat inequalities in health. The findings and conclusions of this landmark report were amplified and developed by Margaret Whitehead in The Health Divide (1987).

The ensuing decade saw a growing rhetoric but a commitment to real action is a latter day phenomenon. The turning point was 1998, with the publication of the Independent Inquiry into Inequalities in Health Report (Acheson, 1998). As with earlier reports, including the Black Report, this inquiry demonstrated the existence of health disparities and their relationship to social class. Among the Report’s findings were that, despite an overall downward trend in mortality between 1970 and 1990, the upper social classes experienced a more rapid mortality decline. The report contains 39 policy suggestions, in areas ranging from taxation to agriculture, for ameliorating health disparities.

In 2002, the Chancellor of the Exchequer commissioned Sir Derek Wanless, a former banker, to undertake a review on prevention and the wider determinants of health in England, and on the cost-effectiveness of action that can be taken to improve the health of the whole population and to reduce inequalities. He envisaged three possible future scenarios, the slow uptake, solid progress and the fully-engaged (where members of the public were fully engaged with measures to improve the public health). He suggested that, for this to happen, people needed to be supported more actively to make better decisions about their own health. This included providing a single accessible source of advice on health issues.
In 2005, the WHO established the Commission on Social Determinants of Health (CSDH) under the chairmanship of Sir Michael Marmot. The Commission reported in 2008. It was recommended that national governments should develop and implement strategies and policies suited to their particular national context aimed at improving health equity. In the UK, the English and Scottish governments have undertaken so-called Marmot Reviews in response to this recommendation that propose evidence-based strategies for reducing health inequalities from 2010.

Since the 1980s, the focus of public health has shifted from individual behaviours and risk factors to population-level issues such as inequality, poverty, and education. Modern public health is concerned with addressing health determinants across a population, rather than simply advocating individual behaviour change, recognizing that health is affected by many factors including the environment, genetics, income, educational status and social relationships, the so-called ‘wider’ or ‘social’ determinants of health. Among those who were instrumental in effecting this shift in focus were those in the health promotion profession, the evolution of which, out of the narrower paradigm of health education, was a feature of the 1980s.

The WHO Regional Office for Europe defined health promotion as the process of enabling people to increase control over and improve their health. In addition to methods to change lifestyles, the WHO also advocated legislation, fiscal measures, organizational change, community development and spontaneous local activities against health hazards.

Two years later, the WHO launched the Ottawa Charter for Health Promotion at the first international conference for health promotion. This identified five action areas for health promotion:

- building healthy public policy;
- creating supportive environments;
- strengthening community action;
- developing personal skills; and
- re-orientating health care services toward prevention of illness and promotion of health.

The WHO also proposed three basic strategies for health promotion:

- advocacy;
- enablement; and
- mediation.

A Committee of Inquiry into the future development of the public health function (Cmd 289) was established and reported in 1988. This was undertaken in the light of continuing concerns among public health practitioners about their role following the NHS reorganization of 1974, and in the wake of a spectacular failure of public health personnel to respond appropriately to a traditional public health challenge: a salmonella outbreak in a large psychiatric hospital in the north of England. Public health was thus defined, in a
much wider context than before, as the science and art of preventing disease, prolonging life and promoting health through the organized efforts of society. This definition reveals key ideas embedded in much contemporary public health, identifying partnership and multidisciplinary working, collaboration, an evidence-based approach and the breadth of action from population health gain through to the provision of health care services. It also illustrates the complex and contested nature of public health.

Dahlgren and Whitehead (1991) described a social ecological theory of health. In this, they attempt to map the relationship between the individual, their environment and disease (Figure 1.1). Individuals are at the centre, with a set of fixed genes. Surrounding them are influences on health that can be modified:

- the first layer is personal behaviour and ways of living that can promote or damage health – individuals are affected by friendship patterns and the norms of their community;
- the next layer is social and community influences, which provide mutual support for members of the community in unfavourable conditions; they can, however, also provide no support or have a negative effect;
- the third layer includes structural factors – housing, working conditions, access to services and provision of essential facilities.

**Figure 1.1** The relationship between the individual, the environment and disease

*Source:* Dahlgren and Whitehead (1991), reproduced with the kind permission of the Institute for Futures Studies, Stockholm
In his seminal text *The Strategy of Preventive Medicine* (1992), Geoffrey Rose summarized the challenges to public health, as he saw them:

and that means a new partnership between the health services and those whose decisions influence the determinants of incidence. The primary determinants of disease are mainly economic and social, and therefore its remedies must also be economic and social. Medicine and politics cannot and should not be kept apart.

*The ‘new public health’*

The term ‘new public health’ (Holman, 1992) has been current since the 1980s but, confusingly, has been used to denote different versions of recent public health. Lifestyle public health of the 1970s, in the wake of the Lalonde Report, emphasized individual responsibility for the prevention of ill health. Limitations of this approach led to a new formulation in the 1980s that focused on environmental concerns and health inequality. The so-called ‘new public health’ movement in the UK was, in part, aimed at recreating the link between environmental health and public health doctors, which had been broken by the NHS reorganization in 1974. Ashton and Seymour’s book *The New Public Health* (1988) became the movement’s landmark publication. The impact on health of the environment and of a range of social factors was seen as crucial by organizations such as the Public Health Alliance, which was established in 1987. More recently, there has been an increasing emphasis on the role of secondary prevention by clinicians and of genetics.

The evolution of public health and public health thinking can be seen in three phases:

- the phase of empirical observation characteristic of Ancient Greece and Rome;
- the phase of empirical action based on such observations which was initiated by Rome and characterized the subsequent period until the middle of the 19th century; and
- the scientific phase which can be subdivided into the microbial phase focused on communicable diseases, sanitary measures and vaccination and immunization, and the multi-factorial/wider determinants phase initiated by the WHO with its Health for All movement and given a fillip by the publication in the UK of the Black Report (DHSS, 1980) and *The Health Divide* (Whitehead, 1987).

An alternative view categorizes this evolution in four stages (Figure 1.2):

- **Stage 1**, lasting until the mid-twentieth century, focused on the environment, interpreted broadly to include flora and fauna;
- **Stage 2**, from 1950 to 1980, where health care was remarkably short, where health care was seen as important;
- **Stage 3**, from 1980 to 1990, where lifestyle was the dominant theme; and
- **Stage 4**, the current position, where the socioeconomic environment comprising the wider/social determinants, is seen as pre-eminent.
Stage 4 represents a gradual shift to the adoption of the concept of wellbeing, with its all-embracing canvas of determinants, and the acceptance of the congruence of the concepts of health and wellbeing conceived by the WHO in 1946, with its landmark definition.

**Current issues**

**Medical hegemony**

Interest in public health, quite understandably, first developed among members of the medical profession. So it was that early public health practitioners, including the first Medical Officers of Health in the UK, were also practising clinicians in the latter case – general practitioners usually.

Well into the nineteenth century, this state of affairs persisted throughout the developed world. In the UK, in spite of the major contribution to public health by lawyer Edwin Chadwick, the state of medical hegemony continued until very recently. Only on the eve of the new millennium was the speciality of public health at last opened up to non-medical practitioners.
In fact, medical hegemony was strengthened in the 1970s when public health, then termed very deliberately ‘community medicine’, was accepted as a medical speciality with the establishment of the Faculty of Community Medicine under the umbrella of the Royal Colleges of Physicians of the United Kingdom. In reaction to this, the non-medical discipline of health promotion evolved out of health education and expanded during this period.

Despite current rhetoric about the decline of medical hegemony, there is a continuing demarcation between medical and non-medical public health appointments. Posts such as regional directors of public health and consultants in communicable disease control remain restricted to medically qualified candidates. Non-medical directors of public health at Primary Care Trust (PCT) level earn significantly less than their medical colleagues doing the same job.

**The contested nature of public health**

As already suggested, public health is a contested concept. It is presented and used in a variety of ways by public health practitioners, researchers and commentators. In the UK at least, it has even changed its name from time to time. In the first half of the 1900s, the term ‘state medicine’ was coined as an alternative, emphasizing the collectivist nature of much public health action. In the 1970s, the term ‘community medicine’ was adopted, following a lead from Morris (1969) focusing on the group nature of the recipients of such action.

Some of the most influential or interesting definitions or accounts of public health include:

Public health is the science and the art of preventing disease, prolonging life and promoting physical health and efficiency through organised community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organisation of medical and nursing service for the early diagnosis and preventative treatment of disease, and the development of social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health (Winslow, 1920).

What we, as a society, do collectively to assure the condition in which people can be healthy (Institute of Medicine, 1988).

The science and art of preventing disease, prolonging life and promoting health through organised efforts of society (Acheson, 1988).

‘Government intervention as public health’ involves public officials taking appropriate measures pursuant to specific legal authority ... to protect the health of the public ... The key element of public health is the role of government – its power and obligation to invoke mandatory or coercive measures to eliminate a threat to the public’s health (Rothstein, 2002).
Society’s obligation to assure the conditions for people’s Health (Gostin, 2001).

Childress et al. (2002) prefer to list features or aspects of public health:

Public health is primarily concerned with the health of the entire population, rather than the health of individuals. Its features include an emphasis on the promotion of health and the prevention of disease and disability; the collection and use of epidemiological data, population surveillance, and other forms of empirical quantitative assessment; a recognition of the multidimensional nature of the determinants of health; and a focus on the complex interactions of many factors biological, behavioural, social and environmental in developing effective interventions.

The diversity of these definitions is noteworthy – some being very broad in their nature and scope, whilst others focus on a more narrow range of considerations. Some are highly normative; others more or less descriptive. Some even contain detailed guidance as to how the relevant ends of public health are to be achieved. The Winslow definition, though written in 1920, has probably been the most influential.

Separation from local government

One of the major impediments to developing the public health agenda in the UK has been the separation of the main parts of the public health function from local government since the reorganization of the NHS in 1974. Active collaboration between the NHS and local authorities on an agreed public health programme is the obvious remedy. However, in the main this has not happened. Differences in culture and issues of organizational language have resulted in a virtual stand-off between local authorities and health service organizations, even though the list of local government functions and services that act to improve the health and wellbeing of the local population exceeds that of any other single public body.

In England, one development that has sought to improve collaboration is the joint appointment of Directors of Public Health by coterminous local authorities and Primary Care Trusts. It is generally felt that this has been helpful – necessary, even – but certainly not sufficient to bring about the level of collaboration required.

Involving the general public

Another area where public health has failed is in involving the public in decision-making. It would appear that there is a tendency among public health professionals to want to shape public behaviour, rather than be informed by it. Put another way, they favour the expert/evidence model of public health practice, rather than the leader/development model.

Working with Community Health Councils (CHCs) to inform the public on
health issues and to seek their views was seen as a key part of the job of community physicians in the immediate aftermath of the 1974 NHS reorganization. It is fair to say, however, that not all CHCs were very interested in public health, as distinct from hospital and general practice health care; and not all public health practitioners understood the fundamental importance of CHCs. The net result was that, overall, public involvement in public health decision-making and activity was negligible. When CHCs were replaced in England, the situation did not improve. Community Health Councils have been retained in Wales, but there is no clear evidence that this has had the effect of improving the public’s involvement in the public health agenda.

And what was true of the statutory public health sector was, unhappily, equally true of the voluntary sector public health bodies such as the UK Public Health Association, the Royal Society for the Promotion of Health and the Royal Institute of Public Health and Hygiene, which saw their main role as representing public health practitioners of various kinds, rather than representing or advocating for the general public.

**Health care primacy**

One issue that arguably dominates all other factors is that of the overriding tension between health care and health, and the continuing imbalance between them. The NHS continues to dominate the health policy agenda, as it has done without interruption since its founding. The result is that health care has been consistently prioritized over public health. As Coote (2007: 138) has it: ‘Health policy has been so thoroughly skewed towards illness and services that a visitor from outer space could be forgiven for assuming that the main role of government in this field is to fund and manage vast armies of doctors and nurses in hospitals up and down the country, all striving to repair sick bodies’.

One development that many in the public health community pressed for was the establishment of a Minister for Public Health to give some political weight to the development of public health policy, and to protect it from the customary depredations of the health care/sickness agenda. The last Labour government did, in fact, respond to this by creating such a post, but did not take the necessary steps of giving the post cabinet status. More importantly, the post of Minister for Public Health was not relocated away from the Department of Health to some more appropriate Department, such as the Cabinet Office or the then Office of the Deputy Prime Minister.

In its NHS White Paper ‘Equity and Excellence: Liberating the NHS’ (Department of Health, 2010) proposals and its stated intentions in respect of the public health function, the coalition government seems to want to dilute this health care domination of the policy agenda.

**Links with primary care**

Although the Dawson Report (1920) promoted the idea of close working between general practitioners and public health practitioners, and the Peckham Pioneer Health Centre experiment was essentially about promoting
community health and wellbeing from a health centre setting, collaboration between primary care and public health has been, in the main, a non-event. The National Health Act 1946 did not include prevention in the general practitioner contract and, even when anticipatory care was included many years later, this tended to be individually oriented clinical anticipatory care, rather than community focused. During the 1960s, when a major health centre building programme was launched, the result was decreased rather than increased collaboration, because general practitioners were suspicious that Medical Officers of Health would seek to coordinate all community-based services. Many influential general practitioners, including Pickles (1929) and Julian Tudor Hart (1988), have argued for primary care to exploit its public health potential and for the public health content of primary care to be explicitly recognized. Mant and Anderson (1985) even suggested that community medicine (as public health was known at that time) and general practice should move towards integration.

With the increasing recognition of the importance of the social determinants of health, the potential role for general practitioners and other primary care staff to look beyond the individual patient consultation to what is happening in the community where their registered patients live, and to apply community development and other techniques to make the community more health-promoting more salutogenic, should be being exploited, developed and researched (Walker, 2009). Sadly, this is not the case and the changes proposed by the coalition government NHS White Paper would appear to make this even less likely in the future.

Cuba has adopted a system where primary care physicians and nurse teams have responsibility not only for delivering health care to their patients, but also for the health of geographically defined populations (Evans, 2008).

**Future challenges**

In 2002, the European Public Health Association looked at the future of public health and identified the following main challenges (Noack, 2006):

- the future of public health can only be achieved if the whole of society invests in it; building partnerships is essential to this;
- the long-term benefits of public health should be taken seriously by policymakers;
- public health should form an integral part of the political agenda in all sectors;
- public health policy should be based on assets, rather than disease;
- research remains a solid basis for the development of public health practice and policy;
- research should focus on the needs of policy and practice;
- researchers should learn how to interact with politicians and practitioners;
- innovative ways to promote health should be encouraged;
- the future of public health should be based on the principle ‘think globally, act locally’, with policies set up at national or international level and
implementation at local level adapted as appropriate to local needs and circumstances.

Looking more parochially, the major public health challenges facing the UK relate to smoking – still an issue, though declining in importance; obesity; alcohol misuse; sexually transmitted infections/teenage pregnancies; and, dwarfing all these, inequalities in health. Drug misuse is also an issue, though more in relation to the evidence-blind, prejudiced approach to policy adopted by the government – the antithesis of a public health approach – than in relation to the scale of the problems caused by drug use, which pale into insignificance in comparison to those caused by alcohol misuse, for example. These challenges are also faced to a greater or lesser degree by other developed countries.

Adopting a global perspective, in *The Public Health System in England* Hunter et al. (2010) add climate change to this list. They conclude that what is needed is a new public health movement, a revival of the spirit of Alma-Ata, to meet these challenges, and suggest that the WHO European Region Health Charter adopted in 2008 in Tallinn could signal such a revival.

To me, it is clear that the immediate challenge to the public health community is to ditch the muddled thinking and internal conflicts, and the preoccupation with occupational positioning of the past, and embrace the new wellbeing paradigm. The public health community has the skills and experience to provide leadership in this new world, but only if it does not look back.

**From public health to wellbeing: the path for progress**

To the ancient Greeks, health (*hygeia*) and wellbeing (*eudaimonia*) were distinct. In Aristotle’s discourse on the meaning of *eudaimonia*, health was a necessary but not sufficient component of *eudaimonia*. To the more practically-minded Romans, wellbeing and health were the same: *salus*.

Until 1946, generally speaking, health was defined in objective terms as the absence of disease within a Cartesian framework where mind and body were conceived as entirely separate. In that year, however, the fledgling WHO defined health as much more than this: a complete state of physical, mental and social wellbeing. The source of this ground-breaking definition is not clear, and no definition was offered of the term ‘wellbeing’. It could be argued that it is conceptually confusing to conflate mental wellbeing (a subjective state of mind) with physical and social wellbeing (clearly, objective states). However, the 1946 WHO definition established that, in essence, health and wellbeing were one and the same thing.

With the dawning and development of the wider determinants perspective on health in the wake of the Alma-Ata Declaration in 1978 and the Black Report in 1980, there began a gradual moving away from the medical model of health as the absence of disease to an all-embracing concept that increasingly matched the 1946 WHO formulation, with an increasing focus on social wellbeing and the social determinants of health. This effectively took health
out of the hands of doctors and the health care community, and handed it to the whole of society.

In spite of this broadening of perspective, the link between health and wellbeing was not acknowledged by the public health community, and the use of the term ‘wellbeing’ in public health discourse was rare. It did gain currency, but in other disciplinary communities – particularly in the field of sustainable development and Agenda 21. (Agenda 21, the outcome of the United Nations Conference on Environment and Development held in 1992, is a comprehensive blueprint of action to be taken globally, nationally and locally by organizations of the United Nations, governments and major groups in every area in which humans directly affect the environment.)

The reticence of the public health community in adopting Agenda 21 is a puzzle; adopting it would allow it to spread its sphere of interest and involvement to, quite literally, every aspect of public sector, voluntary sector and even private sector activity. Naturally, the converse is also true, and it could be that putting up the 'keep out' notice in respect of its own bailiwick is, ultimately, more important to the public health community than expanding its empire by responding positively to the challenge and opportunity of the wellbeing concept. The territorial imperative is very strong, particularly in those who feel insecure!

However, if ‘health’ and ‘wellbeing’ mean the same thing, does it matter which term is used; does using the composite term ‘health and wellbeing’ help? To most people, including politicians and policy-makers, the term ‘health’ is still strongly linked to doctors, nurses and health care, and is thus severely restricted in its field of vision. Without adding the term ‘wellbeing’, the term ‘health’ tends to have the traditional ‘disease focus’. It could be argued that in time this myopia will be overcome as an understanding of the significance of the wider/social determinants grows. However, the current issues and future challenges to public health are with us now and need to be tackled – now.

Adopting the word ‘wellbeing’ instead of ‘health’, it is suggested:

- would make it much easier to engage local authorities, non-health-related disciplines and the public;
- would make partnership working easier, at least for local authorities and the voluntary sector;
- could weaken the impediments of medical and health care hegemony;
- might even, paradoxically, make it easier for general practitioners to take on a local community development role; and
- would make engagement with the sustainable development and inequalities agendas much easier at local, national and global levels.

Adopting Wanless’ (2002) terminology, it is posited that the use of the word ‘wellbeing’ would be more likely to secure the fully engaged scenario in tackling current issues and future challenges than using the word ‘health’. Without a fully engaged scenario, progress will be slow and piecemeal, at best.

It is tempting to conclude that the two terms should co-exist, with each being used in the appropriate context – ‘wellbeing’ when dealing with the
social/wider determinants agenda, and ‘health’ in conversation with the health care community and those involved in the traditional public health fields of public protection and health care improvement. This would be misguided, however, because there is a growing realization that, within the NHS and public health, there is a state of what might be described as ‘institutional disease-ism’; that is, a focus on disease entities, rather than the subjective experience of them. This is not to say that a focus on diseases is no longer important, only that modern enlightened health care and public health practice requires a balanced consideration of both objective and subjective elements. If using the composite term ‘health and wellbeing’ makes it easier for this to happen, this is reason enough to use it. And, lest it be thought that a focus on wellbeing as well as health might compromise the extent to which measurement is possible, as demonstrated in Chapter 2, subjective and objective wellbeing are measureable – often using the same metrics as are used to measure objective and subjective health.

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