ScotPHN report

Scottish Public Health Network (ScotPHN)

Palliative and end of life care in Scotland: The rationale for a public health approach

Briefing Paper 1: The evolution of public health

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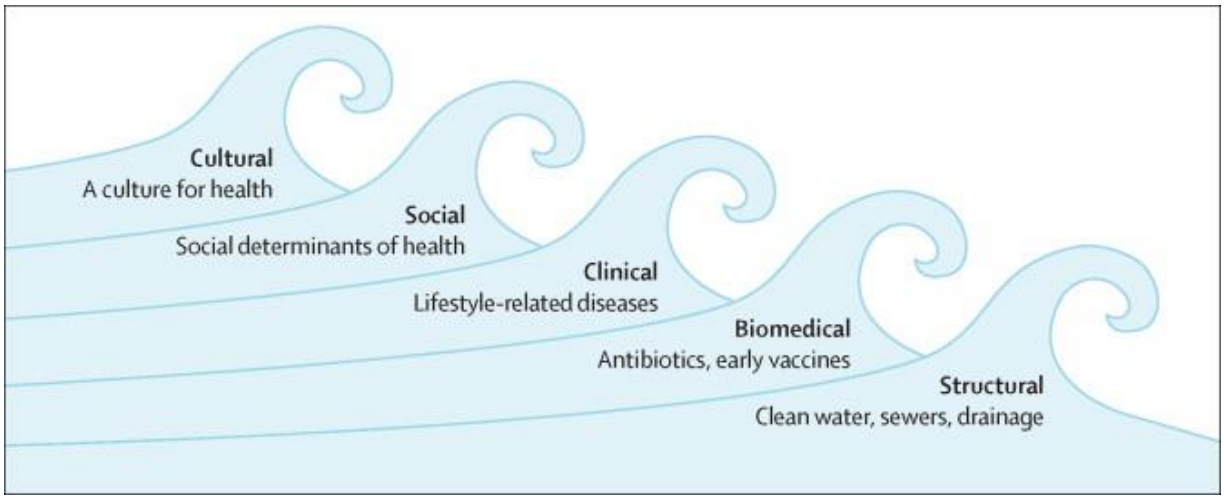
This briefing paper, accompanying the report 'Palliative and end of life care in Scotland: the rationale for a public health approach,' provides a historical perspective on the evolution of public health in the UK context based on the conceptual framework developed by Hanlon and co-workers[1].

The evolution of public health practice in the UK can be conceptualised as a series of interlinked waves (Figure 1) [2]. Successive waves are a response to evolving needs and emergent scientific and cultural norms. The first wave (from around 1830 – 1900) emerged in response to the social and environmental impact of the industrial revolution. This has been characterised as a 'top-down' structural approach to addressing the emergent public health problems of the time – lack of clean drinking water, poor sanitation and overcrowding. These conditions created an environment where infectious diseases such as cholera spread effectively. Public health action focused on structural interventions to improve sanitation, housing and working conditions. The Great Public Work began and embryonic governance structures for public services such as the police force, emergency services and orphanages emerged.

Figure 1. The five waves of public health[2]



This first wave led directly to the second wave (from 1890 – 1950), which is characterised by biomedical advances. Scientific discoveries from the first wave were refined and new advances made in the fields of medicine, engineering, manufacturing and transport. Miasmic based theories of disease gave way to germ based theories of disease. The body was conceptualised as a machine to be fixed. The biomedical models of prevention (vaccinations emerged) and treatment (penicillin was discovered) of disease that remain with us today emerged. The concepts of 'experts' in narrow specialist fields gave rise to a paternalist approach to health alongside structural approaches to health such as The 1853 Vaccination Act.

A third wave (from 1940 – 1980) is characterised by with the growing recognition that despite material advances and public health progress there had been little impact on chronic diseases such as cancer, cardiovascular disease and diabetes. A greater understanding of the causation of chronic disease and the wider determinants of health emerged and health was considered the result of the conditions of everyday life. Structural interventions to improve the health of the population through addressing the wider determinants of health emerge, for example the National Health Service (NHS), the welfare state, universal education and the development of social housing. Latterly a focus on preventative actions to target risk factors for disease in high-risk populations was pursued. These are the origins of stratified medicine.

A fourth wave (from 1960 – present) followed characterised by a preoccupation with *individual* risk behaviours (alcohol us, smoking, diet, exercise), the language of choice and a growing awareness of social inequalities in health. A number of features of modern society emerged over this time. The post-industrial economy moved from manufacturing to service and knowledge industries. Family structures and gender roles changed with falling fertility rates, an increasing divorce rate, rise in lone parent families and a greater number of women entering the workplace. Economic, social and environmental change affected community cohesion with a profound impact on health and wellbeing, as illustrated by the sharp rise in death rates from accidents, violence, suicide, and drugs in young men recorded over this period. Consumer demand and expectation grew as trust in institutions fell. Spiralling health care costs associated with ever advancing medical technologies with diminishing returns led to a focus on evidence based interventions that demonstrated not just effectiveness but cost effectiveness. The re-emergence of infectious diseases such as HIV/AIDS refocused public health activities on population level interventions aimed at prevention and harm minimisation. Through an awareness of the complexity of the existing and emerging pathologies, widening health inequalities and the inadequacy of a clinically orientated service response, a renewed interest in the economic and social determinants of health developed, in the UK pioneered by Sir Michael Marmot. In 'Fair Society, Healthy Lives' Marmot argues that economic growth is not the most important measure of a countries success; social justice, the fair distribution of health, well-being and sustainability are important social goals[3]. This can be achieved through action on policy objectives that include a focus prevention of ill-health and investment in the early years, ensuring a healthy standard of living and creating fair employment, enabling people to maximise their capabilities and have control over their lives, developing healthy and sustainable places and communities.

Internationally, this ethos had been articulated in the 1986 WHO Ottawa charter for health promotion that identified five areas of action to ensure that citizens had an 'economically productive' level of health[4]. These actions included: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, re-orientating health care services toward prevention of illness and promotion of health. There are a number of key components of this charter. Firstly, the recognition that we are all equal citizen with shared responsibilities for health – when considered in relation to delivering public services this is often called co-production. Secondly, that there are wider social, economic

and environmental determinants of health that must be addressed. Thirdly, the need for prevention and early intervention. Fourthly, that this cannot be achieved by strategic health policy alone, but requires people and communities to identify and use the skills, knowledge and potential within them to work together to build capacity and social capital. This is called an asset-based approach, which builds resilient people and resilient, connected communities. A policy programme, Health Cities, was established in 1987 to implement the Ottawa charter[5]. The underlying principles of Health Cities are that health is a positive concept, health is an holistic or ecological concept (not solely concerned with medicine) and that health is concerned with inequalities. These strategies were consolidated in 1997 Jakarta Declaration[6].

This forms the basis of a fifth wave of public health which it has been argued is now needed in light of an increasing burden of disease, persistent social inequalities and their impact on health and well-being and the emergent features of modern society including individualism, consumerism and materialism. It has been argued that a fifth wave of public health is inevitable as an adaptive repsonse to our current development being unsustainable and a growing disasisfaction with modern life. A fifth wave is characterised by a culture for health and wellbeing achieved through co-production and asset based approaches. The biomedical approach has limitations. It is a fallacy that we can create a death defying scoiety. Instead we must focus on what it is to be human, the lived experience and the notion that because health and well-being are societally determined to make a health society we need to begin with compassionate people and communities.

References

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