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# Part I

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## Public Health and Nursing: Origins and Development

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# 1

## Holding Public Health Up for Inspection

JOEL RICHMAN

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The key points discussed in this chapter include:

- public health definitions: the political and social significance of public health in contemporary society
- key historical public health changes that have influenced the development of public health in the UK
- the link between industrialisation and the development of the ‘new public health’ in the twentieth century.

### **Introduction**

The purpose of this chapter is to consider some of the key definitions of public health, highlighting its importance in terms of its analytical and moral status. In doing this the chapter will develop an historical and cross-cultural perspective on public health, noting the diffusion of public health with colonisation (an ‘early stage’ of globalisation). Public health is a multiplex concept consisting of a wide range of interpretations, social, political and economic, with many lay and professional practices, values and ideas embedded within it. From a sociological point of view, consideration is made of the various debates about the ‘new’ public health and especially whether it constitutes a new social movement with a modern health agenda. This necessitates the provision of an outline of some of the discussions about public health within current health delivery. The chapter concludes with a consideration of lay beliefs and their importance in defining ideas about health, as well as a look forward to some of the underpinning issues associated with public health which will hopefully sensitise the reader to their more substantial unfolding in later chapters.

## Differing Perspectives on Public Health

Public health has been variously described as 'old' and 'new'. Ashton and Seymour (1988) locate the 'old' within the excesses of industrialisation in Europe and North America; rapid urbanisation, overcrowding and squalor; one-third of the population of Manchester (1821) living in cellars (see Engels, 1982). Contagious diseases were rampant: smallpox, cholera, tuberculosis and measles. Public health based on environmental interventions was then called the 'Sanitary Movement', spearheaded by medical officers of health armed with National Public Health Acts, for example 1848 and 1875. The 'New Public Health' (often assumed to originate from the report of Lalonde, Canadian Minister of Health, 'New Perspective on the Health of Canadians', 1974) transforms the environment into the social and psychological, with the promotion of healthy life-styles, individual responsibility and risk reduction.

There are numerous perspectives that may be developed on public health, although a focus will be placed on three key approaches that encapsulate much of the debate taking place in the current and last century. First is the belief that we, as consumers, have taken responsibility and control of our own health. This belief incorporates the idea that public health has professional and lay dimensions. The latter focuses on the idea that we, as consumers, are responsible for our own health and historically demonstrates how there has been a shift in power between the professionals and the consumer. It may be argued we are now advised and taught by the professional experts about what we need to do in order to stay healthy (Illich, 1976). Second, and in a related way, it is clear that power relations between the health professional and the client have changed and we no longer need feel that we are dependent on the experts. Third, the notion of health being available from within large institutions such as hospitals is changing and, although we see health care becoming more available, the idea of institutional care is an important part of our awareness of public health (Acheson, 1988).

Public health practitioners (as discussed by Haggart in Chapter 9), recognise that most illness episodes are treated by self-medication with a limited contribution made by health professionals. Diet and exercise are promoted for reducing the demands on the medical hegemony. In Woody Allen's quip, 'you eat brown rice and live forever', we see evidence of the idea that becoming healthy is one issue but staying healthy and being healthy are matters for individual compulsion. Illich (1976) further argued that people should stop being addicted to medicine, that is, having cultural iatrogenesis. Medicine, Illich argues, has mystified everyday life, making us a passive commodity of its production. In order to take responsibility for our own health we need to become more active in challenging

medical beliefs but at the same time develop a more positive orientation and take responsibility for maintaining an optimum level of health. This works well if you are in reasonably good health to begin with and there are no major social issues impinging on your life chances such as poverty or unemployment affecting your health.

The role of the patient has changed and increasingly we are exposed to the idea that we are less dependent on the professional and in the process have become more liberated health consumers. This, as King points out in Chapter 6, has been partly due to the influence of the media in drawing our attention to healthy images and the need for us to develop and become better role models for our children. Does the image of the 'couch potato' conjure up a negative enough image to make us want to start that diet right away? Historically, there has been a shift in power so that we now may be seen as agents of our own health futures. At the same time, however, we are seeing increasing evidence of the non-compliant patient (refuses to obey doctor's orders) becoming a health negotiator, wanting to know why we take the medication, for how long and what the side effects will do.

The third perspective being drawn upon is the idea that health delivery is 'out there' and health is institutionally based. This is an issue discussed in more detail by Haggart in Chapter 9. Historically, the Ancient Greeks, for example, regarded health as part of the cultural component of society and fully visible. Today there are debates as to how far medical control, institutionally based, with its high technological intervention, should contribute to public health. Specifically, feminists, citing the over-use of Caesarian sections, have argued that birth is too high tech. Foetal monitoring is only needed in 2:3,000 cases. The Caesarean section rate of 25 per cent has doubled in the last twenty years (the UK having the highest rate in Europe, Richman, 1987). WHO guidance suggests that Caesareans in developed countries should be no more than 10 per cent. The shortage of midwives has been one of the thrusts behind the increase in hospital Caesarean birth and minimal domiciliary delivery.

## What is Public Health?

For many, public health is 'taken for granted' with no need for definition. Le Fanu's (1999) prize-winning *Rise and Fall of Modern Medicine* does not index 'public health'. Instead, a chapter titled 'Seduced by Social Theory' notes public health targets and is critical of the changing and contradictory health advice provided by certain food manufacturers as 'going beyond common knowledge' (p. 314) and causing illnesses. Porter's (1997) *magnum opus*, a history of medicine from 'antiquity' to the present does

index public health's diverse activities but still does not offer a working definition. Contemporary policy documents such as *The NHS Plan* (DoH, 2000), the template of government policy, sets out a myriad health targets but also omits a public health definition. None of its sections discusses public health. Of the 134 contributors to the plan (Modernisation Action Team Members), only two have the title 'public health' attached to them. Despite this, we are informed by Griffiths and Hunter (1999) that public health has become more fashionable since Labour came to power in 1997 and the appointment of the first Minister for Public Health.

Earlier writers, for example, Brockington (1960) gave more extensive definitions of public health:

The application of hygiene, the science which seeks to preserve health to the body corporate, the community. All knowledge which can help to maintain its health, social, scientific and medical, comes within its purview; medicine plays a predominant but not exclusive role.

It is noteworthy how the nineteenth-century residuality of public health lingered and that medical knowledge, although differently systematised, was still regarded as amicable towards the public health enterprise. This definition relied heavily upon the WHO (1952) extensive framework for public health, a global birthright of health and longevity:

The science and art of preventing disease...promoting health and efficiency through organised community efforts for the sanitation of the environment, control of communicable infections and the education of the individual in personal hygiene, the organisation of the medical and nursing services for early diagnosis and preventive treatment of disease and development of social machinery to ensure for every individual a standard of living adequate for the maintenance of health.

The WHO promotes public health as a fully integrated system, with 'community' as a core unit of social action, but fails to explicate *types* of political, power relationships necessary for transformatory health relations.

## **The Meaning of Public Health**

It would appear that definitions of public health are of limited substance. There is no attempt to define key components, for example, 'community' and 'public', which appear to be used synonymously. Hillery (1995) identified 94 definitions of community; all they had in common was some agreement that it involved people! There are examples of how such

connections have been made in the past, such as the de-institutionalisation of psychiatric hospitals that was similarly predicated on the belief that 'community' was a term which exuded warmth and emotional well-being (Tonnie, 1957). The chameleon of community soon merges with another taken-for-granted, 'environment', and more recently the politically engineered Primary Care Trusts. However, the Jakarta Declaration (1999) did add the refinement that both the public and private sectors should promote health and restrict harmful substances like weapons. To overcome the above difficulties some writers resort to a trait (activity) representation of public health, which is continuously multiplying to now include resistance to antibiotics and fluoridation (once heavily promoted by the dental profession). The latter is now considered an infringement of personal rights. Griffiths and Hunter (1991:1) succinctly sum up our position: 'One of the problems with public health is that it can be everything – the air, the food or water, health behaviours, health sciences.'

The meanings behind public health are often not made clear. In particular, the varied perceptions of 'social health problem' are not explicated, especially when a global perspective is adopted which increasingly happens when using comparative data on health (see Costello *et al.*, Chapter 4 re globalisation issues). Looking at the differing meanings of public health causes the reader to consider to what extent is the reality of public health separate from the rhetoric about health care in general. To develop a wider perspective, then, a closer look at different perceptions of public health is required.

## Perceptions of Public Health

For public health to be regarded as 'totemic', a guide to our sense, it is better to explicate the three categories of thought enmeshed in public health.

First, public health is a *moral category*. To be healthy implies to be in harmony; how and with what raises huge epistemological questions of an essentially philosophical hue requiring cross-cultural reference. Illness is a deviation from accepted standards of well-being. Plato argued, for example, that on balance a healthy life would be more pleasurable. Public health takes this stance, implying it is a moral duty to maintain good health by adopting appropriate practices. Burls (2000:148) comments: 'Many public health practitioners take it for granted that, since their role is to work on behalf of populations to produce *maximum* health gain, utilitarian principles provide the fundamental ethical framework to guide their decisions' (our emphasis). Whether we like it or not we have a duty to have longevity.

Public health is also a *prescriptive category*. leading from the above, public health, like the Talmud or the Koran, injects a sense of religiosity – to do some things and avoid others. It creates new taboos and duties. We have to work at being healthy, following the Protestant Work Ethic – as in the gym, with ‘no pain, no gain’ as a new mantra. The public health gaze defines the world into opposites based on risk–danger/safety. Before we put a supermarket product in our basket it must be critically scrutinised for threatening additives. The risk–danger factor is under constant revision – it’s our duty to educate ourselves about changes (margarine is now a risk product for example). It’s now a duty to participate publicly – democracy in health decisions. The NHS Plan was not only hinged to a patient-centred health service but also has proposals to increase public involvement.

Finally public health is an *analytical category*. Through public health methodologies we are able to reach a greater ‘truth’ about our existence by demonstrating that this or that is valid. Public health contains the tools for evaluating the effectiveness of clinical practice and health interventions; cost-effectiveness and prioritisation (rationing of health) are some of the goals of public health. Public health practitioners are now front-line workers who, with their skills, can map out the needs of a local population and, to some extent, guard the perimeter of infection for families. They are also expected to increase the health resources of their patch – how, is by no means clear. It is expected that by contact with public health practitioners some of their skills/knowledge will pass to consumers like a laying on of hands. However, the role of a public health practitioner is variable and open ended, one that has to emerge by praxis. It is for that reason we now go on to locate the changing patterns of public health according to different contexts, to analyse whether there are threads of continuity.

## **The Origins of Public Health: Historical Perspectives**

Brockington (1960:3) perceptibly noted that public health, in some form, has existed as long as civilisation. ‘Inoculation against smallpox was practised in India and in China before the Christian era. Isolation of leprosy was enforced in the Roman Empire, which built leprosaria: the first isolation hospitals ... many religious abstentions concerned food and excretal pollution.’ Public health historians differ, however, regarding the societies to be taken as benchmarks. Rosen (1993) considers five critical periods: Greco-Roman; Middle Ages, with the devastating Black Death and related plagues wiping out over 30 per cent of the European population; Age of Absolutism (1500–1750); Age of Enlightenment (the foundation of rationality); and

Age of Industrialisation, from 1830 onwards. Brockington considers 'early public health' up to 1830 and then nineteenth-century and twentieth-century public health.

### ***Classical Greek and Roman***

The Romans engineered safe water and sanitary latrines, dating from 3000 BC in Crete. The Romans, especially, created a military medical service; each doctor, given a commissioned rank, looked after five hundred men. Alexander the Great's achievements would have been impossible without his 'field doctors'. The two rival Greek medical traditions based on Cnidos (which stressed the disease and elaborate classification) and Cos (emphasising the patient) were empirically based on observation, removing divine causation. Hippocrates (460–377 BC) in particular argued that epilepsy (sacred disease) had natural causations. In his '*Airs, Waters, Places*' (which can be read as a treatise on public health) he put great emphasis on the environment for well-being. He advised physicians arriving at an unfamiliar town to examine its position in terms of wind and sun. Florence Nightingale was also a great believer in 'invigorating winds/ventilation'. Broadmoor hospital was chosen for these healing qualities. Hippocrates noted that marshy waters gave rise to summer epidemics of dysentery, diarrhoea and malaria. The notion of 'miasmatic disorders' lasted until the late nineteenth century.

### ***Medieval and Renaissance Public Health***

This was a period when Greek and Arabic medical texts were 'rediscovered'. (In fact, Arabic medicine had kept Greek medical thought alive and translated many texts into Arabic.) For example, Alphanus, a Benedictine monk, voyaged to Constantinople in the eleventh century to acquaint himself with Greek texts. The Salernitan Programme of Health emphasised hygiene, diet and exercise as the basis of good living. Porter (1997:107) refers to it as the 'first home health manual'. The dominance of the Church set a rigid framework for medieval practice. Plagues were caused by divine retribution, or by Jewish unbelievers. Death was a church monopoly. The Church set up a register of approved physicians, usually clerics. Pilgrimages and healing shrines, especially dedicated to saints, were recommended. Epilepsy again became a divine illness. Hospitals expanded to treat returning crusaders. In the thirteenth century the professionalisation of doctors took off (for example, 1367 was the Fellowship of English Surgeons). The north Italian city states, Aragon and Valencia, by 1300 had

installed public physicians, later being emulated by the German cities. British cities were slow to adopt this policy. Cities swollen by trading activities initiated public health measures, Bruges being a leader in installing an integrated water and sewage network. To avoid increased pollution, certain tradespeople like slaughterers and dyers were not allowed to dump their waste in public drinking water facilities.

Lepers abounded and were stigmatised; forced into ghettos outside towns, made to comply with distinct 'dress codes' and sounding a bell when people came near. They were subjected to many rites of exclusion; forbidden to marry or to be buried in public cemeteries. Porter (1997:122) estimates that there were 19,000 leprosaria in Europe by 1225. When leprosy died out (no one knows why) the mentally ill, associated with witchcraft, became the new polluting outsiders, often being given to travelling merchants, drowned or locked away.

The largest threat came from periodic plague, often following trade routes from the Levant and China as did the 1347–51 bubonic pandemic. Doctors had no cure. Fires were lit in streets, as the Greeks had done, to disperse the so-called 'contagious miasma'. Commissioners for Public Health, now medical magistrates, with doctors relegated to advisors, were first set up in fifteenth-century Italian city states. Quarantine of people and goods was the only remedy against the plague.

### ***The Golden Age of Public Health***

The golden age of public health is regarded by many as the nineteenth and early twentieth century. During this time, many public health measures were fully institutionalised and engrained in reforming Parliamentary Acts. This section will examine the claims that the latter were more instrumental in raising the nation's health than clinical practices *per se*, as suggested by McKeown (1976, 1979) among others. The role of Florence Nightingale, as a leader of this sanitary movement and developer of community nursing, will also be explored. The impact of early globalisation, for example economic competition from Germany and colonial development, is another public health theme on display. The 'Sanitarian Movement' from the 1830s was stimulated by the morbidity and the mortality toll of rapacious industrialisation. Half of Manchester children died before their fifth birthday. A labourer in Liverpool had a life expectancy of 15 years. Factory reforms, for example, were not entirely based on humanitarian/moral grounds. Workers' revolts in Europe had their counterpart in the Chartist's demands. Unemployed workers formed armed gangs. It was important to neutralise growing discontent. (Marx had predicted that the first workers' revolution would be in England because of its advanced stage of industrialisation.)

However as Hamlin (2000) points out, Chadwick, the first leader of the Sanitarians, argued that poor health was not generated by worker poverty (he had devised the New Poor Law 1834, which forbade relief to the unemployed). Chadwick believed that the free market was God's natural gift. He singled out adequate sewage disposal and clean drinking water as the basis of good health (an old idea). Infections like cholera and fevers were due to miasma, toxic air from rotting debris. Miasma, a foul smelling vapour was the dominant illness metaphor before 1860. Sontag (1979) showed how some illnesses, incompletely understood at the time, like TB, came to dominate cultural understandings. Even the rich with good drains and sound body constitution were not immune from miasmatic illness (see Brocklehurst and Costello, Chapter 3 for further discussion). Its 'randomness' was especially linked to chaotic moral standards and rioting by the masses. It was believed that household overcrowding also precipitated mass incest. Miasma also became a metaphor for progress, Chadwick believed that the drains would not only take the filth away, but it could be transformed into fertiliser to increase food production for the expanding towns.

Chadwick's Public Health Act of 1848 created general boards of health, the first in London; they were set up where 10 per cent of the residents petitioned or where the death rate was above 23 per 1,000. Their medical officers were to remove the 'causes' of disease. The first International Public Health Conference 1851 met in Paris with 12 nations debating for six months. Sardinia, Portugal and Russia, for example, promoted increased use of quarantine. England and France subscribed to the miasmatic theory. By 1900 ten international conferences had met, and were especially concerned with the spread of cholera.

### *Florence Nightingale and Public Health*

Small (1998) discussed how Florence Nightingale, usually considered a founder of hospital nursing, was a convert to public health care. From her base at Scutari, in the Crimea, Nightingale attempted to improve conditions for soldiers affected more by the lack of hygiene than the conflict on the battlefield. She decided that it was necessary to focus on public health issues in an attempt to provide a more healthy environment. Despite her attempts to improve conditions, between 1854–55 ten times more soldiers died from illness (typhoid, dysentery and cholera) than from battle injuries. Besides learning four languages she was a very competent social statistician, being conversant with the work of Alphonse Quetelet (1796–1874) the Belgian social scientist whose statistical findings Comte, a sociological founder of positivism, incorporated in his technique

'Social Physics' and applied to mortality statistics and crime, discovering regularities (for example, crime was lower in countries of high education). Despite Nightingale's breakdown in 1857 (Small suggests guilt from the high mortality at Scutari) she statistically analysed 'her' failures, for example why soldiers amputated in the field mostly recovered but those in hospital did not. With the help of Dr William Farr, Superintendent of the Statistical Department of Registrar-Generals Office, she produced a confidential report on medical failings during the Crimean War. Farr had studied hygiene in the Paris Medical School, but no English equivalent would allow him to teach it; the medical establishment felt threatened by the subject. He questioned the fashionable miasma theory and attacked the doctors in his first report (1839) for being complacent about the infant mortality of 270 per 1,000. In his book *Philosophy of Health* (Farr, 1836), Farr argues that women were the 'original' health teachers and must become nurses.

Nightingale bombarded the Crimean inquiry with statistics: our mortality from diseases of the stomach and bowels at Scutari was 23.6 per cent, in the Crimea 18.3 per cent (Small, 1998:92). Nightingale later refined 'hygiene' to distinguish between personal (clothing and diets) and building hygiene. She argued that doctors were the wrong people to be in charge of 'building hygiene'. Nightingale was an astute politician, using friends in high places to get over her views based on statistical evidence. She replaced Chadwick as the opinion leader of 'public health'. Chadwick had made many enemies and was contemptible of those not sharing his views, attacking the Government for not supplying adequate funds for sewers. He wanted new taxes for these enterprises and for the middle-class electorate to pay more.

Nightingale's *Notes on Nursing* (1860) elevated 'household hygiene', for example, lack of 'white washing', ventilation, random diets all being the major health hazards. She believed that statistical findings, as nature's laws, should guide public health policy. She was deeply religious (not in a fundamentalist way), having claimed to have visions of God in early life. Florence Nightingale also took a great interest in India, noting that the creation of its own public health department was a noble task, creating India anew by introducing a higher civilisation.

Modern nursing was not only for healing the sick, but also for health promotion. Dossey (2000) claims that Nightingale's public health (care) work was a holistic extension of nursing. She criticised doctors for their excess power but was in favour of compulsory smallpox vaccination, which many anti-medical supporters were not. Idealistically, she looked forward to the abolition of all hospitals. She was opposed to women becoming doctors and also to the registration of nurses. Nightingale had studied nursing as practised by the Augustinians at Kaiserworth and

found the 'spirit' more essential to nursing. She regarded nurses more as health missionaries.

### ***The International Dimension of Public Health***

The international dimension of public health became more important towards the end of the nineteenth century. (The 1897 International Conference was concerned primarily with the spread of plague by Mecca pilgrims.) Fears had arisen that Britain was experiencing 'national degeneracy'. Economic superiority was challenged by the USA and German competition, the Boer War produced evidence of the unfitness of recruits. The 'dangerous classes' were aptly named: considered the major source of disease, not institutionalised into schools or work, they could be the instant street source of political discontent and their aggressive street behaviour hassled the middle classes, whose birth rate began falling in 1870. The Eugenic Movement was founded (eugenics was a term coined by Galton) to improve the population stock. It had many left-wing supporters like the Webbs, who had suggested compulsory sterilisation of the unfit. This became policy in Sweden, Germany and elsewhere. The Lunacy Act (1890), supported by notable doctors like Maudsley, classified the mentally impaired into lunatics, imbeciles and idiots; their differing degree of pollution/danger related to their spatial separation, like Indian caste. Maternity and child welfare also improved. The Child Study Movement started in 1896. Milk depots based on the Paris model commenced. The Infant Welfare Movement, initially consultation centres, spawned health visitors. To encourage the registration of births, Huddersfield gave one pound to the mother whose child survived a year. District nursing, the prototype of public health nursing, had commenced in 1859.

The USA, whose industrialisation and 'social evils' commenced later than England's, learned much from its experience. Ward (1972), a sociologist, founded the Henry Street Settlement 1893 for district and school nursing. The USA, similarly feared a decline in 'population quality' with the new immigrants from south Europe who took children's care very seriously. It established the Federal Children's Bureau, in 1908. Public health nursing commenced in the USA in 1887, those supported by private agencies were called 'visiting nurses'. Midwives in England and the USA had to be qualified nurses.

### ***Public Health: Home and Abroad***

There was a symbiotic relationship between the development of public health in England and in the Empire. The health of the 'native' was taken

to be an indicator of good and bad colonial power, with Belgium as the worst colonists. The Congo was treated as a private hunting reserve of King Leopold. Slaves who escaped from the plantations had their feet cut off. The French general, Lyautey, argued that colonialism had many blemishes but was redeemed by the doctor. Florence Nightingale laid plans for irrigation, sewage works, supported famine relief and low interest for peasants' loans. Some administrators did not believe in distributing food during famines; this would disturb the working of the free market. Nightingale supported Indian independence and in the abolition of the salt tax, which later initiated the Ghandi Nationalist Protest Movement. Some diseases were actually transmitted by colonists with syphilis known as 'Firangi Roga', or European disease.

The health of the English colonists, especially the military, was paramount for natives vastly outnumbered them. Parkes, Professor of Military Hygiene, recognised the importance of the soldier's diet, with a balance between fats, carbohydrates and salt, with plenty of fresh fruit. Cattle had to be inspected for anthrax and parasites before being consumed. The Army Sanitary Commission from the 1870s improved the ventilation of the barracks. However, Harrison (1994:70) argues that after the discovery by Robert Koch, 'The bacteriological thesis of disease causation heightened European anxiety about the medical dangers of the Indian people, saturated with infection'.

In 1870 one in twenty soldiers was hospitalised with venereal disease: most officers were unmarried, with prostitution the main sexual release. India's Contagious Disease Act of 1870 was modelled on its British counterpart with the compulsory examination of the suspected prostitutes and medical inspection of the brothels. The British Act only applied to small garrison towns, like Portsmouth, the India regulation to wider populations, like Calcutta. The main concern of the British was famine and the cycle of plague, the latter spread more easily by the extensive railway network. The Plague Commission recommended more 'health officers' to improve death registrations, an early warning system of 'plague'. A major ethical issue was whether vaccination against smallpox (introduced in the 1820s) should be compulsory, the debate mirroring its English counterpart on the freedom of choice. The 'cordon sanitaire' was a major defence against cholera, but this sanitary regulation disturbed pilgrimages. Of greater global concern in contemporary times is the spread of diseases such as TB, once thought to be eradicated. Changing patterns of communicable diseases indicate that certain risk factors have emerged as part of a pattern of globalisation (see Costello *et al.*, Chapter 4). Table 1.1 highlights the impact of selected communicable diseases and the threat they pose to global health as well as the environmental risk.

**Table 1.1** Selected communicable diseases posing a global health and environmental risk

<i>Communicable disease</i>	<i>Selected data</i>
Tuberculosis bacilli	One-third of world's population are carriers Kills 3 million people annually DOTs cost US \$3–5 per healthy year of life and prevents drug resistance which costs up to 100 times more to treat
HIV/AIDS	Infected up to 24 million adults of whom 4 million have died
Viral hepatitis	At least 350 million people are chronic carriers of hepatitis B and 100 million have hepatitis C

### *Global health*

In the late nineteenth century nurses worked in the colonies after their heroism in the Crimea. The Colonial Nursing Association (1895) sponsored suitable candidates, often those with missionaries and doctors as relatives. Initially they nursed Europeans, and were subject to strict sexual regulations keeping them apart from the natives. They were primarily administrators, running the wards with native nurses (often men) under training. European styles of care were introduced, relatives being forbidden to cook on the wards for their sick kin.

The colonies, especially Africa, became a 'laboratory' for testing public health theories. (Anthropology similarly used the colonies, with its 'extremes' of behaviour.) Kenya was a colonial laboratory for testing deficiency diseases; Margaret Mellanby used it for diet and tooth decay. The anthropologist, Audrey Richards, from her research on the Bemba (Zambia) claimed that 'colonial malnutrition' was a modern epidemic. (It must be also noted that African famines predate European colonisation.) Much governmental public health was focused, protecting primarily the health of whites and the African workers in mines and the plantations; rural health of women and children were neglected. Whites were often repatriated to colder climates (England) to recover, especially from mental illness. It is interesting to note that the NHS until recently had a similar policy of repatriation for Blacks suffering from mental illness. Jamaicans were sent to Belleview Mental Hospital, for example.

Summarising, McKeown (1976, 1979) argued that the main improvement in health, as evaluated by a declining mortality from infectious diseases,

was from public health interventions – improved nutrition, water safety and changes in personal behaviour. Future health profiles, although England was a ‘modern society’ in the 1970s, would still be dependent on an individual’s behaviour – diet, smoking and exercise. The mortality rates started falling from the nineteenth century, before key vaccination programmes for TB, measles, polio and successful antibiotics for pneumonia and influenza. McKeown, however, primarily fails to explain how, although there is increased longevity for males and females there remains a five year gap, the women living longer (1998, male 74.9 and female 79.8 years). This is a demographic feature of major industrial societies. Also, focusing on mortality overrides other powerful public health ratings – as with chronicity: despite increased longevity, the years free from limiting, long-term illness has changed only slightly. In addition, McKeown gives little recognition to some doctors’ participation in the public health changes. McKeown could not be expected to have commented upon the recent rise in prenatal deaths, with miscarriages; this also included pregnancy terminations. The latter has not been considered a public health issue, except indirectly related to ‘under age’ and teenage pregnancy rates.

## **What Is New About the Public Health Movement?**

That we talk of a new social movement presupposes there is clear differentiation from the old, that is, they are two separate entities. The issue is complicated: there is no general agreement on what ‘is’ a social movement. Saint Simon (1760–1825), the French ‘positivist’ and social evolutionist, first used the term as a means for bringing about a new ‘scientific age’. It is usually an alliance of different people who seek some aspect of social change. A movement is not as tightly organised as a political party, with its internal discipline of membership, but often has links with parties. They can be narrowly focused, as with the Thalidomide Society, and international with the globalisation movements. Cohen (1985) distinguishes between resource mobilisation, common in North America, and identity orientated movements, common in Europe. The old and new movements have in common mixed memberships, from political figures, health professions (last century mainly doctors) and some benevolent middle classes. The new have more nurses and lay clients, some politically active. Both movements regard good health and safe environment as an extension of citizens’ rights. Both regard appropriate diets/food as essential for maintaining the moral order. The nineteenth-century movement was more concerned with product adulteration and that of the twentieth century with safe levels of cholesterol, additives and fats, and so on. In 1900

Salford had the 'Poison Beer' scandal when 107 people died of arsenic poisoning. Caramel used to colour mild beer was contaminated with iron pyrites, producing arsenic oxide. The Camelford water pollution (1988), when 20 tons of aluminium sulphate was added, indicates that human errors are still possible. However, the distinction between food and medicine is often blurred. Smith (2001:171) exemplifies the latter by recounting how coffee was the most frequently analysed commodity in the Lancet's Analytical Sanitary Commission Reports on adulterations 1851–54. As a result of the development of microscopical techniques the public health discourse could now rely on universal, precise measurements. (The sale of impure coffee actually dates from 1718 legislation.) The medical, nutritional and moral claims for coffee often appeared in temperance literature. The medical claims for coffee covered indigestion relief, mental stimulation (especially for craftsmen) and 'constitutional restoration' (especially from the added milk).

## **Lay Beliefs and Public Health**

We are all able to offer explanatory accounts of health and illness. The explanations offered are often called 'lay beliefs' and are commonly at variance with the explanations produced by the bio-scientific model of the sick role used by doctors. From an early age children begin to learn the 'causation' of illness. Mothers tell children not to go out with wet hair, or to wear a vest, lest they 'catch a cold'. Unless public health specialists are able to appreciate and make sense of lay beliefs, their health promotion models will remain limited.

The new public health launched as the Public Health Alliance (1987), was a patchwork coalition of the 'left' with a new agenda. The old Labour had been out of office for almost a decade and didn't look like immediately returning. The action brought together the Trade Unions, community action groups, local authorities, the voluntary sector and ethnic-based interest together with sympathetic health workers, for example, some radical GPs. After Labour's third election defeat in 1987 it realised that 'classical' class action to reduce inequalities had rapidly faded. The collapse of the Soviet bloc reinforced this view. The much-concealed Black Report (1980) on health inequalities had little chance of being operationalised by the Conservatives. The new public health shifted health responsibility from the individual to the social. The WHO Alma Ata declaration (1978), 'Health for All by 2000', was adopted by the new public health, The Lisbon Healthy City initiatives was also another plank. The new public health was more global in policy than its old counterpart. The new public

health practitioners are part of the service class (which did not exist last century). They work within the ideological state apparatus. They are concerned with the circulation of health resources as well as being consumers of it in their own right. Their targets are state given, for example, the *NHS Plan and Saving Lives: Our Healthier Nation* (DoH, 2000). In all, Labour has set out over six hundred health targets (for example, to reduce the death rate from cancer in people under 75 by at least 20 per cent by 2011). This followed the target style of the Conservatives in their *Health of the Nation* (DoH, 1992), introduced with little consultation from the medical profession. The primordial contract of the individual emerging from the multifarious health targets is that of the one-dimensional individual – holism has been lost with the body and self fragmented into health target areas.

Williams (1983) unravelled the lay logic of health held by early Aberdonians (over sixty years) in middle and working class estates. Both believed that ‘strength’ was an important constituent, a property that could be stored for future use, thereby minimising the effects of impending illness. If it was dissipated, then the capacity for quick recovery would be lost. The Protestant ethic ideologically, too, emphasises ‘conservation’. ‘Fitness’ is the second constituent of health. The young are super-fit – fit for anything. The elderly consider themselves fit for specific activities, for example, shopping, gardening or being able to climb stairs. A third constituent of health is absence of disease. Pain was an indicator of this. Health specialists telling the aged to be highly mobile runs counter to their belief of storing good health for the winter with its potential illness crises. Other strategies to get the elderly to exercise have to be used like entertainment – social dancing, and so on.

The bio-medical model regards lay beliefs as erroneous, trivial, subjective (as opposed to ‘universal’ scientific knowledge). Lay beliefs are held by the majority; invoked to answer the ‘why me’ question which doctors avoid. Paradoxically, when the medical model cannot produce scientific explanations it also smuggles into the consultation its own lay beliefs – for example, the mysterious ‘virus x’ to explain ME as a ‘post viral infection’. Pilgrim and Rogers (1998: 67) argue that there are epistemological grounds for doctors ‘following’ some lay beliefs (they were concerned primarily with psychiatry). Lay accounts are an important resource for understanding the patient’s social context, producing valuable, family knowledge to aid diagnosis, and so on, ‘thus lay knowledge and expert knowledge are mutually dependent and should not be studied in isolation from one another’. On the whole lay beliefs form part of an external health belief model – the causation of illness is ‘out there’; the bio-scientific model is primarily an internal model – causation within the body. However, when the internal model exhausts its explanations it does not hesitate to scour the ‘external environment’ for an illness linkage, like stress as a cancer causation. Many

ancient health beliefs, for example, Chinese or Ayurvedic medicine, are primarily external health belief models.

## **The Future for Public Health**

The future for public health is both challenging and promising in terms of the scope for development of the public health movement and the many possible difficulties it faces. The Secretary of State for Public Health, in a lecture at the London School of Economics, 8 March 2000 commented: 'The time has come to take public health out of the ghetto' (Public Health, Select Committee, 2001:14). The minister argued further that its problems were forcing it to equate with the medical model. Public health as a movement faces enormous challenges and criticisms. One of its central planks is the notion of 'empowerment', which may be seen as a piece of rhetoric which uses the idea of power sharing by providing health recipients with choices but which in practice reinforces an existing paternalistic relationship.

There are numerous changes taking place in public health which are yet to develop into effective policy initiatives (Select Committee 2001:21), such as the development of the Health Development Agency (HDA), Health Action Zones (HAZ), Health Improvement Programmes (HIP), Health Living Centres (HLC), Public Health Observatories (PHO), Health Impact Assessment (HIA) and the National Institute of Clinical Excellence (NICE). Reflecting on these numerous initiatives, it may be argued that New Labour could be accused of 'initiative overload'. The Reporting of the Chief Medical Officer (2001) and Select Committee called for public health to cohere the fragmented NHS structure. There are parallels here with the Barclay Report (1982) with its idealistic design for social work to orchestrate community interests and organisations into a seamless service. The challenge for public health is to establish 'strong partnerships' at all levels for a broad-based approach to public health (p. 120). A new style of 'strong leadership' will be required with the need to build the evidence-based practice. Health policy should benefit the less well off on a sliding scale rather than targeting the most deprived (p. 127). Local leadership should also be involved. The Chief Medical Officer's Report goes over much the same territory and suggests 'strengthening the public health skills' ... 'working alongside clinicians' ... 'to meet needs' (p. 37) ... 'strengthen the multidisciplinary' nature of the public health and PCG/T. There should also be provision for GPs to gain training in public health and have correspondingly a relevant career structure. There should also be a three-year rolling public health development plan for education, training and organisational development covering different sections of the public health workforce

(p. 29). The Select Committee ends by stating that the Government must learn the lessons of previous policy, 'particularly with regard to political leadership and commitment making health improvements a central priority' (p. 136). With its public health proposals, as a prescriptive exercise, it is limited. It fails to give details of much of the operationalisation thrust needed. It assumes 'strong leadership' (undefined); and 'joint partnerships' (undefined) are talisman. The tacit rules of the organisational settings are totally neglected. Giving public health a networking function to cohere disparate health organisations may appear pictographically neat in future health documents, but that does mean a new 'health synthesis' has been achieved. To increase the professional status of public health with new higher degrees and the creation of the new Health Development Agency and Public Health Observatories may actually increase the inter-professional rivalries already existing in health delivery. The Select Committee's suggestion that the NHS Executive Regional Offices can take a greater strategic role in public health (p. 136) may be the catalyst for its networking. Much depends on the Government's serious intent of raising the profile economically and clinically of primary health care at the expense of the entrenched hospital base.

## Conclusion

In conclusion, it may be seen that public health historically has come a long way in the last decade and as health care has become more complex so too has the design and delivery of health services. The chapter set out to open up public health debates for the reader to see how far and how much the movement has progressed. In the following chapters the reader is exposed to the many social and individual issues influencing public health (Chapter 2) and asked to consider the relationship between the underlying causation of illness such as social class differences (Chapter 3) and poverty in order to develop a fuller appreciation of those factors contributing towards public health. Taking into account the multicultural nature of modern society Costello *et al.* in Chapter 4 examine and debate the health needs of diverse ethnic groups and the needs of those seen to be vulnerable in our society (Chapter 5). Chapter 6 considers the way in which media portrayals of health can provide and help to construct a distorted image of health as we struggle to develop a clear picture of what health is. Maria Horne, in Chapter 7, takes us through the process of assessing health needs by focusing on community health issues and the public health assessment strategies used to develop ways of meeting need for large populations. In Chapter 8 Costello's examination of the political

implications of public health describes and analyses the work of the Government's Social Exclusion Units, introducing the reader to the ways in which social change is taking place from a political perspective. In the final chapter, Haggart considers the role of public health nursing and assesses the future of public health from the viewpoint of practitioners who take responsibility for the health of individuals and families.

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