Chapter 2

Promoting the Public Health: Continuity and Change over Two Centuries

Jenny Douglas

Introduction

This chapter explores the origins of public health in the UK, documenting the political influences which led to the passing of the first public health Act in England and Wales in 1848. Although heralded as a turning point in the recognition of the role of poverty and environment in determining health status, the initial permissive public health act had to be strengthened by compulsory legislation and the development of a public health infrastructure which then became dominated by biomedical perspectives. The chapter will outline the more recent development of the 'new public health' and track the emergence of health promotion from the Ottawa Charter (WHO, 1986) to the Bangkok Charter (WHO, 2005). In exploring definitions of health promotion from the USA, Canada, and the UK, it will demonstrate the contested nature of health promotion, the divergence in understandings of health promotion and the relationship of health promotion to the 'new public health'.

Charting the renaissance of public health in the UK from 1988 to the present, the chapter looks at the development of modern multidisciplinary public health. The publication of UK public health strategies heralded a resurgence in public health, changes in the Faculty of Public Health Medicine to become the Faculty of Public Health and the development of competencies for public health. The influence of reports such as the Wanless Reports is explored and the relationship of health promotion to public health as part of multidisciplinary public health is examined. The conflicts and tensions that have emerged as a result of differences between policy and practice are interrogated as is the role that politics has played in developing public health in primary care organisations, local authorities and voluntary organisations.

The origins of public health in the UK

Politics and public health are inextricably linked. The origins of the first Public Health Act – An Act for Promoting the Public Health, 1848 – lay outside the health considerations and

instead with the report of Edwin Chadwick on the state of poor people in England. Critics argue that Chadwick, as the architect and enforcer of the 1834 Poor Law, was not so much concerned with inequalities in health but with reducing costs caused by the death of male breadwinners from infectious diseases, which left families dependent on relief, and that it was in fact the Poor Laws themselves which caused ill health (Hamlin and Sheard, 1998). Whatever the historical reasons, the Public Health Act was passed in England and Wales in 1848 and was stimulated by a concern to improve sanitary conditions in thriving urban areas. A Central Board of Health was established which oversaw the implementation of the Act, although it had few powers and few resources. The Act did enable local people to get involved in health action, however, by allowing local health boards to be established if more than 10 per cent of the population petitioned for one. The Act therefore witnessed one of the first social movements of lay people in public health. Failing to produce the desired results, the 1848 Act was superseded by the 1866 Sanitary Act, which compelled local authorities to remove 'nuisance', and the Public Health Act of 1872, which created organised public heath services across England and Wales, dividing the two countries into urban and rural sanitary districts each with a public health board and its own Medical Officer of Health. Thus even in the 19th century there was a tension between reducing inequalities in health and establishing public health services. From the mid-19th century, however, public health became dominated by doctors and biomedical perspectives of health underpinned by the study of epidemiology.

The 'New Public Health' and health promotion

With the establishment of the World Health Organisation in 1948, notions of health started to change and move away from purely biological explanations. Recognising the limitations of a purely medical approach, Winslow, in a World Health Organisation monograph, defined public health as the 'Science and art of preventing disease, prolonging life and promoting physical health and efficiency through organised community efforts ... 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, 1951), thus moving away from a definition of public health which was located purely in public health services. The evolution of the 'New Public Health' and the birth of health promotion were inextricably intertwined and public health and health promotion have continued to influence each other over the ensuing decades. Both emerged in the 1970s with the publication of the Canadian health minister's report (Lalonde, 1974). While still placing emphasis on behavioural change, the Lalonde report pointed to the importance of the environment as well as biology and health services in maintaining and promoting health.

Health promotion – from Ottawa to Bangkok

From the mid-1980s, the role of health promotion as a movement for social and political change was elaborated in a series of health promotion conferences and charters, starting with

the Ottawa Charter, which defined health promotion as 'the process of enabling people to increase control over the determinants of health and thereby improve health' (WHO, 1986). This definition became widely accepted across the world. However, in the USA, health promotion was defined as 'the science and art of helping people change their lifestyle to move toward a state of optimal health' (O'Donnell, 1986). The US definition of health promotion focused much more on lifestyles rather than on addressing the underlying determinants of health, and was further developed in 1989 to recognise that environments which support good health practice would probably have greatest impact in producing lasting changes (O'Donnell, 1989). While health promotion activities in Canada, Australia and the UK have attempted to focus on structural and organisational change, health promotion activities in the USA have been focused much more on lifestyle and behavioural change, utilizing health education approaches rather than an emphasis in healthy public policy. Here in the UK, however, critiics have argued that although the terminology of 'health promotion' was used, until the development of the healthy cities movement, health promotion practice in the 1980s was very much dominated by health education approaches. By the 21st century the scope and role of health promotion in developing healthy public policy were widely acknowledged. At the 6th Global Conference in Bangkok, the Bangkok Charter for health promotion in a globalised world was adopted. The Charter, recognising the impact of globalisation in the 20 years succeeding the Ottawa Charter, called for strong political action from governments, international bodies and corporate and private organisations (WHO, 2005).

It is worth noting that at the same time as the 'New Public Health' was emerging at an international level, spearheaded by developments in Canada and the World Health Organisation, in the UK, the health and local government reorganisation of the 1970s dismantled the local authority 'public health empire' under the Medical Officer of Health and replaced it with NHS consultant-based community medicine (Berridge, 2001). So while the ideology of the new public health embraced the need to look beyond biomedical understandings of health and to focus on the social, economic and environmental determinants of health, public health services in the UK moved back into the narrow confines of the NHS.

Modern multidisciplinary public health in the 21st century

The WHO's definition of public health was re-stated and further developed in 1988 by the Committee of Inquiry into the Future Development of the Public Health Function: 'science and art of preventing disease, prolonging life and promoting health through organised efforts of society' (Acheson Committee Report, 1988). Initiated by a concern about the continual reorganisation of the NHS and the marginalisation of public health and health protection, the review of the public health function in England led to the change of terminology from 'community medicine' back to 'public health' and the re-stating of the broader role of public health to take action on the wider determinants of health. The Acheson Report also called for the appointment of a Director of Public Health in each district and regional health authority and the production of an annual report on the state of the public health of the population, although public health services remained in the NHS.

The first formal public health policy in England was *The Health of the Nation* (Department of Health, 1991). Although this policy set clear targets for reducing ill health, the report was

heavily criticised for its focus on disease to the exclusion of an examination of inequalities in health. The election of a new Labour government in 1997 placed public health policy and practice high up on the agenda of health and social care agencies. It placed an emphasis on reducing inequalities in health and social inclusion and each of the countries in the UK published a public health policy which reflected this. While the scope and purpose of public health appeared to be huge and expanding, the concept of what constitutes 'public health' was still open to debate and challenge.

In England, The Chief Medical Officer's Project to strengthen the public health function (Department of Health, 2001), concluded that 'the aim is a strong, effective, sustainable and multidisciplinary public health function which is in good shape to underpin the delivery of the NHS Plan and to improve health and reduce inequalities' (Department of Health, 2001: 43). Recognising that people from a range of backgrounds contribute to the public health workforce, the report identified three different levels of involvement in public health: public health specialists from a variety of professional backgrounds, such as directors of public health and environmental health officers; public health practitioners, including nurses and health promotion specialists; and professionals whose work includes elements of public health, such as social workers, teachers and police officers.

Thus by the 21st century it was widely acknowledged that modern public health was multidisciplinary in nature and that an effective multidisciplinary public health workforce required that all public health workers were adequately trained. This gave rise to the question of competency to practise public health given that the public health workforce would be coming from diverse professional backgrounds. To this end, a competency-based framework for public health was developed in 2001 by Healthwork UK on behalf of a tripartite Steering Group comprising the Faculty of Public Health Medicine, the Multidisciplinary Public Health Forum, and the Royal Institute of Public Health and Hygiene, supported by the health departments of the four UK countries (Faculty of Public Health, 2005). National Standards for Specialist Practice in Public Health were produced and a voluntary register for public health specialists was established. The voluntary register for generalist specialists opened in 2003 and by 2006, 80 generalist public health specialists were registered. This was extended in 2004 with the development of a set of competencies for public health practitioners, although no register was established for this group.

Critics of the competency-based framework argue that the voluntary register reinforced an artificial divide between specialists and practitioners and served to reinforce 'old' hierarchies – namely between medically trained public health specialists and other groups. Furthermore, it is argued that individual public health specialists or public health practitioners could not be expected to meet the competencies in all ten key areas, and that if a truly multidisciplinary approach were to be adopted, the competencies should be measured across a multidisciplinary public health team. Nevertheless, standards for defined specialists (e.g. health promotion, information specialists) have been devised and the voluntary register for defined specialists opened in 2006. In nursing, public health competencies are outlined in the third pathway for NMC registration (Nursing and Midwifery Council, 2003).

There has been keen debate about the boundaries between public health and health promotion. MacDonald (1998: 28) has stated that: 'the principles and content of modern health promotion are identical to those of the new public health'. However, as public health has risen up the political agenda, critics have argued that health promotion and health promotion specialists seem to be disappearing (Scott-Samuel, 2003). Health promotion specialists are a group of health professionals who have received limited attention in the

academic literature on developing the public health workforce, although they make up the bulk of the multidisciplinary public health workforce (Department of Health, 2005). Despite the 20-year history of health promotion, new terms such as 'health improvement' or 'health development' are increasingly being used. For some, health promotion is seen as an integral part of the public health function.

Despite the rhetoric espoused by successive UK governments' public health strategies about the importance of a multidisciplinary public health workforce, differentials persist between the professional status and financial remuneration of different professional groups. While health promotion specialists make up the bulk of the multidisciplinary public health workforce in England and Wales, many health promotion practitioners point out that they do not receive the same remuneration or professional recognition as medically qualified public health practitioners.

Despite the reviews of public health in the four UK countries and the development of public health White Papers, it was the Wanless Reports which placed public health high up on the government agenda. In 2002 Derek Wanless, a former banker, produced a report for the Treasury that assessed resources that would be needed to provide high-quality health services (Wanless, 2002). This report examined future funding in the context of three possible future directions – 'slow uptake', 'solid progress' and a 'fully engaged' scenario – and set out an economic case for effective public health. A second report, *Securing Good Health for the Whole Population* (2004), looked at the cost of a fully engaged scenario and assessed the actions that would need to be taken to achieve the relative reductions in future demand for healthcare services and the improvements in the health of the population implied by the fully engaged scenario. The report concluded that one of the underlying reasons for the lack of progress on public health was a lack of political will and political importance attached to public health by successive governments (Wanless, 2004).

Continually changing organisational structures and positioning of public health has led to instability in the public health workforce. With the development of Primary Care Trusts (PCTs) in England in April 2001, each PCT was required to appoint a Director of Public Health. Although there was no requirement to appoint medically qualified directors, the majority of PCTs have appointed medical directors. This development led to a recognition of the importance of public health and an expansion in the multidisciplinary public health workforce. The Faculty of Public Health (2005) reported that a much larger public health workforce was needed. However, it was judged that the newly configured PCTs were not economically viable and in 2006 PCTs and strategic health authorities were reconfigured. Many practitioners fear that this, accompanied with a refocusing of resources in the NHS, will lead once more to the marginalisation of public health and health promotion and the gains that were made in the early part of the 21st century. There is the scope, however, for joint appointments of Directors of Public Health, with local authorities, particularly where newly formed PCTs are coterminous with their local authority. Such a move could place Directors of Public Health in a position to influence local authority agendas and the health of the local population.

Since the reforms of 1974, when public health services in the main were taken out of local authorities, the influence of public health has been greatly reduced. Although environmental health departments continued to have some statutory responsibilities for aspects of public health, limited resources meant that these responsibilities were discharged with a fairly narrow focus, with only a few environmental health departments developing a wider role in promoting public health. In the 1980s some local authorities set up 'Health

Douglas-3453-Ch-02.qxd   9/16/2006   5:15 PM   Page 17

Units'(e.g. Lambeth), which were part of the egalitarian thrust of welfare policy. These recognised that individuals' health experiences were shaped by wider structural factors and that local authorities were better placed to take action on the determinants of health. The 1980s saw the development of the Healthy Cities Movement and many towns, cities and boroughs set up Healthy City Units (e.g. Sheffield, Liverpool, Camden). More recently, while some local authorities have used the Health Scrutiny Committee to call for action on inequalities in health, the role of local authorities on advocating for public health has been greatly diminished in the last two decades.

Many voluntary and community organisations have maintained a lobbying and campaigning role supporting public and lay activism around health issues. The widening social movement in health has been effective in challenging the UK governments on a range of public health policies. Organisations such as the UK Public Health Association, National Heart Forum, Action for Smoking on Health, Diabetes UK, the Sickle Cell Society, to name but a few, have been influential in changing the public health agenda and ensuring the continued involvement of the public.

One of the fundamental contentions of public health and health promotion is individual versus structuralist approaches. Individual approaches focus on encouraging people to change their behaviour and adopt healthy lifestyles. Structuralist approaches focus on changes in legislation, taxation, public policy, ecological or environmental measures. It can also be said that some health protection approaches, such as immunisation and screening, lie between a lifestyle approach and a structuralist approach as they involve both changes in behaviour and changes in service provision. These are sometimes referred to as upstream and downstream approaches, where upstream approaches represent structuralist approaches.

One of the reasons that it is very difficult to define public health is because it represents a number of different understandings of 'health' and the causes of health and illness. Public health can be seen from two ends of a very broad spectrum. One end of the polarity sees health as determined by biology or medicine. In the medical model the causes of ill health are seen to be due to disease or other medical concerns and the explanations of ill health are much more biological in nature. At the other end of the polarity poor health may be seen to be caused by a range of social, economic or political factors and hence the explanations of health and illness are much more sociological. Although the social model of health and the biomedical model of health are sometimes presented as oppositional perspectives, or two extremes of a binary divide, an understanding of both perspectives is essential to developing an understanding of health and health inequalities.

Conclusion

So how far have we got with promoting the public health in the 21st century? What is modern multidisciplinary public health? It is important for those people involved in promoting public health to have a historical perspective to understand the present and to recognise that what might appear to be a shift in the present may be a move to the past. The contention about definitions of public health in relation to addressing inequalities in health continues, as do the struggles surrounding its organisational positioning. Having experienced a renaissance in public health in the latter part of the 20th century and early part of the 21st century, practitioners fear that organisational changes to primary care trusts

and strategic health authorities introduced in England in 2006 may once more relegate public health to the margins. Many authors argue that although there are public health strategies in each country of the UK, the fact that public health services are still located in the NHS restricts the potential of public health to act in the interest of the health of people. Despite the limitations of the 1848 Public Health Act, some public health practitioners have called for a 21st-century Central Health Board and a shift of public health services from the NHS back to local authorities, where action on the determinants of health can be more effective. More than ever there is a need to bring the politics back into public health as without political will and commitment the continuing widening inequalities in health in the 21st century will not be stemmed and public health will not be equipped to deal with the challenges of modern society and increasing globalisation.

References

Acheson Committee Report (1988) *Public Health in England: The Report of the Committee of Inquiry into the Future Development of the Public Health Function*, Cm 289. London: HMSO.

Berridge, V. (2001) Constructing Women and Smoking as a Public Health Problem in Britain (1950–1990s), *Gender and History*, 13 (2): 328–48.

Department of Health (1991) *The Health of the Nation*. London: The Stationery Office.

Department of Health (2001) *The Report of the Chief Medical Officer's Project to Strengthen the Public Health Function*. London: Department of Health.

Department of Health (2005) *Shaping the Future of Public Health: Promoting Health in the NHS*. London: Department of Health.

Faculty of Public Health (2005) *The Ten Key Areas for Public Health Practice*, http://www.fphm.org.uk/about_faculty/what_public_health/10key_areas.asp.

Hamlin, C. and Sheard, S. (1998) Revolutions in public health: 1848 and 1998?, *British Medical Journal*, 317: 587–91.

Lalonde, M. (1974) *A New Perspective on the Health of Canadians*. Ottawa: Ministry of Supply and Services.

MacDonald, T.H. (1998) *Rethinking Health Promotion: A Global Approach*. London: Routledge.

Nursing and Midwifery Council (2003) *Third Part of the New Register. Proposed Competency Framework for Specialist Community Public Health Nurses*. Consultation document. London: NMC.

O'Donnell, P. (1986) Definition of health promotion, *American Journal of Health Promotion*, 1 (1): 4–5.

O'Donnell, P. (1989) Definition of health promotion. Part III: Expanding the definition, *American Journal of Health Promotion*, 3 (3): 5.

Scott-Samuel, A. (2003) Specialist health promotion – can we save it?, *Public Health News*, 5 December.

Wanless, D. (2002) *Securing our Future Health: Taking a Long-term View*. London: HM Treasury.

Wanless, D. (2004) *Securing Good Health for the Whole Population: Final Report*. London: HM Treasury.

WHO (World Health Organisation) (1986) *Ottawa Charter for Health Promotion*. Geneva: WHO.

WHO (2005) *The Bangkok Charter for Health Promotion in a Globalised World*. Bangkok: WHO, http://www.who.int/healthpromotion/conferences/6gchp/bangkok_charter/en/.

Winslow, C.E.A. (1951) 'The cost of sickness and the price of health', *WHO Monograph*, 7: 28. Geneva: WHO.