Title: A Historical Reflection on Prevention and Public Health

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In this article I argue that for public health to be effective in preventing poor health outcomes we need to focus on reducing wider inequalities in society and take a collective approach to addressing health problems, rather than blaming individuals for making poor choices. We also need to consider the structure of our health systems and the role and funding of public health.

Prevention has always played a significant role in how modern public health has been conceived. For example, John Snow removing the Broad Street water pump handle in 1854 to stop the spread of cholera in Soho, and campaigns encouraging parents to vaccinate their children against a range of early childhood diseases in more recent times. In the last forty years, ideas about prevention have focused on individual behaviour and single issues rather than broader collective approaches to wellbeing. Coupled with this has been the changing role and status that public health has had within health systems as many, including the NHS, have been subject to multiple re-organisations.

Numerous countries have seen rising levels of inequality because of the implementation of neo-liberal policies.[1] This growing economic divide coupled with continuing and long-standing discrimination based on ethnicity (as well as other factors) has resulted in increasing inequities in health outcomes and well-being. This is in stark contrast to the declaration made at Alma Ata in 1978 which emphasized health as "a state of complete physical, mental, and social well-being" and highlighted the importance of reducing inequities, collective planning in health and the role of primary care.[2]

Again, at Ottawa in 1986 a Charter for Health Promotion was signed which identified re-orienting health services towards prevention of illness and the promotion of health as one of five key action areas.[3] Broader social and economic determinants of health were recognised as being fundamental as well as a stable eco-system. However, as we have seen time and again, international attempts to address the climate crisis have been insufficient and this is having an ever-increasing impact on the well-being of the world's population, especially those in low- and middle-income countries. The important role that prevention and public health could play in addressing income and ethnic inequities and the climate crisis is continually undermined by the policies of many governments, including that of the United Kingdom.

Since the 1970s there has been an increase in what have been termed "lifestyle diseases", namely illnesses which have been attributed to physical inactivity, diet and the consumption of tobacco and excessive levels of alcohol. Peder Clark has written about the growing emphasis on prevention and personal responsibility in addressing these problems in the 1970s.[4] He argues that the combination of the financial pressures that the NHS was under, coupled with the publication of epidemiological studies showing that smoking, poor diet and physical inactivity were risk factors for chronic disease resulted in the idea that it was a citizen's duty to be healthy and that not to take individual responsibility for one's health would result in NHS resources being "wasted". The growing emphasis placed on personal responsibility from the 1970s signalled an important shift away from the post-war settlement and the concept of collectivism which had underpinned the establishment of the NHS.

While the concept of collectivism was important in the establishment of the NHS, it inherited geographical and sectorial inequities from the pre-existing health system. From the outset the NHS was dominated by hospitals, with most funding being directed to secondary care. Initially public health remained the responsibility of local government albeit with Medical Officers of Health having their

[1] For example, see Thomas Piketty. *Capital in the Twenty-First Century.* (Cambridge, MA: Harvard UP, 2014); Danny Dorling. *Injustice. Why Social Inequality Still Persists.* (Bristol: Policy Press, 2015).
[2] Declaration of Alma-Ata, September 1978, accessed at: https://cdn.who.int/media/docs/default-source/documents/almaata-declaration-en.pdf?sfvrsn=7b3c2167_2 on 4 May 2022.
[3] The Ottawa Charter for Health Promotion, 1986, accessed at: https://www.who.int/teams/health-promotion/enhanced-wellbeing/first-global-conference on 4 May 2022.
[4] Peder Clark. "'Problems of Today and Tomorrow': Prevention and the National Health Service in the 1970s." *Social History of Medicine,* 33, no.3 (2019), pp.981-1000.

inter-war "empires" reduced, but as part of the 1974 reorganisation, public health roles were moved into hospitals and away from local government, which reduced the scope of their influence. In the 1980s there was a broader public health response which included GPs, but public health remained medicalised which reduced the potential for a cross-sector approach. As well as this divide within public health and the separation of public health specialists from communities, the health system resembled more a series of silos where physical and mental health were treated separately, and the emphasis was on curative approaches. Added to this, public health initiatives were located within local government institutions or the health system, leaving little opportunity to address the wider social and economic determinants of health.

The importance of the social and economic determinants of health, that is those factors such as housing and food which do not form part of the health system, but which greatly influence our health and well-being, have long been acknowledged, especially since the 1930s with the establishment of the study of social medicine. Inequalities, both within the health system and in wider society, and their impact on health and well-being have been highlighted numerous times in the last half-century. In 1971 Julian Tudor Hart wrote an article in the *Lancet* entitled "The Inverse Care Law".[5] Tudor Hart, a GP who worked in South Wales argued that the availability of good medical care tended to vary inversely with the need for it in the population served, demonstrating that inequities within the NHS are not a recent problem and that they pre-date Thatcherism and the implementation of neo-liberal policies. In 1980 the Black Report was published which argued that material and economic circumstances played the largest role in health inequalities and should be the focus of government policy.[6] The report had been commissioned by the Labour government but was delivered to a new Conservative government which did its best to bury the report. The Blair government commissioned the Acheson Report which was published in 1998 and echoed many of the recommendations of the Black Report.[7] Targets to reduce health inequalities were introduced and remained until they were abandoned by the Conservative government in 2011.

Labour introduced several initiatives to reduce inequality such as the Health Action Zones, Healthy Living Centres and Health Improvement Programme. However, as Clare Bambra has shown, even by its own targets, Labour failed to substantially reduce inequality.[8] Moreover, since the election of the Conservative government in 2010 inequality has worsened and continues to do so as the country faces a cost-of-living crisis. In 2017 Public Health England published the first of its Health Profiles for England, a report which highlighted significant inequalities in health.[9] In 2020 the Mental Health Foundation published a report arguing that inequality increases mental health problems.[10] Other research has shown an increasing gap between the life expectancy of rich and poor people in England and Wales.[11] Thus over the last fifty years it has been shown on many occasions that reducing socioeconomic inequalities is a key component of reducing health inequities and therefore improving

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[5] Julian Tudor Hart. "The Inverse Care Law." *Lancet,* 297, 7696 (1971), pp.405-412, DOI: https://doi.org/10.1016/S0140-6736(71)92410-X

[6] Douglas Black et al. *Inequalities in Health.* (London: DHSS, 1980).

[7] Donald Acheson et al. *The Independent Inquiry into Inequalities in Health Report.* (London: Stationery Office, 1998)

[8] Clare Bambra. *Health Divides. Where You Live Can Kill You.* (Bristol: Policy Press, 2016).

[9] Public Health England. *Health Profile for England: 2017.* Available: https://www.gov.uk/government/publications/health-profile-for-england. Subsequent reports were published in 2018, 2019 and 2021 and are also available from the same website.

[10] https://www.mentalhealth.org.uk/sites/default/files/MHF-tackling-inequalities-report_WEB.pdf

[11] Gareth Iacobucci. "Life Expectancy gap between rich and poor in England widens", *BMJ,* 364 (2019), p.1492, doi: https://doi.org/10.1136/bmj.l1492.

health and wellbeing.[12] Yet, even governments ostensibly committed to this goal have great difficulty in making substantial progress in reducing inequities and governments, like the current UK government, which do not have such a commitment have allowed inequities to worsen, to the detriment of society, but particularly the most deprived. Despite the rhetoric, we are most certainly not all in this together.

Connected to the issue of socioeconomic inequality, is the long-standing problem of ethnic inequities in health outcomes. This issue has received considerable attention in the media because of the Covid-19 pandemic, but the government has shown little sign of addressing this problem. In fact, in recent years the government's immigration policy has resulted in members of BAME communities being excluded from the health system as NHS providers have been tasked with checking immigration status before providing care. Taking a longer-term perspective, many politicians as well as others, demonstrate a historical amnesia when it comes to the British empire and this prevents them from recognising the impact that colonialism and racism has on mental health, the inter-generational trauma it has caused, and the resultant distrust of biomedicine and institutions by some members of the BAME community.

While many of the underlying causes relating to ethnic disparities in health outcomes require addressing outside of the health system, the introduction of compulsory cultural safety training for all members of the healthcare workforce would be a good starting point. Cultural safety is a concept developed in New Zealand by a Māori nurse and anthropologist, Irihapeti Ramsden, in the 1980s. Its focus is on providing effective healthcare to a person or family from another culture through a process of self-reflection on one's own cultural identity and how this impacts the way in which an individual provides care to others.[13] Currently cultural safety training is available in Britain, but it is not compulsory. Widespread cultural safety training would improve the care that BAME communities receive from the NHS (including public health) and could also introduce wider discussions about the long-term impact of colonialism and racism on the health of BAME communities.

The Covid-19 pandemic has highlighted and accentuated the inequities in British society, and this is now being compounded by a cost-of-living crisis as well as the ongoing and increasing climate crisis. Preventive public health policies need to focus on these enormous issues as currently the situation is worsening. Until governments accept that collective solutions which recognise the broader shared benefits of equity of outcome in terms of health and wellbeing are required there will be little significant progress towards meeting the goals outlined at Alma Ata in 1978. As well as requiring collective solutions which focus on prevention, we also need to support those for whom preventive solutions are too late without apportioning blame to individuals. Given the significance of the wider social and economic determinants of health we need to think about public health very broadly, but we also need to reconsider the role that public health officials have within the NHS and re-examine how the health budget is apportioned to the various arms of the health service. Critics may argue that focusing on reducing socioeconomic inequalities is all well and good but that these goals are too vague and too difficult to achieve. However, I would argue that it is possible, and indeed necessary, to address these huge issues as a community (both nationally and internationally). We need to move past thinking about ourselves solely as individuals and consider how as a community we can live in a

[12] For example, see Kate Pickett & Richard Wilkinson. *The Spirit Level. Why Equality is Better for Everyone.* (London: Penguin, 2010); Michael Marmot. *The Health Gap. The Challenge of an Unequal World.* (London: Bloomsbury, 2015).

[13] Elaine Papps & Irihapeti Ramsden. "Cultural Safety in Nursing: the New Zealand Experience." *International Journal for Quality in Health Care,* 8, no.5 (1996), pp.491-497.

more equitable way which will improve our well-being and that of the planet. Reducing inequities is the most effective form of preventive public health.

While I have focused on Britain, in broad terms the inequities which exist within countries provide a microcosm for inequities that exist between high income and low- and middle-income countries. Just as we need to address inequities at a national level, we also need to address systemic inequities at an international level.