

From past to present; the changing focus of public health

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Environment, infectious disease, locating public health, the enlightenment, the Sanitarians, national provision of services, the inception of the National Health Service, 'crisis in health', The New Right, The Third Way, new public health.

Public health, the new ideology may be taken to mean the promotion of healthy lifestyles linked to behaviour and individual responsibility supported by government action; whereas traditionally the description tended to relate more to sanitary reform and 'healthy conditions'. The chronological development of public health is mapped out, supported by the outlining and discussion of the emerging themes and influences pertaining to the study of public health. The approach to public health is positioned alongside the health of the population and the prevailing political/societal influence at the time. Public health is impacted on by poverty and environmental factors. Presently government policy to improve public health is delivered in a strategy that recognises the need for health improvement at times when the greatest impact on health is poverty and exclusion. The evidence reviewed demonstrates clearly that poor health without appropriate resources or intervention is cumulative and that the 'right' form of intervention can bring about long term health gains. Intervention from a national agenda needs to include individual's health and the health of the community brought about through joint partnerships and multi-sectorial working.

The environment

Historically, the environment was seen to be causative of ill health and disease, precipitated by inadequacy of the air. Humid, marshy areas or toxic, rotting debris were thought to cause 'miasmatic disorders', and it was thought best to reside in airy, well-ventilated places. The supposition being, miasma could be seen or smelt and disease produced by miasma was transported through breathing contaminated air or absorbed through the skin. The presence of disease was acutely observed in the summer season, when the smell would be particularly offensive. Unfortunately the corresponding link between rotting debris, flesh and heat with an increase in pests and rodents, which would inform later health initiatives, was not made at this time (Cipolla 1992). Belief systems were influenced by naïve sensory perceptions linking

odour and miasma with overcrowded spaces as places of disease. Those financially better placed began to deodorise their environment with aromatic oils, flowers and herbs (Wear 1992). The environment was also seen as significant in humoral theories, where the body was thought to need a healthy balance of four humours: blood, phlegm, yellow bile and black bile with four elements: earth, air, fire and water and four qualities: hot, cold, wet and dry (Nutton 1992). Being cold or wet was often seen as the cause of colds or fevers; perspectives still present in popular lay discourse today.

Infectious disease

In earlier times levels of understanding relating to infectious diseases was demonstrated with the Romans building isolation hospitals known as Leprosaria, quarantining their plague victims. Quarantine was associated with a contagionist understanding of ill health. Disease and isolation in this approach was separating the ill and infectious, to control the spread of disease (Lupton 1995). Quarantine stemmed from the belief that disease resided in places and bodies were responsible for the transmission of disease from infected to non- infected place (Armstrong 1993).

Fear and suspicion co-existed with ignorance and lack of education and the plague was construed, as a case of divine retribution in the absence of popularly understood causative indicators. The contribution of the church in leading a crusade against disease or indeed identifying causative behaviours was said to be welcomed when so little was known about the causes of these diseases. This resulted in an association between spiritual uncleanness and pathological condition, with the church prescribing segregation and exclusion to control disease, further reinforced by a system of notification, where those who fell ill were reported to the local authorities and isolated in their homes with all who had been in contact with them or removed from their homes when dead, through the window, into a barrow to be buried outside the city.

The onus on notification of infectious disease is still seen today in the Control of Disease Act 1984 and the Regulation of the Infectious Diseases 1988. This may have positive benefits to public health, limiting illnesses such as food poisoning and rapid identification of outbreaks of bacterial meningitis, measles and other illnesses through prompt notification and medical or environmental intervention. The role of 'social conscience' however and its manifestation in social control may have been

responsible for dividing communities through encouraging individuals to report their apparently ill neighbours.

Locating public health

The tradition of public health and inherent understanding of the term, dates back as early as pre-Christian times, classified in five periods or bodies of thought: The Graeco-Roman period with emphasis on water and sanitation, the Medieval emphasis on epidemics, the Enlightenment emphasis on disease prevalence, the Industrialisation emphasis on working conditions and Modern era emphasis on bacteriology and virology (Rosen 1993 cited in Costello and Haggart 2003). A prevalent feature throughout the earlier periods being religious control, utilising methods ranging from diabolism which was thought to wreak bodily evil, sickness and ill health to the use of moral metaphors and victim blaming which gave way to rationalist, 'scientific thinking' during the enlightenment.

The perspective of public health over the past two centuries has been broken down into four major regimes and linked to mechanisms for social control by Armstrong (1993):

- 1) Quarantine – inclusion or exclusion and dominant up until mid 19th century,
- 2) Sanitary science – regulating the movement between different spaces environmental,
- 3) Interpersonal hygiene psychosocial attitudes and behaviours,
- 4) New public health (social and environmental patterns from the 1970's).

Armstrong states that 'new public health' differs from the earlier three in the way it increases the scope of surveillance, gears behaviour to health targets and generalises danger. Armstrong's use of the word 'regime' when categorising this period is also revealing. Bennett and DiLorenzo (1999) accuse 'new public health' of 'nannying' and imposing moral regulation on the population. A position further supported by commentators stating that:

'The new public health can be seen as but the most recent of a series of regimes of power and knowledge that are orientated to the regulation and surveillance of individual bodies and the social body as a whole' (Peterson and Lupton 1996, p3).

Some commentators suggest that the 'old' public health lasted only until the 1870's when it was replaced by a more individualistic approach with germ theory and

discoveries such as immunisation and vaccination (Ashton and Seymour 1988). Others state that 'new public health' emerged during the 1914-1918 war but accept that it goes further than a biological stance and recognises health problems linked to social conditions and lifestyles (Watterson 2003).

The concept of a 'new public health' is distinct from the 'old public health' in its departure from the biomedical model of disease and the adoption of a social model of health which

'advocated a multi-causal approach that saw infectious and chronic degenerative disorders as being the result of a complex interaction between biophysical, social or psychosocial factors' (Brown and Duncan p363).

Whether there is a reliance on the medical model in new public health may be disputed but public health policies that recommend preventative strategies seen in earlier Conservative government documentation such as Promoting Better Health (DH 1987) and Health of the Nation (DH 1992) increased the remit and power of health professionals (Peterson and Lupton 1996). The act of authority inherent in surveillance, screening and measuring targets is usually ascribed to a powerful medical model.

The Enlightenment

The origin of sanitary science and interpersonal hygiene appears in developments from earlier periods. One example, the discovery of vaccination, actually emerged in the eighteenth century but did not gain validity until Edward Jenner publicised the vaccination against smallpox, which then became commonplace and compulsory in the mid nineteenth century (Fisher 1991 cited in Baggot 2000). The enlightenment (late 17th century to late 18th century), a subdivision of the quarantine period, was highly significant to public health and medicine, representing a period of change, with the rise of scientific method and the decline of unquestioning religious belief and superstition (La Berge 1992). The possibilities for medicine within this new paradigm were vast, with opportunity for learning through anatomical research and scientifically supported diagnosis. Medicine was identified as key in reducing ill health from the increasing urbanisation and industrialisation resulting from the capitalist labour market.

Public Health Acts and interventions began to emerge during this time. The Gin Act 1751, came about when high infant and adult mortality began to be linked with the intake of cheap gin. Some municipal corporations acquired Private Improvement Acts in an attempt to tackle problems in their immediate environment, but they invariably lacked local support if the proposed legislation was detrimental to the mode of capitalist production. The new, scientific approach magnified medical dominance when hospitals, which began to be built from 1720 by voluntary organisations, spread across the country to patronise the deserving poor, those whose misfortune was seen to be through no fault of their own (Porter 1996).

Poor health and disease was not confined to the unemployed or homeless. The concerns regarding the poor health of those recruited to the army and navy, the new immigrant workers to the industrial towns and the health of those in hospital and prisons was championed by reformers such as John Howard. Public health, at this time under the auspice of the social medicine movement, adopted enlightenment principles and a trend for paternalism (Turner 1990). Iron and steel, ship building, cotton and coal were all growing industries and many industrial philanthropists at this time were expressing concern about the health and welfare of their workers, going as far as building housing and hospitals, schools and villages for them to live and work in. It could be argued that the good health of the workers improved capitalist production and subsequently profit, for the industrialists, however the improved social conditions most definitely went some way in improving life expectancy and resistance to disease at this time.

This parallel, of personal health and environmental influences, illustrated the association of health as more than an individual issue. Through the concept of governmentality (Foucault 1991) regulatory activity both for self and external influences was employed, shaping beliefs and behaviours. The movement for health reform at this time adopted a wider view, accepting social determinants of health as influential in the causation and containment of disease. The study of epidemics evolved, including both the search for cause and patterns of disease and the medical gaze began to focus on disease and the events surrounding its development (Foucault 1975).

The sanitarians

The concern regarding epidemic disease advanced with the unfolding of a new understanding relating to endemic disease. Smallpox and typhoid were rife and

despite an understanding of the social determinants of health beginning to emerge, malnutrition was widespread. The modern public health movement began to evolve, with the move from sanitary to state medicine (Wear 1992). At the forefront of this change were individuals such as Edwin Chadwick, Sanitary Commissioner and Poor Law Reformer. The Poor Law commission was established in 1834 to reform the system of poor relief and reduce the burden on tax payers, with John Simon (the first medical officer for the government) being given a place on the General Board of Health, after Chadwick in 1854.

The need for sanitation and clean drinking water appeared to be only fleetingly understood, until the social changes brought about as a consequence of the agricultural and industrial revolutions, conveyed large proportions of the working population to a short life, of poverty and ill health. This urbanisation, produced overcrowded cities where families became wage dependent and reliant on factory systems (Iphofen and Poland 1998) and illness and disease became rife due to living conditions and limited resistance to ill health. The 1848 Public Health Act was implemented to improve water systems and sewerage. This act attempted to standardise the supply of water, to improve health and, resembling other initiatives in public health at this time attempted to provide the 'greatest good for the greatest number'.

The preventative collectivist approach was favoured in policy formation, setting out to reduce environmental harm and secure health improvement. Environmental harm at this time included occupational features linked to industrialisation, such as respiratory disease from the weaving industry, hearing problems caused by noise in factories and accidents due to large and dangerous machinery. The need for sanitation was seen as elementary. Chadwick described as the 'first leader of the sanitarians' stated that sanitation was the foundation of good health and poor health was not caused by worker poverty and (Hamlin 2000). Poverty was not acknowledged as primarily responsible for illness and disease at this time of industrial capitalism. Public health at this time although favouring a preventative approach to improving health (McKeown 1976) was actually an 'admixture of benevolent despotism, rate payers' self-interest and social control, instigated for, rather than by, the mass of the people, who were treated as an homogenous group' (O'Keefe, Ottewill and Wall 1992 p176). This was further manifested by the belief that the poor needed social order, education and training, not aid (Kelly and Symonds 2003).

When looking back at this period McKeown (1976) believes that the pre-industrial era had higher mortality, mainly due to malnutrition, semi-starvation and inability to resist disease. Industrial capitalism brought more wealth and increased food production it unarguably brought more exploitation and dependency, with the end of self-sufficiency and a reliance on a market economy. The latter part of the Industrialisation period did bring an increase in life expectancy but was consequently responsible for an increase in occupational ill health and life limiting disease.

The sanitation debate was minimised further when the experience of the Crimean war led Florence Nightingale to describe hygiene as critical in preventing ill health. Whilst accepting sanitation as fundamental she defined the four main causes of disease in a simple form as overcrowding of the sick, lack of bed space, lack of fresh and lack of light and air (Nightingale 1859 cited in Kelly and Symonds 2003). Nightingales influence has been described as politically powerful, securing improved environmental conditions, but it is argued that her popularity at the time may have been manipulated politically, with her being used as a screen to hide the horrors of war rather than national support for the evidence she presented. However, whatever the reasoning behind her rise to the public eye, she continued to exercise her considerable influence in the campaign for sanitary reform (Holiday and Parker 1996).

The notion of hygiene took on alternative significance and alluded to the individual person, their 'cleanliness'; not only referring to their personal hygiene but also their behaviours and their interpretation as moral, clean and educated or blasphemous, uncontrolled and sexually depraved. The poor and working classes were depicted as uncivilised and in need of example through demonstration and education by the civilised middle classes (La Berge 1992). The high levels of infant mortality and low rate of adult life expectancy were becoming both a political and social issue. Morbidity not only affected quality of life, it interfered with industrialisation, capitalism and the functionalist requirement inherent with the individual's role within society. Hygiene was now the driving force to bring about the civilisation and discipline, ultimately to secure an economically productive population (Jones 1986).

Women were identified as 'reputable' or 'disreputable' depending on how they cared for their family and their observable behaviours (Finch 1993). This principle was perpetuated during the early part of the next century in the drive for national efficiency, where women as mothers were seen as both the cause of and solution to

physical degeneracy (Kelly and Symonds 2003). A lay perspective, some may suggest has influenced the gender debate to the present today.

The improvement in health during this period appeared to be attributable to sanitary reform and the increasing numbers of doctors. However critics commented that this amounted to environmental engineering and a soft approach towards the damaging effects of capitalism when radical social change was needed (Turshen 1989). The move towards personal hygiene was described as 'relocating the responsibility for health improvement with individuals, as opposed to collective or community action or state intervention' (Winslow 1952 cited in Adams L, Amos M and Munro J 2002 p7).

At the early part of the twentieth century more sinister eugenicist beliefs, combined with the emphasis on social class, disease and social Darwinist doctrines, suggested that ill health, disease and high infant mortality were paving the way for 'race decay' and that 'poor housing was the natural environment for of an unfit class preparing the way for its own extinction' (L. T. Hobhouse, 1922, quoted in Wohl 1983p 335). Whilst this opinion may have been of the minority, the underlying principles on a wider scale depicted a victim blaming approach where the onus is on the individual to live a 'healthy lifestyle'.

Educational reform supported the drive for improved public health with emphasis on exercise, diet and regulation. The major determinants for health from the nineteenth century were identified as nutrition, public hygiene and contraception (McKeown 1976). With the public health measures such as sanitation, drinking water and housing being implemented over several decades, culminating in the Great Public Health Act 1875 and the factors of nutrition and contraception, change began to be effectuated.

A decline in fertility rates starting from around 1870 and falling family size was outlined as responsible for reducing death rates for mothers and babies. This was due to many variables ranging from reducing risks through pregnancy and childbirth or by the possibility that smaller families start with a healthier better fed mother, and end with a more robust infant with a better birth weight; an infant more likely to get adequate food and nutrition, subsequently making the child and mother less vulnerable to disease and ill health (Hart 1985).

The improvement of general health for the population was paramount and the Fabian eugenicist, Sidney Webb (1901), stated 'that the prevention of disease and premature death, and the building up of the nervous and muscular vitality of the race was essential' (Donald 1992 p 28) and suggested that education would be the vehicle for such a vital strategy. The strategy of education supported the drive for national efficiency following the Boer war when the full extent of appalling public health was identified and acknowledged, when a large proportion of recruits for the war were found to be unfit for service.

The purpose was to educate the poor on self-care and the subsequent adoption of hygienic habits would improve both national efficiency and support eugenicist ideals by improving the calibre of the population (Wear 1992). Moral worth was directly linked to hygienic behaviours and the extremists believed that true social improvement of the race depended upon assiduous breeding out of undesirable racial or social characteristics, so that the fittest survived. The political position on Public Health was fortunately more far sighted and adopted the notion of improve, rather than remove, as their remit.

The Balfour Act (1902) outlined the responsibility of Local Education Authorities statutory duty to provide elementary education for children up to the age of fourteen. Webb believed that 'collective provision for welfare through the state was an essential, and inevitable, development within British capitalist society' (Alcock 2003 p5). This belief about the necessity for collective provision by the state for welfare to raise the standards of health, education and housing of the population was influential in the overhaul of welfare and social security and set out as a manifesto on National Efficiency (1901), a programme of social reform based on state control (Mackenzie 1979). The ultimate plan was to remove social ills and reform and reorganise British society to enable Britain to become a world leader.

The interest in the manifesto of national efficiency was cross-political (Searl 1971), not surprising in a time when the 'discourses of imperialism, social efficiency and motherhood became inextricably linked with an eugenicist drive to improve the 'quality' of the population' (Kelly and Symonds 2003 p19). The evidence from the Boer War, reports from social surveys such as Charles Booth's study of London and Benjamin Seebohm Rowntrees study of York highlighted the extent of deprivation at the turn of the century. The breadth and depth of deprivation gave prominence to the need for national provision of welfare services.

National provision of services

A potent role for medicine materialised in this era of 'governmentality' (Foucault 1991) in the diagnosis and treatment of individuals. This would ensure that individuals were fit to return to their place in society, which from a reductionism perspective views the capacity for work as their only substantive asset (Costello and Haggart 2003). National provision for health education, supplements and services such as baby clinics and school health clinics began to emerge and although offering sound advice and guidance, served also to represent the political interest in surveillance and standardisation to maintain the health and productivity of the population.

School medical inspection was followed by the Children's Act (1908) to convene children's health and welfare. The following period saw the introduction of a progressive tax system in an attempt to implement state financial systems through social policy. The purpose, allowing for the provision of economic assistance to improve material circumstances of those living in poverty through the Introduction of State Pensions for the elderly in 1908 and the National Insurance Scheme. This was followed up by the introduction of a National Health Insurance (NHI), funded by employer, employee and state to provide treatment for illness to the employee. This provision excluded dependants and did not give specialist treatment other than for tuberculosis.

The majority report of 1909 (cited in Baggott 2000 p39) called for a more acceptable system of care for the ill treated under the poor law, but retained the opposition view to free medical care and preferred that local authorities administered health service to the poor. The minority report (cited in Baggott 2000 p39) recommended the amalgamation of poor law health services and sanitary authorities, to combine their services. The poor law system continued however until the 1929 Local Government Act saw poor law boards replaced by local authority assistance committees and a more comprehensive service was developed for sufferers of tuberculosis, the blind, the mentally infirm and maternity and child welfare. The pre-existing Poor Law workhouses were identified for redevelopment as local hospitals, running alongside voluntary hospitals.

This time of expansive service provision brought about the era of the 'golden age of public health' (Holland and Stewart 1998). Although the altruistic concern for the well

being of society predominated at this time, there unarguably remained the requirement for a physically fit population, not only for capitalist production, imperialism and armed forces, but also now for maintaining the welfare system through contribution. The Medical Officers for Health (MOsH) believed the 1929 Act would lead to the development of an integrated public health service but critics argued it was detrimental to public health and that the public health departments had gathered services up without fully considering the uniqueness of public health (Lewis 1986). The resulting reduced attention to the community watchdog function and increased attention to service delivery, antagonised the general practitioners (GP's). Services for health or ill health, whether provided through public health clinics or general practitioner (GP), dominated and the overriding principle was that health was a moral duty and a prerequisite of a functional society.

The functionalist perspective of health was demonstrated by Parsons 'Sick Role' (1951), where with emphasis on a consensus model of health, the practice of medicine contributes to maintaining social order. However equality of access to the legitimate sick role was not population wide. Further criticism surrounding the authenticity and validity of the medicalisation of health suggests that medicine expanding into life experiences such as pregnancy (Oakley 1984) may offer up technical solutions but in doing so, circumscribe to moral decision-making (Zola 1972).

The 1944 Goodenough Committee on medical education saw social medicine as a crucial part of the medical training curriculum, drawing on perspectives gained from groups such as the Women's Group on Public Welfare and the work of the Peckham Health Centre, which identified the concept of health as separate from the cure of disease (Wear 1992). Social medicine focused on either environmental relationship with the individual and their hereditary make up or social factors affecting their health status.

The drive for 'social medicine' was increasing, as was the need for a social conscience influencing the perception of health, but as it gained impetus, critics reflected on the reality of the term social medicine and the fact that the use of the word social and an understanding of social influences of health was not reflected in the training curricula of social and community medicine within medical schools. This remains so today although to a lesser extent as it could be conceded that at least in relation to Public Health medical officer training the study of epidemiology remains

paramount and added value inherent in the control of communicable diseases (Evans 2003).

The inception of the National Health Service

The Beveridge Report in 1942 addressed the role of the state in meeting collective welfare need with subsequent post war reforms being introduced by the Atlee government. This welfare state attempted to tackle what Beveridge had described as the 'five major ills' afflicting society and was set out as:

- The NHS to combat disease
- Full employment to combat idleness
- State education to age fifteen to combat ignorance (introduced in 1944)
- Public housing to combat squalor
- The National Insurance and Assistance schemes to combat want

Correspondingly, local authority Children's and Mental Health Departments introduced a more comprehensive form of social service provision. This was said to be the creation of 'social citizenship' (T H Marshall, cited in Alcock 2003 p7) and embodied the role of state as provider for collective welfare. The advent of the National Health Service (NHS) in 1948, was in fact a compromise vision of the original, as a result of many battles with the medical profession and the medical profession managed to both retain their power and receive financial reward.

A Weberian approach to the study of professions suggests that 'tradition; charisma and rational-legal authority maintain legitimate domination' (Hart 1985 p111). In medicine, tradition: charisma and status have been acquired through time and opportunity, rational-legal power has been conferred as power of office and political organisation.

Critical analysis reveals that not simply an altruistic desire to contribute to the well being of society gave doctors such high status and reward but an occupational strategy of exclusion through restricted, lengthy training and the exercising of power demonstrated at the time when national investment was in the development of the NHS. The medical profession fought to retain the right to practice medicine privately outside of the NHS (Senior and Viveash 1998) and bio-medicine was again triumphant through the medicalisation of public health.

The type of health service which Britain adopted based itself on access to medical services (Klein 1989). This brought about change and reform in healthcare with the move from a community perspective to a focus on hospital treatment. The previously powerful departments with MOsH traditionally responsible for the clinics and services for vulnerable members of the population, were now deployed into administering basic preventative services (Adams et al 2002). Some critics state this reorganisation led to a reduction of power for the MOsH evolving from the inter-war years, when what was seen as the 'old public health' declined. This came about when increasing emphasis on bio medical responses and curative approaches to ill health was not matched by growth and redefining theory in public health. MOsH were increasingly committed to establishing personal health care services and in doing so, overlooked the key functions of community watchdog and their role in supporting immunisation and researching health in relation to unemployment and morbidity/mortality statistics (Lewis 1986).

During this transitory time when the emphasis on public health changed from societal to the individual (RUiHBC 1989) there was no specific reason why the MOsH could not combine the benefits of a wider public health remit such as the determinants of health and environmental influences, with the emphasis on provision of services and individual responsibility, but it was suggested they lacked the strength of resources and political will (O'Keefe et al 1992). Where health is seen to be not directly related to environment, social conditions or factors such as epidemiology but located within the individual, then the influence of the MOsH is subjugated and as a result, a new dimension must be applied to regain medical control and prominence.

In the early part of the 2000 decade there were four major areas of responsibility for public health physicians which included: Advising on the purchasing for health services, based on a knowledge of community health need and population social structure, the control of communicable diseases, research in communicable disease and public health and the design, management and evaluation of health promotion activities. (Farmer, Miller and Lawrenson 1996). Recently, in 2009, this remains much the same but with increased emphasis on assessing evidence and impact of programmes for health intervention through statistical databases and national collaboration, through public health observatories.

The focus on health as a separate entity was further emphasised following the WHO (1946) definition of health. 'Health is a state of complete physical, mental, and social

well being, not merely the absence of disease and infirmity' (cited in Seedhouse, 1986 p31). This sustains the notion of health as an achievable, sustainable state that the public have a right to expect. It could also be determined that the introduction of the welfare state would have come some way in making provision that attempted to address at least a portion of the determinants that effect the 'complete' acceptance of health. However the consummate and fixed position contained within this statement that to be healthy is to have complete physical, mental and social well-being, is open to dispute and ignores the right to well-being by those diagnosed with chronic illness and disability.

This version of health and well-being appears exclusive, potentially prohibiting some members of the population from being viewed as in a state of health. This positive declaration of health whilst unarguably altruistic, demonstrates similar parallels to the consensus model of health seen in functionalism, through its assumption of totality and disregard for individuals not fitting the criteria of either being completely well or being ill. Striving for the state of complete health appears to have become synonymous with the strive for perfection (Fitzgerald 1994) which in relation to resources available to improve health, will always be beyond the bounds of possibility.

Community medicine (1960-1988) was revived when the Seebohm Report on the Social Services (1968) forced social medicine into backslide (Robotham and Sheldrake 2000). The new community physician was to integrate the health services, be a specialist adviser and a skilled epidemiologist. The new social service professional was to provide a generic holistic personal social service. The 1974 reorganisation of the NHS brought about the inclusion of all subsequently local authority health services into the jurisdiction of the NHS. Local authorities employed environmental health officers and these were responsible for hygiene, sanitation and environmental safety, replacing public health inspectors. This was followed by the appointment of community physicians using their skills in infant and maternal welfare and replacing the MOsH (Kelly and Symonds 2003).

The rationalisation of public health and general practice defined GPs as taking over the work of personal health promotion, diagnosis and treatment leaving the community physician to be both an advisor to the health service and perform health needs planning (Lewis 1999). Some critics suggest rather than community medicine becoming a popular vehicle, it was a last-ditch rescue attempt to repackage public

health by renaming it community medicine, but doomed to fail as a result of the reduction of power and surveillance within the environmental health domain resulted in a continuing erosion of confidence within the auspices of public health (Lewis 1986).

Crisis in health

The 1970's personifies a time when critics began to question the efficiency and effectiveness of medicine and the associated link with medical and surgical iatrogenesis (Illich 1976). There was a view that not only were a proportion of medical diagnosis and interventions through pharmaceutical treatments and surgery ineffective but that they were also potentially harmful. Social action groups were in the forefront, fighting for the improvement of living conditions and recognition of human rights (Lupton 1995). The control of infectious diseases was identified as responsible for the drop in mortality (Mckeown 1976). These circumstances brought about a retraction from the pre-existing ideas of public health, centred round the bio-medical model and behaviourist health education approaches and a return to the public health principals adopted in the nineteenth century, environmental conditions in relation to health (Young and Whitehead 1993).

The environmental concerns from the 19th century had been replaced with a new set of environmental concerns for the 20th century, still relating to the primary issues of water, air and poverty. The secondary causes had now changed and 'new threats to public health emerge with technological change and the changing pattern of industrial production and consumption' (Public Health Alliance 1988 p6). The similitude between the public health practices of the nineteenth century and the 1970's is that they were established from grave concern of the socio-environmental hazards to health. The functionalist perspective may suggest that what had been described as pioneering vision, may simply be a pragmatic approach in returning the able bodied to supply the demand by capitalism for an increasing workforce and to diffuse the disaffected working classes (Lupton 1995).

The reliance on bio-medicine was being challenged alongside the realisation that more than simple diagnosis and treatment occurred during doctor/patient contact. The capitalist use of medicine in social control was linked to state institutions, as 'ideological state apparatus' (Althusser 1969) where control over numbers diagnosed as well as numbers treated, was used to legitimate illness. The interpretation of the role of medicine in social control and governmentality as offered by Parsons (1951)

and Zola (1972), regained prominence with theories that brought lay health perspectives to the forefront (Levin et al 1977) and suggestions that a consultation was a dynamic social construction (Dingwall 1976). The limitations of positivist research were recognised in parallel with an advancement of an interpretative approach. An understanding of phenomenology and action theory was utilised in interpreting the subjective meaning of illness (Schutz 1972) and the idea that 'health and being healthy' (RUIHBC 1989 p 38) are not one and the same thing. The notion of ill health had multiple interpretations and it was not always possible or desirable to provide a curative diagnosis.

This period was clearly a time of transition, with marxist and other radical debate effectuating the rise of the 'New Left' and the awareness of the role of the welfare state in its consensual approach in supporting capitalism and the perpetuation of class division through social housing and welfare benefit. The New Left argued for a 'political economy of the welfare state' and the appropriate positioning of state welfare within a capitalist economy (Gough 1979). The mounting social awakening combined with increased economic instability during the 1970's prompted what has been described as a 'rebirth of social medicine' (Adams et al 2002 p9).

The foundation for renaissance was launched by writings from the Fabian society (Townsend and Bosanquet 1972) principally relating to inequality, an issue that continued to gain momentum, culminating in the Black report of 1980 (Townsend and Davidson 1982). This report was suppressed by the conservative government, perhaps due to the shocking extent of inequalities highlighted and proposed national intervention for issues such as child poverty, which would have been in opposition to the government stance on state involvement in welfare. It was nevertheless influential in public health and as outlined in the Health Divide (Whitehead 1987) the gap between rich and poor was ever increasing. Whether the situation was obvious or suppressed, the pre-existing health and welfare provision was clearly not delivering a service to meet demand or expectation and a need to look elsewhere, adopting both responsiveness to, and an awareness of, global issues became paramount.

The emergence of health promotion merged with empowerment was the 'hidden ingredient' that brought policy together. The health promotion movement embarked with the Lalonde report, A New Perspective on the Health of Canadians (1974), World Health Organisations (WHO) Global Strategy for Health for all by the Year

2000 (1981) and its Ottawa Charter for Health Promotion (WHO 1986). Lalonde suggested ill health could be diminished by an awareness of environmental causation of ill health and the influences in respect to individual lifestyle choices (Bunton and Macdonald 1982). These were the impetus for the new public health movement. This was followed up in Britain by the policy document, Prevention and Health: Everybody's Business (DHSS 1976) the underlying belief in this suggested individuals were responsible for their own ill health and the popular behaviourist approach of victim blaming prevailed (Webster 1996). Critics agree that the document was significant but the prevention section described as rhetorical and the commitment amounted to 'nobody's business' (Watterson 2003 p 4).

The following document Priorities in the Health Services: The Way Forward (DHSS 1977) focussed on co-ordination of services and although encouraging preventative measures, remained vague in relation to resourcing these. Lalonde did succeed however in drawing attention to the high cost of traditional health care, treating pre-existing disease rather than improving the environment with a change in individual behaviour and that

'most direct expenditures on health are physician-centred, including medical care, hospital care, laboratory tests and prescriptions for drugs' (Lalonde 1974 p11-12).

Although Lalonde was widely acclaimed in the emergence of the 'new' public health movement, critics suggest that the report did little to control environmental risks and put their all into attempting to modify morally displeasing individual behaviour through the idea of health education empowerment (Tsalikis 1984).

The Lalonde Report (1974), World Health Organisation (WHO) Health for All (HFA) by the Year 2000 (1981) and the Ottawa Charter for Health Promotion (WHO 1986) were described as seminal documents in launching the health promotion phase of public health (Adams et al 2002). The significant feature between health promotion and new public health is in the interpretation of health as a positive concept, a right to be healthy, health as both achievable and sustainable. The HFA was updated and became Health 21 (WHO 1999). The HFA 21, described as consistent with the values of new public health but not those of bio-medicine, remains a central player. Some positive initiatives have come out of this and it has readily been accepted by action groups, but faces stiff opposition in a climate of globalised capitalism, where

human health and ecological environmental concerns are secondary to the pursuit of economic wealth (Halliday cited in Adams et al 2002).

The falling economic growth in the 1970's reverberated across the substance of society. The poor economical outlook provided little growth of available finance for the demands of the constantly increasing welfare state and a 'crisis' loomed, where policy planners and politicians would have to make unpleasant choices when faced with the harsh reality of a crisis in the welfare state (Mishra 1984). The ever-increasing cost of health care and finite resources were recognised as a crisis in health. This crisis had gained momentum in an atmosphere of escalating and conflicting demands on overstretched services, with limited available resources.

The demographic structure of the population was changing with older members making up an inverse demographic triangle. The reduction in infectious diseases and childhood illness and diseases was bringing about epidemiological transition, where the increased episodes of ill health were cancers and degenerative illness. At this economically unstable time unemployment was high, which would prevent the state monetarily balancing its books. There was crisis, with more expected to go out in benefits and health costs than it was expected would be retrieved in taxation. The persistent Fabian domination of social policy, which had remained tenacious since the post war period now underwent recapitulation from the left, and as outlined earlier, particular challenge from the 'New Left', although even the right had critics opposed to the intrusion of state provision into the mechanics of capitalism (Hayek 1944 cited in Alcock 2003).

The 'New Right'

The subsequent election of conservative Prime Minister, Margaret Thatcher in 1975 allowed the inception of the 'new right, a neo-liberal critique of state welfare and Fabian politics' (Alcock 2003 p11). This 'new right' also known as 'Thatcherism' became the ideology of the 1980's. The laissez faire attitude with diminished commitment to welfare highlighted the importance of a free market in protecting individual choice but the new right was a combination of economic liberal and conservative authoritarianism.

Whilst the government on one hand wished to withdraw from its universal provision and economic intervention, on the other, it wanted to increase the realm of its power over the population. The agenda was conspicuous in its ambition for privatisation.

The idea being that all members can choose and access 'health' which is a commodity available to all through the development of the market. However as we see through literature analysis, access to the market for individual health was performed by a third party, the GP. The conservative government went on to win the election in 1983 despite concern relating to the safety of the NHS following their suggestions for privatised health care and reinforcement in means testing for welfare benefit.

The recommendations from the Griffiths report (DHSS 1983) were implemented to increase efficiency and effectiveness and the advent of 'professional management' (Kelly and Symonds 2003) attempted wresting of power from the medical profession in relation to decision making and administrative control. This removal of administrative control was welcomed by those who saw the medical profession's lack of administrative control as a central problem in the first place (Alcock 2003).

The economy of health care was revolutionised by the introduction of the White Paper Working for Patients (DH 1989) where hospitals were to compete with other hospitals for patients and to be a patient was to be an active consumer (North 1997). Critics proposed however that this increased medical dominance, it was not the patient that was given choice as an individual, but the GP given the power to act on their patient's behalf. This was reinforced by The NHS and Community Care Act (DH 1990) with the proposal for a quasi-market and the subsequent purchaser provider split (Bartlett 1991, Bartlett and LeGrand 1993). This saw the increased status of the GP fundholders, with power to allocate spending to state or private service provider and the concentration on health relating to the GP catchment area and funding for services within restricted criteria.

The community professionals involved with these practices have been described as being 'owned' by the fundholding practice (Watterson 2003) and therefore restricted from previous joint working and providing public health on a broader scale. This position whilst accurate to the point for broader public health, was slightly inaccurate in regards to improving public health generally, because a proportion of fundholding employed health professional actually had resources allocated to them to provide services for their clients, albeit attached to the practice. In fact the position of privilege of knowledge relating to the needs of the target area actually opened up opportunities for health professionals in commissioning services, but on the downside, the fragmentation of resources and staff had the adverse effect of

increasing the difficulties in providing a co-ordinated service (Weaver 1996). The initial criteria for fund-holding was for practices over 11,000 patients which excluded most single handed GP's in inner city practices.

By 1994 80% of practices in affluent or rural locations were fundholding and only 4% in inner cities, due mainly to the highly mobile population and increasing workload (Pulse 1994). Successful practices benefited from generous budgets, manageable clientele and could manipulate their position for shorter waiting times and a wider choice of service. The GP practices that were not fundholding were becoming part of consortia commissioning groups; this increased their purchasing power through sheer number. They formed an alternative influence, locality commissioning (Rivett 1997). Total purchasing practices also emerged with business managers and large budgets. Made up of consortiums of fundholders they were responsible for providing for all hospital and community services including emergency treatments (Salter 1998).

Was this purchaser/provider split the best way forward for health care provision and the improvement of public health? Those fortunate enough to be a patient on the books of a successful GP fundholding practice, were without doubt receiving improved services to a degree, but this had effects on overall cohesion of the NHS. The government described the internal market as necessary by the government, to restrain the escalating costs of health services and control health professionals through managed competition (Naidoo and Wills 2000).

The NHS has been described as bringing together disparate units, eliminating gaps in the system and reducing inappropriate competition with the purchaser/provider split an action of deconstructing the NHS (Rivett 1997). The gaps in this system being the health of a proportion of the general public. The drive to reduce the NHS from being a service for illness to a service of prevention was outlined by the Promoting Better Health (DH 1987) and Health of the Nation (DH 1992). These documents focused on health promotion, setting targets for health improvement. They directed their focus onto individual behaviour and whilst certainly setting targets to demonstrate the drive to improve public health in areas such as accidents, cardiovascular disease, cancers and mental health, in actuality, they failed to acknowledge the influence of economic factors and social circumstance on health. It was also said that too much prominence to the role of the health service in delivering

this health promotion was given at the expense of social, economic and educational policies to promote health (Watterson 2003).

The 'Third Way'

The internal market, without doubt gave more power to managers, whether in acute care or primary care and that far from improving efficiency and effectiveness, an increasing amount of time was now taken up with budgets and administrating finances and contracts (Alcock 2003). When the labour party came to power in 1997, fundholding was removed and the third way began, described as a system of partnership and performance, a non-beaurocratic, non-divisive market approach as outlined in the White Paper, *The New NHS – Modern, Dependable* (DH 1997). Fundholding was replaced by the formation of Primary Care Groups (PCG's) and then later, to Primary Care Trusts (PCT's). PCG's were large groups of GP practices serving populations of 250,000 who were answerable to the district health authorities who were the key figures for planning health services within this designated area and allocating resources to the PCG's. The vision was for strategic allocation of health resources in relation to local health needs and the drawing up of Health Improvement Plans (HImP). The overall desired outcome was a correlative process focusing on user (the patients, community) their life circumstances, lifestyle and health but assessing these against national standards. The document *A First Class Service* (DHa 1998) expressed health improvement aims and clinical excellence and clinical governance emerged.

The Acheson Report (1998) was commissioned by the new government to assess health inequality and guide future policy development. Although the report appeared to formulate as a review of the Black Report (1980) it avoided reference to the cost of health care and set out instead to raise awareness for family health services, in particular, families with children. There was an acceptance of environmental influences of health and ill health. Whether it was to benefit the state, industry or the individual, the central focus was on the health of the public, a necessity for a productive society. The public health agenda appeared re-energised within the strategy to strengthen public health (Calman 1998) with accompanying documentation comprising of white paper *The New NHS* (DH 1997) and green paper *Our Healthier Nation* (DHb 1998). Supporting these documents was the government drive to develop a multi-disciplinary workforce in public health. An issue of possible contention, raised from the initial literature search and reappearing throughout the study, was the 'ownership' of public health by the medical profession. This ongoing

situation of professional protectionism and control although having its foundations of supremacy firmly placed historically, has politically been apparent from the appointment of the first medical officer for the government, John Simon who was given a place on the General Board of Health in 1854.

In his speech, Alan Milburn, the English Secretary for Health (March 2000) spoke about 'taking public health out of the ghetto'. This has been interpreted as attempt to remove the complete control over public health by the medical profession with a proposed development of a new non-medical role of specialist in public health. (Milburn 2000). Prior to 2002, applications for senior public health specialist posts were restricted to the medical profession, despite the medical professions ineptitude in making public health central to the medical curriculum or a medical speciality (Lewis 1991). This is supported by other critics who have suggested there are fundamental inadequacies in the public health function which clearly amount to a need for restructuring of the discipline (Sally 1996).

The profession has been repeatedly questioned for their narrow medical definition of public health (De Witt and Carnell cited in Griffiths and Hunter (1999). Furthermore it has been suggested that faced with the 'location paradox' of their professional and procedural role they cannot effect change sufficiently to either improve public health or reduce health inequality (Goraya and Scambler 1998). Debate has taken place particularly since 1972 surrounding the development of non-medical public health posts but it was said the perceived enhancement embodied within maintaining links with the Royal Colleges of Physician held too much allure and there have been either exclusions to training and funding for non-medical professionals or poorly defined career pathway (Evans 2003).

New Public health

Commentators have suggested that public health is ever changing and 'the practices and discourses of public health are not value free or neutral, but rather are highly political and socially contextual, changing in time and space' (Lupton 1995 p2). With the review of the literature supporting this, we have seen how the agenda for public health has presented in different formats throughout history and as knowledge developed, so did the practices of public health. It can be seen through literature review, that most of these relate directly to the political influence of the time.

The current position, despite technological and medical advances is an environment 'where the health gap between rich and poor is growing in line with the income gap and a generation of overweight and under-exercised individuals is maturing' (Hunter 2003 p 573). The gap has been identified as growing faster in some countries than others, but it is not actually closing anywhere (WHO 2002). The 'place', be it work or living space clearly remains instrumental in shaping the future health of individuals.

Some commentators suggest that interest in public health in the United Kingdom is actually marginalised by interest and commitment to the mainstream sector and that fundamentally, public health lacks both distinct direction and an adequate infrastructure (Hunter and Goodwin 2001). This may be supported by the apparent investment in the NHS Plan (DH 2000) and the Inquiry by the House of Commons Health Committee into Public Health (2001), which followed.

Public health is about multi-disciplinary practice and partnership working (Baggott 2000, Cowley 2002, McPherson and Fox cited in Scally 1997). The reality of working in such a diverse format would be a complex task in view of the individual and localised nature of some of the partnerships and therefore could not be prescribed too rigidly. The inclusion of these wider partnerships involves community development, education, health promotion, housing and work with various disciplines in an attempt to improve the health of the public (Griffiths and Hunter 1999).

The nature of joint working and multi-sectorial approaches to public health, whilst perhaps benefiting from a degree of flexibility, fundamentally need to be set in unambiguous frameworks and with clear objectives. Whilst these could be said to be unequivocal in the earlier policy documentation (DH 1998, DH 1999) there is awareness that the previously high profile of public health was not perpetuated in the NHS Plan (DH 2000). There was grave concern that public health had been downgraded and the document was vague in relation to public health, with little to say on the crucial issues of joint working (Baggott 2000, Hunter 2003).

Public health was central in the document Tackling Health Inequalities- A programme for action (DH 2003) where a clear plan was set out to reduce inequality, reduce infant mortality and improve life expectancy. The Wanless report – Securing good health for the whole population (DH 2004) acknowledged the determinants of health and the prevention of ill health and was accompanied by economic investment and more policy development. The NHS improvement plan (DH 2004) set out priorities

for health between 2004 and 2008, with a vision for public health in 2008 and support for the 10 year process of reform as outlined in the NHS plan (DH 2000). In recognising the changing context of health needs and the ever increasing issue of health inequality, a range of forward looking policy documents followed, Choosing Health: Making Healthier Choice easier (DHc 2004), encouraging individuals to take action on avoidable ill health and improving communities for all including particularly the vulnerable.

The consultative green paper, Creating a patient led NHS (DH 2005), outlined the need for a health care service designed around the needs of the patients rather than the patients needs being forced to fit the services already provided. Another key document, Our health, Our care, Our Say (DH 2006) highlighted the need for a public health focused workforce, that is skilled, flexible and well resourced to underpin the move from acute hospital based care to care that is provided in the community. The emphasis now firmly fixed on improved choice and improving long term health with greater prominence on health promotion, prevention of ill health and health support. Furthermore there are clear messages for improving public health in the interim report by Lord Darzi, Our NHS, Our Future (DH 2007) where the six key goals for health improvement are linked to both social and behavioural factors. These social factors are known as the social determinants of health and are seen to be the factors that influence people's health (CSDH 2005). The final report of Lord Darzi: High quality care for all (DH 2008) underpins these goals for improving health with plans for investment in well being and prevention services. This investment will involve health authority and local authority joint working to tackle the six key goals of tackling obesity, reducing alcohol harm, treating drug addiction, reducing smoking rates, improving sexual health and improving mental health. The role of the NHS in this is set out clearly as an NHS that helps people to stay healthy. Darzi refutes the term 'nanny state' saying 'for the NHS to be sustainable in the 21st century it needs to focus on improving health as well as tackling illness' (DH 2008 p9).

Conclusion

The issue of defining public health through review of the literature has proved complex, the term 'public health' means different things to different people. It is about the health of the public, but how we define the 'public' is open to discussion. The term suggests a collective ownership, but in the decade leading up to 2010, the responsibility lies with the individual in maintaining their personal health, supported

by society and the government agencies and can encompass a broad range of relationships between those receiving and those providing services.

Who owns the public's health? Is the term 'public health' an oxymoron? Can we ever have public health in the true sense? Public health may be seen as a collaborative effort. It may be a necessary pre-requisite for modern life, to support initiatives for a longer, healthier life span, or it may be a product of social engineering to ensure a physically able, regulated workforce, which translates into an ordered, controlled population.

Through deconstructing ideologies, it can be seen that public health relates to society and its profile and purpose in modern day relates directly to the influence of the political party in position at the time. The political party may also in turn be influenced by societal shifts, which may force change. The 19th century 'sanitary reform movement' preceded further reform through individuals such as Jeremy Bentham and Edwin Chadwick. These reforms like those experienced in earlier and later times, were undoubtedly of some altruistic value from a humanitarian perspective but they were also beneficial in maintaining a productive workforce. This productive workforce is in turn of value to the employee in acquiring income and the employer in gaining wealth. This may generate an affluent society but it also has a bearing on health and the influences of health, particularly those on reduced incomes.

The similarities in past and present behaviours are worthy of comment. Reflecting on the pre-enlightenment era, fear and suspicion, fuelled ignorance particularly in relation to the control of infectious diseases and communities were encouraged to report members who were displaying symptoms of illness and disease but in modern times the idea of such over-reaction to newly recognised illness seems primeval, but fear and ignorance sustained the population's reaction. Some critics have drawn similarities with the late 1980's, early 1990's and the over-reaction and retributive victim-blaming surrounding the diagnosis of HIV/AIDS. In the absence of an immediate and convincing 'truth', lay perspectives, fuelled by an iniquitous and misapprehending media onslaught, appeared to take refuge in a convenient interpretation, with limited positivistic knowledge, the result of which was stigma and labelling in an attempt to control and comprehend the spread of disease and ill health.

The age of industrialisation brought rapid social change, slowly accompanied by acknowledgement of the social model and the effect of the social determinants of health. The period of industrialisation highlighted the issue of social control, where from a Marxist perspective, the poor and ill proletariat could be said to need to return to health and work to ensure the wealth of the bourgeoisie and a functionalist perspective where conforming to prescribed rules and regulations promotes social order.

Throughout this study the chronological development of public health has been mapped out, supported by the outlining and discussion of the emerging themes and influences pertaining to the study of public health. The initial challenge was the difficulty in defining public health. Public health, interpreted through the use of a multitude of definitions appears to refer to the general health of the population and their longevity and resistance to disease. The influences of public health are acknowledged as extensive, setting public health in a model that is a juxtaposition of science and art. The outside influences on health such as social policy must in response to this, develop a strategy that recognises the wider determinants of health and the role others outside bio-medicine can play in improving public health. To be successful in raising the profile of public health and bringing about improvement, researching the topic has shown that we must direct our approaches through the most appropriate model for our society, at a given time, supported by a comprehensive and explicit definition.

There is clear revision of the model of public health delivery with the recent public health documentation appearing to recognise the challenges facing public health such as inequalities in health, chronic illness, poverty and lack of services (DH 1999, DH 2003, DH 2006, DH 2008) and setting out through action plans and initiatives new ways of working, to strengthen the role of the NHS in improving health and preventing ill health (DH 2000, DH 2004a, DH 2006). We have observed that health funding cannot increase at the rate of growth required to sustain demand. What is not clear is whether this funding pertains to caring for ill health or improving health. Key studies have illustrated how inequalities in health still persist and life in a modern society presents many new risks.

This leads to the conclusion that public health has been remodelled not only to gain the interest and support of voters, but also in an attempt to demonstrate responsiveness to the changing needs of society and implementing initiatives to

improve the health of young children and families. The general understanding of the public health agenda from the third way onwards translates into a different style from public health approaches preceding it. It acknowledges the wider determinants of health and a broad identity. The historical approaches to public health have included many differing criteria the most commonly presenting factors were that of environment, sanitation and individual behaviours. There is an acceptance that the environment and sanitation have a direct effect on health, demonstrated through contamination and industrial /work related illness, from the past and in the present, the prevailing domination of capitalism however limits progress and sets differing patterns of inequality that cannot be simply rectified by redistribution of income and resources.

It is appropriate that government policy to improve public health be delivered in a strategy that recognises the need for health improvement at times when the greatest impact on health is poverty and exclusion. The evidence reviewed demonstrates clearly that poor health without appropriate resources or intervention is cumulative and that the 'right' form of intervention can bring about long term health gains. Intervention from a national agenda needs to include individual's health, the health of the community, improved access to services and cultural and value changes. The message is clearly to reduce the domination of the medical profession over the delivery of public health and awareness of the failure of technical knowledge in bringing about substantial improvement in public health.

Review of the literature has demonstrated that approaches to public health come in and out of vogue. They are also influenced by the prevalent government ideology. The ambition for the future of public health must be to reflect on the past and bring forward the successful reforms and innovative practices to inform the future. Public health must also be informed by the dialogue of wider lay discourse. The one certainty must be that public health remains a significant issue and will not be easily overlooked, whichever political party is in power and the historical adversaries, the social determinants of health, namely education, housing and poverty, remain constant in their ability to influence health of the individual and the population, throughout the lifespan.

References

Acheson D (1998) Independent Inquiry into Inequalities in Health, the Acheson Report, London. T.S.O.

Adams L, Amos M and Munro J (2002) Promoting Health Politics and Practice. London. Sage.

Alcock P (2003) Social Policy in Britain. (2nd Ed) Hampshire. Palgrave Macmillan.

Armstrong D (1993) Public health spaces and the fragmentation of identity. Sociology, 27 (3) 393-410

Ashton J and Seymour H (1988) The New Public Health. Milton Keynes. Open University Press.

Baggott R (2000) Public Health, Policy and Politics. Basingstoke. Palgrave.

Bartlett W (1991) 'Quasi-Markets and Contracts: A Markets and Hierarchies Perspective on the NHS Reforms', Public Money and Management. (11) 53-61

Bartlett W and LeGrand J (1993) Quasi-Markets and Social Policy. Basingstoke. Macmillan.

Bennett J and DiLorenzo F (1999) The Food and Drink police: America's nannies, Busybodies and Petty Tyrants. New York. Transaction.

Brown T and Duncan C (2002) Placing geographies of public health. Area (2002) 33.4, 361-369 Royal Geographical Society.

Bunton R and Macdonald G (1992) Introduction. In Bunton R and Macdonald G (eds) Health Promotion: Disciplines and Diversity. London. Routledge.

Calman K (1998) Chief Medical Officers Project to Strengthen the Public Health Function in England: a Report of Emergent Findings. Leeds. NHS Executive.

Cipolla C M (1992) Miasmas and Disease: Public Health and the Environment in the Pre-Industrial Age. New Haven, CT. Yale University Press.

Costello J, Haggart M (2003) Public Health and Society. Basingstoke. Palgrave Macmillan.

Cowley S (2002) (ed) Public Health in Policy and Practice: A sourcebook for health visitors and community nurses. Edinburgh. Balliere Tindall.

CSDH (2005) Commission on Social Determinants of Health. Action on social determinants of Health: learning form Previous Experiences: background paper prepared for the Commission on Social Determinants of Health, WHO. Geneva WHO

DH (1987) Promoting Better Health. The Government's programme for improving primary health care. Cmnd 249. London. HMSO.

DH (1989) Working for Patients, White Paper. CM555 London. HMSO.

DH (1990) The NHS and Community Care Act. London. HMSO.

DH (1992) The Health of the Nation: A Strategy for Health in England. London. HMSO.

DH (1997) The New NHS: Modern, Dependable, CM 3807 London. HMSO.

DH (1998a) A First Class Service. London. The Stationery Office.

DH (1998b) Our Healthier Nation, Green Paper 3852 London. HMSO.

DH (1999) Saving Lives: Our Healthier Nation White Paper, CM 4386, London. The Stationery Office.

DH (2000) The NHS Plan. A plan for investment, a plan for reform
London. The Stationery Office.

DH (2003) Tacking health Inequalities: a programme for action. London HMSO

DH (2004a) Securing good health for the whole population. The Wanless report.
London HMSO

DH (2004b) The NHS improvement plan: putting people at the heart of public services. London HMSO

DH (2004c) Choosing Health: Making Healthy Choices Easier HMSO London

DH (2005) Creating a Patient-Led NHS, London, HMSO

DH (2006) Our Health, Our Care, Our Say, London, HMSO

DH (2007) Our NHS, Our future. The interim report by Lord Darzi. dh.gov.uk

DH (2008) High Quality care for All. Next stage Review, Final Report by Lord Darzi. London, TSO

DHSS (1976) Prevention and Health: Everybody's Business. London. HMSO.

DHSS (1977) Priorities for the Health and Social Services: the Way Forward. London. HMSO.

DHSS (1983) NHS Management Inquiry (Griffiths Report). London. HMSO

Dingwall R (1976) Aspects of Illness, London, Martin Robertson

Donald J (1992) Sentimental Education: Schooling, Popular Culture and the Regulation of Liberty. London Verso

Evans D (2003) 'Taking public health out of the ghetto': the policy and practice of multi-disciplinary public health in the United Kingdom. Social Science and Medicine (57) 959-967

Farmer R, Miller D and Lawrenson R (1996) Epidemiology and Public Health Medicine. 4th ed. Oxford. Blackwell Science.

Finch L (1993) The Classing Gaze: Sexuality, Class and Surveillance. Sydney Allen and Unwin.

Fitzgerald F T (1994) The tyranny of health. New England Journal of Medicine. 331 (3):196-198

Foucault M (1975) The Birth of the Clinic: An Archaeology of Medical Perception, New York Vintage Books.

Foucault M (1991) Governmentality. In Burchell G, Gordon C and Miller P (eds) The Foucault Effect: Studies in Governmentality. Hemel Hempstead. Harvester Wheatsheaf.

Goraya A and Scambler G (1998) From old to new public health: role tensions and contradictions. Critical Public Health 8, 141-151

Griffiths D and Hunter D (1999) (eds) Perspectives in Public Health. Oxford. Oxford Radical Medical Press.

Gough I (1979) The Political Economy of the Welfare State. London. Macmillan.

Hamlin C (2000) Public Health and Social Justice. In The age of Chadwick: Britain 1800-1854. Cambridge. Cambridge University Press.

Hart N (1985) The Sociology of Health and Medicine. Lancashire. Causeway Press Limited.

Holland W and Stewart S (1998) Public Health: The Vision and the Challenge. London. Nuffield Trust.

Holliday M, Parker L (1996) Florence Nightingale, Feminism and Nursing. Journal of Advanced Nursing 1997, 26 483-488

Hunter D and Goodwin N (2001) How to get promoted. Health Service Journal, 111 (5674), 26-27

Hunter D J (2003) The Wanless Report and Public Health, Editorial. BMJ 2003;327:573-574 (13 September 2004) accessed at <http://bmi.bmjournals.com>

Illich I (1976) Limits to Medicine: Medical Nemesis: the Expropriation of Health. London. Marion Boyers.

Iphofen R and Poland F (1998) Sociology in Practice for Health Care Professionals. Basingstoke. Palgrave.

Jones G (1986) Social Hygiene in Twentieth Century Britain. Beckenham. Croom Helm.

Kelly A and Symonds (2003) The Social Construction of Community Nursing. Hampshire. Palgrave Macmillan.

Klein R (1989) The Politics of the NHS. London. Longman.

La Berge A F (1992) Mission and Method: The Early Nineteenth-Century French Republic Health Movement. Cambridge. Cambridge University Press.

Lalonde M (1974) A New Perspective on the Health of Canadians. Ottawa: Health and Welfare. Canada.

Levin L.S., Katz A.H., and Holst E. (1977) Self-Care: Lay Initiatives in Health. London, Croom Helm

Lewis J (1986) What Price Community Medicine? The Philosophy, Practice and Politics of Public Health since 1919. Brighton Harvester Wheatsheaf

Lewis J (1991) The public health: philosophy, practice and politics of public health since 1919. Brighton. Wheatsheaf Books.

Lewis J (1999) The concepts of community care and primary care in the UK: the 1960s to the 1990s, in Health and Social Care in the Community. 7 (5) 333-341

Lupton D (1995) The Imperative of Health. Public Health and the Regulated body. London. Sage.

Mackenzie N and J (1979) The First Fabians. Guildford. Quartet Books.

McKeown T (1976) The Role of Medicine: Dream, Mirage or Nemesis? London. Nuffield Provincial Hospitals Trust.

Milburn A (2000) A healthier nation and a healthier economy. The contribution of a modern NHS. LSE annual lecture, 8 March 2000. (www.doh.gov.uk/speeches/marchspeech.htm)

Mishra R (1984) The Welfare State in Crisis. London. Wheatsheaf.

Naidoo J and Wills J (2000) Health Promotion. Foundations for Practice. 2nd ed London. Balliere Tindall.

North N (1997) Consumer Service Users or Citizens? in North and Bradshaw (eds) Perspectives in Health Care. Basingstoke. Macmillan.

Nutton V (1992) Healers in the medical marketplace: towards a social history of Graeco-Roman medicine, in Wear A (ed) Medicine in Society: Historical essays, p 15-58 Cambridge. Cambridge Open University Press.

Oakley A (1984) The Captured Womb: A History of the Medical Care of Pregnant Women. Oxford. Blackwell.

O'Keefe E, Ottewill R and Wall A (1992) Community Health. Issues in Management. Sunderland. Business Education Publishers Limited.

Peterson A and Lupton D (1996) The New Public health; Health and Self in the Age of Risk. London. Sage.

Porter R (1996) (ed) Cambridge Illustrated History Medicine. Cambridge. Cambridge University Press.

Public Health Alliance (1988) Beyond Acheson: an agenda for the new public health. London. Public Health Alliance.

Pulse (1994) Fundholding GP's winning the battle for London? Pulse 1994; Sept 17: 34

Research Unit in Health and Behavioural Change (1989) Changing the Public Health. (RUiHBC). University of Edinburgh reprinted 1993. Chichester John Wiley and Sons.

Rivett G (1997) From Cradle to Grave, Fifty Years of the NHS. London. Kings Fund Publishing.

Rosen G (1993) A History of Public Health Baltimore: John Hopkins University Press cited in Costello and Haggart (2003)

Salter B (1998) The Politics of Change in the Health Service. Basingstoke. Macmillan.

Scally G (1996) Public Health Medicine in a new Era. Social Science & Medicine, 42, 777-780.

Scally G (1997) Progress in Public Health. London. FT Healthcare.

Schutz A (1972) The Phenomenology of the Social World. London. Heinmann.

Searl G (1971) The Quest for National Efficiency. Oxford. Blackwell.

Seedhouse D (1986) Health: the foundations for achievement. Chichester; John Wiley.

Senior M and Viveash B (1998) Health and Illness. Basingstoke. Palgrave.

Townsend P and Bosanquet N (eds) (1972) Labour and Inequality: Sixteen Fabian Essays. London. Fabian Society.

Townsend P and Davidson N (1982) Inequalities in Health: the Black report. London Pelican Books.

Tsalikis G (1984) The consequences of Canadian health policies, in Issues in Canadian Social Policy, Volume 2, Canadian Council of Social Development, Ottawa 121-160

Turner B S (1990) The interdisciplinary curriculum: from social medicine to post-modernism. Sociology of Health and Illness, 12 (1), p1-23

Turshen M (1989) The Politics of Public Health. London. Zed Books.

- Watterson A (2003) (ed) Public Health in Practice. Hampshire. Palgrave Macmillan.
- Wear A (1992) Making sense of health and the environment in early modern England. In Wear A (ed) Medicine in Society: Historical Essays. Cambridge. Cambridge University Press.
- Weaver R (1996) Localities and inequalities cited in Bywaters P and McLeod E (ed) Working for Equality in Health. London. Routledge.
- Webster C (1996) The Health Services since the War, II The Government of Health Care. The British National Health Service 1958-1979 . London. The Stationery Office.
- Whitehead M (1987) The Health Divide. London. Health Education Council.
- WHO (1981) Global Strategy for Health for All by the Year 2000. Geneva. World Health Organisation.
- WHO (1986) Ottawa Charter for Health Promotion. Geneva. World Health Organisation.
- WHO (1999) Health 21: The Health for All Policy Framework for the WHO European Region. Copenhagen: WHO Regional Office for Europe.
- WHO (2002) Public Health Management. World Health Organisation – University of Durham meeting report. Prepared by Prof. D J Hunter, University of Durham, England.
- Wohl A S (1983) Endangered Lives: Public Health in Victorian Britain. London. J M Dent & Sons.
- Young I and Whitehead M (1993) Back to the future: our social history and its impact on health education. Health Education Journal 52 (3) 114-119
- Zola I (1972) Medicine as an institution of social control. Sociological Review 20 (4) 487-594

