

Introduction: Challenge and Controversy in Promoting Public Health

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Multidisciplinary public health as an approach and an ideal emerged relatively recently; indeed, it could be argued that it is still rhetoric rather than reality. It is still raw at the edges: conscious of its roots in medical public health and struggling to incorporate other professional groups, disciplines and sectors that may view the world and health priorities in very different ways. Its gaze is still arguably medical, dwelling on prevention, rather than social, looking towards positive health and wellbeing.

In this Reader we will be investigating the different dimensions of multidisciplinary public health, not only in their own right but also to help us understand and chart public health into the future. For if public health in the UK started with health protection – the famous Dr Snow taking the handle off the Broad St water pump in London in 1854 and demonstrating the practical impact of epidemiology – it now has to encompass health education, health promotion, health improvement and a range of sub-disciplines and approaches. Alongside policies to improve the prevention and control of infectious diseases and other environmental threats to population health – from chemicals, air pollution, and so on – sit policies to tackle health inequalities, promote healthier choices, enable individuals and communities to take greater control over their lives and build healthier public policy. In addition to epidemiological surveys and randomised controlled trials, researchers in multidisciplinary public health now have a battery of other methodologies and techniques to deploy in order to build evidence-based practice, some of which engage communities and service users directly in the research process.

Public health needs to be multidisciplinary in another sense too. It has arguably been disadvantaged by its close historical association with health service provision focused largely on medical treatment. But prevention of ill health, and beyond this promotion of enhanced health and wellbeing, cannot be achieved by any one policy sector acting alone. The priority is for multi-sectoral policy development and action at global and international level, across government, local authorities, the voluntary, independent and for-profit sectors and embracing many organisations and agencies.

A further dimension relates to the changing workforce. Multidisciplinary public health is an arena of struggle to fix new boundaries and keep or gain recognition. As the health sector has been successively restructured across the UK, the position of some groups, notably those involved in health promotion, has become precarious. The majority of directors of public health and senior public health practitioners still have a medical background, although

registration is no longer restricted and includes some with backgrounds in social science, nursing, health promotion and psychology. In contrast, the wider public health workforce is made up of increasingly heterogeneous professional and ancillary groups, distributed across the health and social care sectors, in education, local authorities, police and prisons, workplaces and the voluntary sector. The logic of public health development is that it should become 'everybody's business' in the challenge to create healthier societies.

All these dimensions of multidisciplinary public health will get a hearing but we start in Part I by taking stock of the scope and ambition of contemporary public health. In particular, the focus is on the increasing reach and complexity of public health activity as it has developed over the last century and how far tensions inherent in such expansion need to be resolved. Over the last twenty years, for example, a 'new' public health has been forming, influenced greatly by health promotion, which responds to growing evidence about the social determinants of health and health inequalities by a renewed commitment to public policy change. On the other hand, there are suggestions that health promotion has thrown the health education baby out with the bathwater and that a 'new' health education is now needed to push towards empowerment and social change (Green, 2008). A related question is whether public health can really expect to prioritise healthy public policy, community health development and health education, when these approaches are rooted within very different cultural and political traditions.

Part II looks at the tools and techniques for developing evidence-based practice and seeks to make explicit the links between approaches to public health research and knowledge about health. Rooted in epidemiology, public health research has gradually become more reflective and eclectic. The questions to be asked have been extended to encompass positive health and wellbeing and exploration of the broader determinants of health. Because of this, new debates have surfaced about what counts as evidence, how effectiveness should be measured and what constitutes robust evaluation. Tantalisingly, the researched are themselves becoming co-researchers. The hierarchy of research methods is finally being challenged by multidisciplinary research teams who are forging the evidence base for public health by pioneering new approaches and mixing methodologies.

The public health evidence-base feeds both policy and practice. During the last decade UK politicians have made much of the need to build the evidence base in areas such as health determinants and inequalities and apply it to policy making. At an international and global level there has also been a steady stream of evidence documenting the global health challenge. Part III juxtaposes evidence of the significant advances made in global disease control with evidence of the threat presented by new diseases such as SARS and the continued challenge posed by poverty and natural disasters. At national, international and global levels the policy debate turns on the response that public health should make and how extensive this should be. What are the implications of viewing security, human rights, fair trade, good governance and global citizenship as concerns for public health rather than matters lying outside the health arena? Should we combat transnational health problems by building global governance in the name of health?

The evidence base also enriches, and is fed by, public health work at a local level. Communities and organisations provide the settings within which policies are tested, implemented, adapted or discarded. They in turn feed the policy-making process by providing evidence of innovations, workable solutions and sometimes costly failures. Part IV considers the implementation of policy in local communities and the barriers to, and enablers of, participatory and community action for health. The settings approach has

always been a backbone of health promotion and the potential for work in settings which challenges a narrowly medical approach to health is evaluated. For most of the history of public health localities and organisations have been viewed in terms of a deficit model in which public health professionals compensate for the inadequacies of the community. Thinking about communities in terms of social capital begins to shift that view and focus on local resources and strengths.

Finally, in Part V, we turn to look at the future for multidisciplinary public health. What does it hold and how will multidisciplinary public health develop? As more is understood about the social determinants of health, proposed interventions become more complex and wide-ranging and public health extends its boundaries further. Has public health lost its way, by trying to reach into and regulate every part of life as some would argue (Peterson and Lupton, 1996)? Or is the more pressing problem the relatively lowly position that public health still occupies in contrast to the imperatives of economic growth, consumption and material prosperity? Are we comfortable with the imperialism of public health: claiming new areas for action and finding new public health-related problems? Should we be conceptualising health within a rights-based framework as a 'global public good', as Kickbusch and Seck claim in Chapter 19, or should public health be content to focus more modestly on tackling ill health and changing health behaviour? Is public health inevitably a political endeavour as well as an arena for professional engagement? Or perhaps, after all, it is possible and necessary to juggle all these goals, to combine public health, health promotion and a reinvigorated health education and to create a powerful multidisciplinary public health for the twenty-first century and beyond.

References

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