

## **Health and Environment - Integration**

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This morning, Dr. Rafei very kindly referred to the New Public Health, reminding us that the focus of public health has transferred from the environment towards personal hygiene and therapy. He continued by emphasizing how we have become very skeptical in the last ten or twenty years about the potential for universal health improvement from such therapies. This concern underlies the discussion of the New Public Health. Dr. Griffiths reminded us, this morning, of the important role of local action in public health improvement. Also, Dr. Stamps focused our attention on international trade considerations and our concern with the Seattle discussions and the impact that they will have on health.

When we examine the definition that Dr. Rafei gave of public health, which is derived from discussions by Charles Winslow in 1920, it seems remarkably modern. But when we closely examine it, we realize how biased health care systems have become. I have an increasing concern with the use of the term, "health system," when what is meant is "health care system." William Henry Duncan, Liverpool's (indeed the world's) first Medical Officer of Health in 1847, was very much an environmentalist. He was very concerned about sanitation, water systems, and other public health matters. Gerry Kearns, a historian of public health in the United Kingdom, reminds us that those earlier medical officers of health had three functions: they registered births and deaths, notified cases of infectious disease, and advised local government on appropriate action.

We have relearned that, generally, good health is actually lost through factors that have very little to do with health services. Sian Griffiths reminded us of the recent British White Paper, which identifies the determinants of health, including poverty, employment, sanitation, housing, environment, water quality, social networks, diet, smok-

ing, alcohol, and access to quality services; health services are only one among many. The debate about the New Public Health, which has continued for about twenty years in different countries, has obviously also occurred here in the South-East Asian region. I do not think that it is appropriate to be too disheartened over the achievements of the past few years, but, at the same time, the challenges are very urgent, and the public health agenda is dynamic and fast-paced.

The focus on rural health, which (until eight years ago) was a common feature of WHO policy, has shifted to a more urban focus. The interplay of environmental factors was discussed at the Geneva World Health Assembly in 1991, and the chairman of the technical discussions, Sir Donald Acheson, concluded the following: decentralize services, mobilize the population to cooperate to improve environmental health, invest in the environmental infrastructure, and improve the quality of homes. A Liverpool community group, which is very actively involved in improving their community-owned enterprises, has an interesting expression concerning the city council: "When they want your opinion, they will tell you what it is." That phenomenon is actually very common. Although Sir Donald was referring to the problems of developing countries, the implications have universal applications.

If we study the history of public health, we find that, in many countries of this region, public health was grounded in the existing sanitary problems. The solutions were very typical: they were Victorian-based and involved the construction of sewage pipes that carried sewage into the environment, polluting rivers. Only in the last twenty or thirty years have we realized the essentially crude nature of the entire "sanitary" public health movement. It now is quite poignant to look at Albert Schweitzer's comment (when he was regarded

as an eccentric)—that man “has lost the capacity to foresee and to forestall, he will end by destroying the world.” We must think of ourselves as an animal species in a habitat. Today, that habitat is essentially becoming an urban habitat, and we must learn to live in this environment. The recognition that the New Public Health must be based in ecological, rather than sanitary, ideas should be the basis of our thinking.

Approximately ten years ago, WHO, in Europe, held a workshop to explore the ecological aspects of town planning. Four principles were derived from the discussions:

- 1) Maximum variety — “Don’t put all your eggs in one basket.”
- 2) Closed systems – If we study urban areas like Calcutta or London and examine their environmental footprints (the relationship of those cities with their environments, such as the use of raw materials, the pollution, and the impact of greenhouse gases) we realize that closed systems which consume their own pollution, as much as possible, are needed.
- 3) Minimal intrusion into the natural state – We have become very arrogant with our engineering. Because we have the capabilities, we perform actions, despite the fact they are not in accordance with our relationship to nature and environmental stability. Consider Los Angeles: a large proportion of the Los Angeles area is covered by tarmac. When it rains, the water drains into the Pacific Ocean. Southern California has a desperate water shortage, and most of the water supply must be shipped across the Great Divide. They built the tarmac for automobiles, but created the horrendous environmental problems for themselves.
- 4) Optimum balance between population and resources – Experience indicates that when a city is larger than one quarter or one half a million people, managing and satisfying its citizens’ needs for basic public health infrastructure becomes much more difficult.

In the United Kingdom, an environmental commission (of which I was a participant) produced a document stating that the agenda for change con-

verges in two ethical imperatives concerning social justice and sustainability. These ideas are based on North American Indian beliefs that we should care for the elements that take care of us.

We know, from public health, that we must think about our population in three ways:

- As an entire population
- As sub-populations at risk
- As groups, within those populations, with specific health problems

The British public health policy has objectives for improving lives – not only by prolonging peoples’ lives, but also by increasing the quality of their lives and reducing health inequalities. A program and agenda are currently being designed to tackle these inequalities, in relationship to all of these three elements.

I have attempted to distinguish the health care system from the larger health system. Most primary health care is external to health services. If you have diabetes or arthritis, the real task is to become your own health expert, since you do not have an available doctor or nurse for 24 hours a day. Most of the health system is not a health care system. Most care is self-care or non-professional care; however, continued confusion about these differences exists. Repeatedly, when people discuss the health system, they mean the health care system.

Health improvement programs, health action zones, and healthy living centers are intended to produce, what the British government calls, “joined-up policies”— pooling plans among different agencies and producing integrated approaches in order to build health resources that are community-led and community-driven.

We confront the problem of having a set of institutions without purpose, and workers who are not trained for purpose. We have problems with organizing ourselves with some kind of order. The information that we have is not what we need. One of the proposals of the public health strategy is to establish regional public health observatories to provide timely intelligence to support public

health action. Another problem is that we do not train people for public health in “the real world.” We need to ask the following questions, “What is the direct impact of health services? What is the role of partnership? What is the agenda-setting role of health services? New concepts are beginning to emerge, but public health has virtually no experience in “asset mapping” for communities. This skill is essential if we are to build on the innate abilities which are in all communities. New techniques of health impact assessment are being developed to enable us to explicitly define and optimize the impact of health policies in different areas of every day life.

Finally, the “Healthy Cities” concept has helped us to rediscover skills to integrate local policy. This has led to the development of an entire series of

other initiatives that frequently focus on settings, such as schools and neighborhoods, enabling us to develop integrated approaches at the local level. Increasingly, we have tools to help us, and we must be open to learning from each other.

### **Further Reading**

Ashton, J., and Seymour H. *The New Public Health*. Milton Keynes, United Kingdom: Open University Press, 1988.

Ashton, J. (ed.). *Healthy Cities*. Milton Keynes, United Kingdom: Open University Press, 1991.