1

UNDERSTANDING HEALTH: DEFINITIONS AND PERSPECTIVES

Health is a social, economic and political issue and above all a fundamental human right. Inequality, poverty, exploitation, violence and injustice are at the root of ill-health.

People's Health Movement (PHM), 2000

A "toxic combination of bad policies, economics and politics is, in large measure, responsible for the fact that a majority of people in the world do not enjoy the good health that is biologically possible".

Commission on Social Determinants of Health (CSDH), 2008, p. 26

KEY CONCEPTS

INTRODUCTION

The above quotes sum up the approach to health taken in this book. Through this book we will explore the underlying social and economic determinants of health in detail. But first it is important to understand the many ways in which health is understood and

used. The word 'health' carries considerable cultural, social and professional baggage, and its contested nature suggests that it is a key to our culture and a word that involves important ideas and strongly held values (Williams, 1983). Using it in different ways gives rise to particular ways of seeing the world and behaving. Definitions of health structure the ways in which the world is viewed and how decisions are made. Health policies, for example, are shaped by policy makers' assumptions about what health is.

Most public health workers see health as central to their work and often assume that everyone sees their world revolving around the pursuit of health. The blinkered view this can lead to was brought home to me forcefully when I was speaking to a community audience in Adelaide about the new public health and waxing lyrical about its virtues. I was stopped in my tracks by an older woman in the audience who raised her hand in order to ask me, 'Excuse me dear, what are we allowed to die of?' I had not only assumed health to be central but also that life and health were limitless! Health is a preoccupation of modern society. Crawford (1984, p. 63) views health as a cultural factor and comments: 'Health is a particularly important concept in the modern West. In disenchanted, secular and materialist cultures, health acquires a greater symbolic importance. Health substitutes for salvation and becomes a salvation of its own.'

The cultural importance attached to health and illness in Western society has been well illustrated by Susan Sontag (1979), who noted that not being healthy and being ill have often been seen as undesirable and as states that imply adverse moral and psychological judgments about the ill person. Being healthy is viewed as so important that it affects both the way people experience illness and the way they regard those who are ill.

Understanding the place and role of public health in our society requires an understanding of health and its manifestations. This chapter presents five main perspectives on health: health within the medical 'clockwork' model, health as defined by ordinary people, critical understandings of health, health as an 'outcome' and health as a characteristic of place or environment. It concludes with a consideration of the crucial difference between population and individual perspectives on health.

HEALTH: THE CLOCKWORK MODEL OF MEDICINE

For much of the past two centuries the discourse of Western health has been overshadowed by a biomedical perspective (Foucault, 1973). This operates from a clockwork definition of medicine in which the body is studied through its component parts (Underwood, 1986). Health is defined as the body operating efficiently like a machine. Any breakdowns in the body system mean that it is not healthy. The isolation, labelling and systematic classification of specific diseases by Linnaeus in the eighteenth century was an important part of the development of the clockwork model, later consolidated by an increasingly sophisticated understanding of the specific causes of diseases. What biomedicine has not done well is to consider disease within the context of the lives of people with disease.

HEALTH AS THE ABSENCE OF ILLNESS

Biomedicine does, however, distinguish between disease and illness (Curtis and Taket, 1996). Disease involves a set of signs and symptoms and medically diagnosed pathological abnormalities. Illness is primarily about how an individual experiences the disease. Illness can be culturally specific and may have social, moral or psychological aspects. Disease is viewed as more objective, involving professional rather than lay diagnosis. But both disease and illness can detract from health.

However, other perspectives on health have existed alongside the biomedical view. Traditional midwives, herbalists, indigenous forms of healing, Ayurvedic and Chinese medicine all operated from a significantly different view of health. There has always been a tradition of social medicine that has been more concerned with social and economic factors that affect health (Underwood et al., 1986), but it has consistently been the poor relation of the clockwork model.

Behavioural psychology added another dimension: the need to protect and maintain the body by appropriate lifestyle behaviours that minimise risk of disease. So, as is discussed in chapter 20, behavioural change and the promotion of healthy lifestyles have become major factors in the professional perspective on health over the past three decades.

The limitations of the clockwork model of health have been widely recognised. It has been accused of being too mechanistic and ignoring the social, psychological and spiritual aspects. It suggests that if a body is not diseased then it must, by implication, be healthy. This conception of health is dependent upon there being some idea of what constitutes normal functioning so that abnormal, diseased states can be identified. However, Litva and Eyles (1994, p. 1083) point out that standards of normality are 'almost impossible to discern', even for physiological phenomena.

The biomedical model of health assumes a mind/body dichotomy, and it does not place much emphasis on how an individual's mental health might affect physical health status. The ways in which Western medicine defines, diagnoses and treats mental illnesses have been much disputed, with debates between the psycho-analytical and the biological schools about definition and treatment. The whole definition of mental illness has been severely criticised by the anti-psychiatry movement (Laing, 1982) and others (Cochrane, 1983; Seedhouse, 2002), who have suggested that it is socially and culturally defined and far from being as 'scientific' as psychiatry makes it appear.

Curtis and Taket (1996) point out that the biomedical model of health has less legitimacy than it had in the past. Building on the work of Foucault, an increasing number of critics are demonstrating that the medical definitions of health reflect its culture. They (Curtis and Taket, 1996, chapter 3) give three examples that show how medical diagnoses have reinforced aspects of the existing status quo. Their first example is 'hysteria', which was a common medical diagnosis for women in the eighteenth and nineteenth centuries. It has since been contested by feminists. They discuss the medical labelling of homosexuality as a mental disorder and show that this reflected the contemporary values of society. Finally, they discuss how HIV has been presented

(for example, as a 'gay plague') and consider the social consequences. They conclude by stating that accurate definitions of 'health', 'disease' and 'illness' are not important. More important are the 'multiple and complex ways in which these terms are used discursively' (Curtis and Taket, 1996, pp. 72–3).

The biomedical model has also been critiqued for extending the definition of disease. This has been described as 'disease mongering' and linked to pharmaceutical companies seeking new markets (Moynihan and Henry, 2006). Risk factors are also defined as a disease; for example, obesity itself is now often conceptualised as a disease.

Blaxter (2010) notes that the concepts of health and ill health are asymmetrical and not simply opposites. The absence of disease may be part of health, but health is more than the absence of disease.

HEALTH AND WELL-BEING

The limitations of health being defined as 'the absence of disease' led to the World Health Organization (WHO) defining it as the 'complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity' (WHO, 1948). This has been criticised as being too Utopian and unachievable (Nutbeam, 1986; Sax, 1990, p. 1), but has provided a vision of health beyond that suggested by the biomedical model. It has been an important impetus for broadening health activity beyond disease prevention. However, the definition of a state of well-being has proved tricky. Aitkin (1996, p. 14) explained the problem thus:

> Throughout my early life the word that was commonly used was 'health' and its antonym of course was 'disease'. And if we weren't diseased by implication we were healthy.
>
> In the past 20 years or so we have begun to realise that we need something more positive than both of those words. We need something which I suppose was captured by the Victorian novelists who talked about a 'rude health'—that is a great state of gruntle, where the world feels a very good place, where we feel we ourselves are very good people, that problems and responsibilities are within our compass and do not exceed it.

A recent focus on mental health has led to definitions that go beyond the concentration on physical factors. VicHealth offers the following positive definition: 'Mental health is the embodiment of social, emotional and spiritual well-being. Mental health provides individuals with the vitality necessary for active living, to achieve goals and to interact with one another in ways that are respectful and just' (VicHealth, 1999, p. 4).

Indigenous definitions of health focus on the whole person within their context of land, community and culture. The National Aboriginal Community Controlled Health Organisation (NACCHO, 2014) says Aboriginal health is 'not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community'.

MEASURING HEALTH

Measuring this state of well-being has not proved easy. Many instruments have been developed (for example the Nottingham Health Profile, SF36, McMaster Health Index), but none adequately captures a positive health state measure. They are also static and so do not express the dynamic picture of health that appears to more accurately represent the ways in which health can be interpreted. Bowling (2005) has reviewed the range of measures that have been developed to view health in relation to quality of life, dividing them into six categories: measures of functional ability, broader measures of health status, measures of psychological well-being, measures of social networks and support, and measures of life satisfaction and morale. Bowling notes that all the measures she reviews have serious limitations in terms of reliability, validity and techniques of analysis, and that most are developed from professional definitions. Overall, health has defied any straightforward quantitative measurement, reflecting both the limitations of questionnaire surveys and the actual complexity of health. It is easier to measure disease or its absence than to measure a more positive state of health or well-being.

Even in health promotion, there is a tendency for a disease and risk factor orientation to continue. This was noted by Antonovsky (1996), who called for a salutogenic orientation to the study of health, as this would operate from a continuum rather than a dichotomous model and would incorporate notions of health and disease. Building on this notion, public health researchers are now trying to discover how lay people define health.

HEALTH: ORDINARY PEOPLE'S PERSPECTIVES

> … if we are in the business of health promotion in the widest sense we should always remain sensitive to the enormous number of ways of defining health and disease which are held by ordinary people.
>
> *Maclean, 1988, p. 43*

Health literature recognises that ordinary people may not see health in the same way as health professionals. Research findings indicate that health is a complex concept that combines a number of different dimensions.

People find it harder to define health than illness, probably because illness presents as a problem to which societies have to respond (Locker, 1981, pp. 98–101). Being healthy requires no action (unlike being ill) and may be taken for granted (Pill, 1988). Three main domains relating to the definition of health are found: health is not being ill, it is a necessary prerequisite for life's functions and it is a sense of well-being expressed in physical and mental terms. WHO's positive definition of health given previously reflects how ordinary people define health more accurately than do medical perspectives. In her study with working-class mothers in South Wales, Pill (1988) found that health was seen as an absence of illness, in terms of functional capacity and as a positive condition of

mental and physical well-being. She found that the mothers who were more aware of the effects of lifestyle factors on health were also those who could perceive the dynamic relationship between individuals and their environments. Herzlich (1973), working with a French middle-class sample, found that health was defined as the simple absence of disease, a positive state of well-being and as having a reserve to cope with life and illness.

One of the most thorough delineations of the lay understanding of health has come from Blaxter (2010). Combining a survey with detailed follow-up of a sample of the survey group, she set out to define what people mean when they talk of health. She defined eight main perspectives, which elaborate on the three key categories listed earlier. Her findings suggest that health is variously viewed and is a complex and dynamic concept involving a number of different perspectives. The health definitions that she identified are shown in box 1.1.

BOX 1.1 DEFINITIONS OF HEALTH (BLAXTER'S SURVEY OF BRITISH SAMPLE)

- **Health as not ill/diseased**: typical comments were Health is when you don't have a cold or Health is when you don't feel tired and short of breath. Some responses indicated a view that people could be healthy even if they did have a disease: I am very healthy apart from this arthritis.
- **Health as a reserve**: some people saw health as a reserve—if someone becomes sick, they are able to recover quickly.
- **Health as behaviour, health as 'the healthy life'**: primarily used when describing the health of other people as opposed to the respondent's. I call her healthy because she goes jogging and doesn't eat fried food. She walks a lot and doesn't drink alcohol.
- **Health as physical fitness**: particularly popular with young men and less favoured by older people. Men tended to express health in terms of physical strength and fitness. Typical quotes were: There's tone to my body, I feel fit; I can do something strenuous and not feel that tired after I've done it. Women were more likely to define health in terms of outwards appearance, such as being slim, a good complexion, bright eyes and shining hair.
- **Health as energy, vitality**: seen in terms of both physical and psycho-social energy to do things, signified by being able to get up easily, not feeling tired and getting on with activities, having energy and enthusiasm for work and generally feeling good.
- **Health as social relationships:** defining health in terms of relationships with other people, and more likely to be expressed by women. Younger people saw this as being able to have good relationships with their families: having more patience with them, and enjoying the family. Older people saw it as being able to help others and enjoying doing so: You feel as though everyone is your friend.
- **Health as function**: health is the ability to do things, which overlaps with the association between health and energy and vitality. More older people mentioned this,

possibly because they no longer took doing things for granted: She's 81 and she gets her work done quicker than me, and she does the garden.

- **Health as psycho-social well-being**: some people defined health solely in terms of their mental state, typified by the statement: I think health is when you feel happy. When I'm happy I feel quite well.

Source: Blaxter, 2010.

Blaxter asked her respondents to differentiate between health in themselves and in others. She found that being healthy for oneself was to be unstressed and able to cope with life. For other people, health was fitness, the ability to work and perform normal roles and simply 'not being ill'. Litva and Eyles (1994), based on work in an Ontario community, report similar findings. They argue that it is useful to distinguish between 'being healthy' and 'health'. They define health as an abstract state of being—not being ill. Being healthy is having the resources for everyday life and 'a social construction that helps us understand our place in the world and that of others. It affects the ways in which we see the "causes" of illness. It makes being not ill very important unless we are willing to be viewed as deviant. It becomes a moral code' (Litva and Eyles, 1994, p. 1084). Popay et al. (2003) found a similar moral view of health among the working-class respondents they spoke with. When asked to account for the existence of health inequities between richer and poorer areas their accounts suggested they saw being healthy as an important part of their moral identity and the view was stressed that they should not 'give in to illness'. Blaxter (1997) in examining the strength of moral framework in lay accounts of health and illness suggests that to acknowledge health inequalities 'would be to admit an inferior moral status for one's self and one's peers'. However, Davidson et al. (2006) found in Scotland and the north of England that people from deprived backgrounds were very aware of the ways in which their health and well-being was affected by their circumstances, especially in terms of feelings of shame, anger, frustration, rejection, injustice and alienation they had in relation to other people. This was seen as being related to sleeplessness, fear, anxiety and stress. Thus while the cause of inequality was rooted in material circumstances the disadvantage was perceived as being compounded by comparison with the circumstances of others.

Another feature of lay definitions of health is that people with some disability or disease often describe themselves as healthy, especially on days when their disabilities seem less severe. People assess their own health subjectively and in terms of a reasonable expectation for their age and disability.

PUBLIC AND PRIVATE LAY ACCOUNTS

Another useful perspective has come from the work of Cornwell, who interviewed working-class men and women in the East End of London. She found that they offered public and private accounts of what they understood by health, and that she only heard the private accounts when she knew them reasonably well. This implies that studies

based on one-off interviews may not get to people's private accounts of health. Cornwell (1984) reports that her respondents, in their public accounts, presented a view of health that conformed to a biomedical model, tended to have a moral component and divided causes of illnesses into those that were or were not the individual's fault. The private theories, by contrast, were based on their own experiences or those of people they knew. These explanations brought out a more complex view of health that involved the interplay between individual and structural factors on health. Health was now seen as intimately tied up with an individual's overall life circumstances.

HEALTH IN CULTURAL AND ECONOMIC CONTEXTS

Crawford's (1984) work involved interviews with 60 adults in the Chicago metropolitan area. He found that interpretations of health reflect the cultural and economic context of people's lives. For most people health represents a status, socially recognised and admired. He discovered two main discourses of health—health as a means of exerting self-control and health as a release mechanism—suggesting that health fulfils different functions for different people. He expanded on these two notions of health as follows:

- ***Health was seen by some as self-control*** and a set of related concepts that include self-discipline, self-denial and willpower. This was primarily the view of middle-class professional people, but also of some blue-collar workers. Health was something to be achieved through healthy behaviour. Health was not seen as something that springs from normal everyday activity. People felt they did not have time to be healthy and sometimes decided to pursue goals other than health. Judgment of others and self-blame are themes running through Crawford's interviews. He found a strain of moral judgments about being able to keep healthy, and commented: 'thinness is believed to be an unmistakable sign of self-control, discipline and willpower. The thin person is an exemplar of mastery of mind over body and virtuous self-denial … Conversely, fat is a confirmation of the loss of control, a moral failure, a sign of impulsiveness, self-indulgence, and sloth.' Crawford interprets this as internalisation of medical knowledge so that the body is seen as an object of rational control. The values of self-control, self-discipline and self-denial fit with modern individualism (see part 2 of this book) and the Protestant work ethic, and so attitudes to health become one expression of dominant values. Crawford also noted that his respondents appeared to feel that the macro-conditions that affect health were out of control (toxic environment), so self-control over the range of personal behaviours that also affect health was the only remaining option. People did not dwell on environmental hazards. A typical comment was 'Why worry about something you can't do anything about?'
- ***Health was seen by some respondents as a release mechanism***, who equated it with feeling good as distinct from following rules of medical authority. Life is seen as a series of pressures, anxiety, frustration and worry, and as leaving no time for

health-promoting activity. Health is not rejected as a value but is often repudiated as a goal to be achieved through instrumental action. The working-class males Crawford spoke to were particularly likely to see leisure as free from concern about health, and there was some resentment of a public discourse that instils fear and demands more controls over behaviour in order to achieve health. There appears to be both interplay and contradiction between the two perspectives on health. Crawford believes this is understandable, given the contradiction between production and consumption in our culture—managers of labour want disciplined work forces but advertising encourages hedonism. Culturally, release is a means by which societal tensions are managed and is important in keeping consumption growing.

SPIRITUAL ASPECTS

Lay definitions of health may also include a spiritual dimension. Stainton-Rogers (1991) reports that some people saw their health as dominated by external religious or supernatural powers. Healing could result from intervention by God or some other supernatural power, as could falling ill in the first place. Indigenous people are particularly likely to have a belief system that is related to health and illness, which emphasised spiritual dimensions. The position of traditional healers may often rest on their perceived ability to call on external forces.

The growing literature on lay definitions of health presents a picture of complexity and cultural and social embeddedness. Health makes sense within the context of people's everyday lives—it is not something that can be neatly defined in static categories. The following perspective on health builds on these insights from ordinary people's definitions, but adds a political explanation for the existence of culturally dominant definitions of health.

HEALTH: CRITICAL PERSPECTIVE

Critical perspectives on health are those that seek to explain the purposes that are achieved through particular means of defining health. They are critical in the sense that they look beneath the surface appearance of a concept or phenomenon and offer an explanation as to why it is this way.

One such perspective on health that has been particularly influential is that which maintains that health is defined in such a way by the dominant forces in a capitalist society that it becomes a defining and controlling mechanism. Writers adopting this perspective use a Marxist analytical framework (Doyal, 1979; Navarro, 1979, 2002). Central to this view is the idea that capitalist societies are structured in such a way that they produce illness. The system is geared up to maximising profit rather than protecting the health of workers and their families. Health is affected by practices such as shiftwork, overtime,

monotonous work tasks and dangerous chemicals in the workplace. It is defined in terms of the ability of people (particularly workers) to function and carry on with their normal activities. Doyal (1979, p. 34) comments: 'The defining of health and illness in a functional way is an important example of how a capitalist value system defines people primarily as producers—as forces of production.' She goes on to say that the functional definition of health does not concern itself with people's fears, anxieties, pain or suffering, and that this may limit expectations about health.

The People's Health Movement (www.phmovement.org), whose Charter was quoted at the start of this chapter, takes a critical view on health. The People's Health Assemblies held in Bangladesh in 2000, Ecuador in 2005 and Cape Town in 2012 have been grounded entirely in a critical understanding of health whereby the dominant global economic structures in the world are seen to have a massive effect on shaping ordinary people's health experiences. From a postmodern perspective, Petersen and Lupton (1996) also take a critical look at definitions of health and conclude that health maintenance has become an important aspect of being a 'good' citizen. They say that in contemporary Western society the pursuit of good health is both a right and an obligation. Individuals are obliged to remain healthy because being ill means they cannot be good citizens, and may become an economic burden.

The political economy perspective on health also criticises the individualistic definition of health that it sees as prevalent under capitalism. Doyal (1979, p. 35) comments that this 'emphasis on the individual origin of disease is of considerable social significance, since it effectively obscures the social and economic causes of ill health'. The issue of individualism and health is discussed in more depth in part 2 and is of central importance in understanding public health. It underpins a notion of health that stresses personal (and even moral) responsibility for maintaining health. This perspective that defines health in terms of individual responsibility absolves other factors from responsibility. McKinlay (1984, p. 12) noted:

> the emerging emphasis of personal responsibility for health mystifies the social production of disease and undermines demands for rights and entitlements for health care. Beneath the rhetoric about the cost of medical care and the obligation of the individual to remain healthy lies a political problem to shift the burden of costs back to labour and consumers and to paralyse regulatory efforts undertaken to control environmental and occupational hazards.

The political economy view sees health in terms of its distribution in society (and so focuses on inequities in health status, especially those resulting from class differences) and in terms of the structural factors that create or detract from health, such as environmental, housing and occupational conditions. From this perspective, studying the health of individuals is less valuable than studying the collective health of societies and the social and economic forces that affect collective health. Increasingly the political economy view (see chapter 5) stresses the connections between the health of peoples in rich countries and those in poor countries as the processes of economic globalisation continue apace.

HEALTH AS 'OUTCOMES'

Around the world health departments and ministries are seeking evidence that their efforts result in health outcomes. Almost always this search reflects a clockwork view of health in which short-term improvements brought about by clinical interventions are able to produce an outcome that can be measured by a randomised control trial. Rarely does the use of the term imply an understanding of the complexity of health or the social and economic context in which poor health is produced.

In order to be able to attribute a change in health status to any particular intervention it is necessary to exclude the contribution of all other factors, which is generally very difficult to achieve as it requires a research design that controls for all other possible factors. Generally a randomised controlled design (see chapter 7) can only be used to study clinical interventions. Ethical and practical grounds restrict their use in most other circumstances. 'Health' in clinical trials is invariably reduced to an absence of the particular ailment the clinical intervention was designed to cure. More sophisticated definitions of health defy the type of simple measurement required in experimental designs. Many of the measures used to measure health within the health care system present a health service provider rather than user perspective. For people themselves (and for their families, friends, employers and others) crucial factors not covered might be their ability to function, their quality of life and the extent to which they can live their lives normally.

The focus on health outcomes is laudable insofar as it requires health care providers to be accountable for expenditure and to demonstrate that the work they do is beneficial—requirements that have been less pressing in the past. Often, however, the concept is dealt with naively and risks becoming no more than an unreasonable demand for evidence that particular health services can demonstrate an impact on population health status in a short period of time rather than evidence concerning a broader aspiration for the well-being of society as a whole.

In practice, most of the outcomes measured relate to individuals and not populations. For many, health promotion and public health outcomes are crucial, but it is often more feasible to measure outcome in terms of capacities rather than health status (Baum, 1998). The value of health promotion and public health interventions over clinical care should be in their capacity to improve health in the longer term. For public health, intervention to improve health is akin to an investment in the future.

However, 'health outcomes' in the current health system discourse refer to accountability mechanisms and measures of the effectiveness and efficiency of particular (predominantly sickness-care) interventions. The term is rarely used within bureaucracies to refer to a broader project of improving health in a social or environmental sense. The Commission on Social Determinants of Health (2008) stressed the importance of measuring health outcomes according to health equity, which concerns its distribution within and between countries. Both the World Bank and WHO have used economic measures of health as a yardstick for the success of their programs. This reflects an underlying assumption that economic productivity is paramount. This is nowhere better illustrated than in the use of disability adjusted life years (DALYs) or DALEs (disability

adjusted life expectancy) to determine the value of a health intervention. DALYs are calculated by assigning values to years of life lost at different ages. The value for each year of life lost rises from zero at birth to a peak at age 25 and then gradually declines with increasing age. As the very young, the elderly and people with disabilities do not contribute much to economic development, treatment aimed at them would result in fewer DALYs than treatment aimed at people in their early twenties. The DALY or DALE measures make the ethically questionable assumption that a year of life for a person with a disability is of less value than a year of life for a person without a disability.

HEALTH AND PLACE: DEFINING COLLECTIVE HEALTH

Most literature that defines health does so in terms of what it means to individuals, but in recent times health promotion has given more attention to what constitutes health in terms of a place or a population as a whole. For example, 'Healthy Cities', 'Healthy Schools' and 'Healthy Workplace' projects have attempted to define what would constitute health for each of these contexts. A concern of the Healthy Cities movement has been to move beyond a deficit model (for example, for a city, how many unemployed, how many households without running water) to one that captures the more dynamic and positive aspects of health (the number of trusting people, the availability of community meeting spaces). WHO's list of the qualities of a healthy city appear in box 1.2 and put as much emphasis on the processes within the city as they do on the physical features.

BOX 1.2 QUALITIES OF A HEALTHY CITY

A city should strive to provide:

1. a clean, safe, physical environment of high quality (including housing quality)
2. an ecosystem that is stable now and sustainable in the long term
3. a strong, mutually supportive and non-exploitative community
4. a high degree of participation in and control by the citizens over the decisions affecting their lives, health and well-being
5. the meeting of basic needs (food, water, shelter, income, safety and work) for all the city's people
6. access by the people to a wide variety of experiences and resources, with the chance for a wide variety of contact, interaction and communication
7. a diverse, vital and innovative city economy
8. connectedness with the past, with the cultural and biological heritage of city dwellers and with other groups and individuals
9. a form that is compatible with and enhances the preceding characteristics
10. an optimum level of appropriate public health and sick care services accessible to all
11. high health status (high levels of positive health and low levels of disease).

Source: WHO Regional Office for Europe, 2015a.

The raison d'être for WHO's Healthy Cities and Healthy Settings initiatives is the view that the collective structures of a community form the crucial determinants of a population health status. In this view health is not only a characteristic of individuals but also of a city or community. A WHO document on urban health, for instance, noted:

> Physical, economic, social and cultural aspects of city life all have an important influence on health. They exert their effect through such processes as population movements, industrialisation and changes in the architectural and physical environment and in social organisation. Health is also affected in particular cities by climate, terrain, population density, housing stock, the nature of the economic activity, income distribution, transport systems and opportunities for leisure and recreation.
>
> *WHO, 1993, pp. 10–11*

Lay and health professional definitions of health rarely encompass these wide-ranging social, physical and economic factors, perhaps because people take them for granted. A critical perspective, based on an analysis of structural factors, leads to a broader view of health as does a perspective that takes as its starting point a consideration of collective entities (such as workplaces, schools, hospitals, cities, villages, country towns). Defining health in such terms is useful for the new public health because it appears more likely to keep a focus on positive definitions and on structurally rather than individually driven factors that affect people's health.

In recent years the concept of 'ecosystem health' has been used by ecologists. Healthy ecosystems are characterised by diversity, vigour, effective internal organisation and resilience. This approach to health integrates an overall consideration of the environment and the interdependence of systems with the overall ecosystem. This approach is characterised by holism and stresses that the health of people is dependent on the health of the biosphere, which is increasingly under strain and threat. Brown et al. (2005) argue strongly that such an approach to health is essential in the face of the threatened collapse of these systems and their ability to support human health.

POPULATION VERSUS INDIVIDUAL HEALTH: THE HEART OF PUBLIC HEALTH

The distinguishing feature of public health is its focus on populations rather than individuals. Public health studies the distribution of disease and positive attributes of health in whole populations. Clinical work is based on work with individuals who are either at high risk for a disease (e.g. who have high blood pressure or genetic susceptibility for a particular disease such as breast cancer) or who have a disease. Table 1.1 illustrates the difference between an individual and a population perspective by showing how the two approaches give rise to different questions. Understanding this difference is vital. Both are important but the new public health primarily concerns itself with population issues rather than those designed to cure individuals when they are sick.

TABLE 1.1 INDIVIDUAL AND POPULATION HEALTH PERSPECTIVES: THE DIFFERENCES EXPLAINED

	Individual (clinical) questions	Population questions
Smoking	How can we stop individuals smoking?	How can we change the social and economic environment so it discourages smoking?
Childhood obesity	How can we encourage children to lose weight?	What social and economic trends contribute to higher rates of childhood obesity in our society than in the past?
Diabetes	How do we encourage people with diabetes to self-manage their disease?	How do we alter food supply systems so they help prevent rates of diabetes going up?
Depression	How do we best counsel teenagers with depression?	Why have rates of teenage depression gone up in the last ten years? What can be done to prevent depression?
Homelessness	How can we provide homes to homeless young people?	How can we design a housing system that ensures no one is homeless?
Drug use	How can we educate people to use drugs responsibly?	What legislation and policies can we adopt to reduce harm from drugs?

Treating high-risk or diseased individuals does not have much impact on population health levels overall, but changing a risk factor across a whole population by just a small (and often clinically insignificant) amount can have a great impact on the incidence of a disease or problem in the community. This paradox makes it very hard for public health to be newsworthy. The changes that affect population health are usually not dramatic, but spread thinly across a population. Yet they can make significant improvements to health and well-being (see box 1.3 for further explanation).

BOX 1.3 HOW DOES A POPULATION HEALTH PERSPECTIVE DIFFER FROM AN INDIVIDUAL OR CLINICAL ONE?

Understanding this distinction is fundamental to good public health practice. The distinction is neither intuitive nor obvious. But it is crucial that every student of public health grasp this understanding.

Changing a risk factor across a whole population by just a small (and usually clinically insignificant) amount can have a great impact on the incidence of a public health problem in the community. This creates the prevention paradox expressed as follows by Geoffrey Rose:

> A preventive measure which brings much benefit to the population offers little to each participating individual. (Rose, 1985, p. 38)

EXAMPLES

Seat belts

If everyone in a population wears a seat belt while driving, the burden of mortality and morbidity from road accidents will reduce. However, very few of the individuals doing so will benefit directly—only the few who are involved in a life-threatening accident.

Body mass index

While a small reduction in the mean body mass index of a population will make very little difference to any one individual it would be significant in terms of the disease burden across the population.

Rose (1992) considered the distribution of a range of health risk factors in 32 societies—factors such as obesity, high blood pressure, heavy drinking. He found that the proportion of people with these risk factors was a reflection of the society's average behaviours in relation to these risks. Thus the proportion of heavy drinkers was a function of the society's average alcohol consumption, obesity of the average body mass index, high blood pressure of average blood pressure. Thus those with dangerously high levels were not minorities behaving very differently from the rest of their society but were part of a behavioural shift to which the norms of the whole of the rest of society seemed to contribute. This demonstrates how individual behaviour is strongly influenced by social norms.

Analysis on an individual level may be appropriate for understanding how individuals may be affected by a disease or some other problem, but may miss the influence of broad structural factors on health. Marmot (2001) illustrates this by quoting Sen's argument that famines do not occur in countries with well-functioning democracies, for a range of structural reasons. Comparing individual starving children in a refugee camp could never lead to this conclusion. The relevant level of analysis is social, political and economic. Similarly, Durkheim's (1979 [1897]) famous sociological analysis of suicide rates in the late nineteenth century determined that it was the characteristics of a society at large (such as the types of social relations and the ways in which the society understood suicide and related it to other social phenomena) that determined the rate rather than a simple aggregate of individual factors in relation to suicidal tendencies. He concluded from this that responses to suicide should be collective rather than focused on individuals: 'The only possible way, then, to check this current of collective sadness is by at least lessening the collective malady of which it is a sign and a result' (Durkheim, 1979 [1897], p. 391).

So viewing health and disease from a public health perspective means taking a view of the health of populations, not just of individuals within them.

CONCLUSION

Comprehending the various ways in which health is understood is an important background to appreciating the change in thinking about health that is called for by the new public health movement with its emphasis on the social, environmental

and economic determinants of health. Health is viewed as a complex outcome that results from a range of genetic, environmental, social, political and economic factors. The next two chapters demonstrate through a history of public health that such broad interpretations have been accepted before but have rarely assumed a dominant and driving position in public policies.

CRITICAL REFLECTION QUESTIONS

1.1 How is it that a person with disabilities can experience health?

1.2 To what extent do the qualities of a Healthy City listed in box 1.2 apply to the city or community you live in?

1.3 How do an individual clinical and a population health response to a health issue of your choice differ?

Recommended reading

Blaxter, M. (2010) *Health*. Provides a detailed guide to definitions and constructions of health and how it relates to culture, social systems and medicine.

Rose, G. (1992) *The strategy of preventive medicine*. Provides the epidemiology argument for the importance of public health approaches over clinical approaches in maintaining and improving health in populations.

Useful websites

www.naccho.org.au
National Aboriginal Community Controlled Health Organisation

www.who.int/social_determinants/en
World Health Organization Social Determinants of Health