The McKeown Thesis

Rethinking McKeown: The Relationship Between Public Health and Social Change

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Thomas McKeown was a rhetorically powerful critic, from the inside, of the medical profession's mid-20th-century love affair with curative and scientific medicine. He emphasized instead the importance of economic growth, rising living standards, and improved nutrition as the primary sources of most historical improvements in the health of developed nations.

This interpretation failed to emphasize the simultaneous historical importance of an accompanying redistributive social philosophy and practical politics, which has characterized the public health movement from its 19th-century origins. Consequently, the current generation of public health practitioners are having to reconstruct such a politics and practice following its virtual dismantlement during the last 2 decades of the 20th century. (*Am J Public Health.* 2002; 92:722–725)

THE TERM "PUBLIC HEALTH" is nicely ambivalent. It refers to a descriptive notion of the measurable state of a population's health. But it also refers to a historical, self-conscious social and scientific movement. With its associated complex range of institutions, the transgenerational public health movement has conspired to act on the public's health, locally, nationally, and internationally, for at least the last 2 centuries.

Indeed, without all the apparatus of tax-funded and state-administered vital registration and census systems, at the very least, we could have no intelligence as to the changing and variable state of the public's health.[1,2] Without the intellectual disciplines of public health medicine, epidemiology, and demography, we would have precious little understanding of the meaning of all the data these formidable bureaucratic structures accumulate on our behalf. We literally create our public health, our understanding of it, and our capacities to monitor and improve it through a continuous historical practice of acts of political will to bring about, fund, and support this area of knowledge and to act on what we learn about it.

The field of public health is thus a grand social intervention. It is politically created in a particularly thoroughgoing sense. Its relationship with social change is therefore as politically and ideologically intimate as can be found in the range of the human, social, and biological sciences. When Thomas McKeown launched his brilliantly conceived and innovative project to investigate the historical demography of 18th-century Britain and the historical epidemiology of Victorian Britain,[3,4] he was making a powerful play, with high political stakes, to influence the future direction of the medical profession in its overall approach to the promotion of the public health.

He succeeded, probably beyond his dreams, in pinioning his primary target. The medical profession's scientific leaders have, since McKeown's time, had to change their tack and concentrate on the future, rather than the past, as the field in which they can stake the claim that they can save humanity from all its ailments with science.

But if, in his own day, he successfully denied the decorated and honored knights of scientific and curative medicine the use of the past as a rhetorical resource, McKeown was also content—unfortunately, in my opinion—to deny it to the whole body of toilers on behalf of the public's health.[5] The British nation's cadre of Medical Officers of Health were the mere captains and lieutenants of the medical profession. From the 1870s they had worked tirelessly throughout the country, leading forward the foot soldiers under their command: humble employees of local government such as sanitary inspectors, housing officers, lady health visitors, trained midwives, and school medical officers.[6–9]

In putting such exclusive emphasis as he did on the "invisible hand" of the rising standard of living and the presumed ability of economic growth to put more and better food in the mouths of the majority of the people as the principal source of the modern decline in mortality, McKeown allowed himself the luxury of arguing for the relative unimportance of all forms of socially organized intervention in relation to the history of public health. This is a dangerous untruth. Public health is an intrinsically political subject, and it cannot be divorced from intentional, organized human agency.

In Britain, as elsewhere, the crucial decisions that sanction and fund the public health effort always come, ultimately, from the political realm. This means that it is incumbent on the leading practitioners of public health to argue their scientific case with all the rational and rhetorical resources they possess—as the most influential proponents of public health always have, from Villermé and

Chadwick in the past to Rose and Wilkinson today.[10–13] McKeown himself certainly appreciated this; witness his marvelously accessible and popular 2 books of 1976.[14,15] However, in drafting these powerful texts, McKeown, I think, became the victim of his own most cherished social and political assumptions.

MCKEOWN'S HISTORICAL BIAS AND POLITICAL VULNERABILITY

For McKeown and most of his generation, who dominated the public health field from the 1950s until the 1970s, it would have seemed inconceivable that Victorian laissez-faire, free-market economic liberalism could make a comeback as a governing ideology of both domestic and international affairs. Likewise, they would have found it incredible that there could in the immediate future be a reversal of the historic trend of gradual redistribution of income and wealth from the very rich to the poorest. This progressive trend had clearly become well established in most developed countries since more or less the beginning of the 20th century, and certainly since the Second World War, with the consolidation of welfare states throughout the West.

Thus, McKeown himself would have seen his almost exclusive emphasis on the importance of rising living standards and improved nutrition in reducing mortality as a vindication of the importance of that historic trend toward greater social and economic equality—the ever wider distribution of the material means to good health, which now appeared to be a secure feature of the political landscape in all advanced liberal democracies. The egalitarian implications of this relationship between improved living standards and reduced mortality were extremely radical: that the health of the populace could eventually be maximized only when the material living standards of all were optimized in common, as has been recently argued by, inter alia, Wilkinson in his influential *Unhealthy Societies*.[13]

If this rendering of the assumptions of the "McKeown generation" (1940s through 1970s) is historically correct, the problem is that they remained just that—unarticulated assumptions. McKeown failed to take into account the possibility that these assumptions might one day not prevail—one day quite soon, in fact. Consequently McKeown, in effect, took for granted the protracted political and ideological battles that had been fought over the previous century or more to establish this viewpoint as the orthodoxy of his mid-20th-century generation, and he discounted the vulnerability of its victories. The quarter century that has elapsed since 1976, when McKeown published his 2 popular texts, has demonstrated how extremely politically fragile that orthodoxy was and what would happen to McKeown's position when the assumptions no longer held.

In rapidly changing ideological circumstances, McKeown's findings were gratefully absorbed by the rising ideology of the New Right, which radically questioned the value of the whole welfare-state system and its associated policies of full employment, income redistribution, and free public services. McKeown's influential interpretation was now taken as supporting the view that organized social intervention—as practiced by medicine and the state—had never played an important role in improving human health and welfare and that only strong economic growth was the principal guarantor of such improvement. According to the conservative prescriptions, economic growth, in turn, required that the greatest scope be given to the free market and that all forms of public services be reduced.

Of course, McKeown was by no means alone in the public health field in being overtaken by the changing ideological climate. At the same time, as Colgrove's excellent survey makes clear, along with various critiques by Cochrane, Illich, Lalonde, and others, new thinking within the public health profession in the mid-1970s was already moving to embrace the importance of individuals' responsibility for their lifestyles and behavior.[16–19]

This departure was originally premised on progressives' dissatisfaction with the record of the welfare state in failing to reduce the relative health disadvantages of the poor (though it had done a good job in reducing *absolute* disadvantages)—a theme famously explored in the Black Report of 1980.[20]

These progressive critics assumed that the welfare state would continue to provide a full and generous framework of social security on which these additional health-enhancing individual behaviors could be laid. But this new professional focus on individual choices and its accompanying innovative methodology for identifying "risk factors" was subsequently all too easily co-opted into a larger and very different political project.

When the encompassing ideological climate changed so markedly during the late 1970s and early 1980s, the growing scientific capacity of clinical epidemiology for identifying individuals and groups with "risks" was extremely useful to the politicians and the new managers they installed to run the health services on more businesslike lines. They were ideologically opposed to publicly funded, "expensive" universal health and social services; they wanted to focus on a mutually exclusive alternative of "cost-effective" targeted treatments for differentiated sections of the population—an alternative justified on the basis (since proved to be mistaken) that this would be cheaper.

BACK TO POLITICS

Colgrove is surely right that McKeown remains a major reference point for live debate in the international field of public health because, with great rhetorical skill and boldness of style, he produced accessible and widely read texts that provoke readers to confront this intrinsically political subject's perennial "practical and ethical challenges."[16] McKeown was right that material living standards—availability of food, and therefore economics—are of crucial importance to the health of populations. The international experiment of the last 2 decades, in which it has been argued that the "laws" of free-market economics require that the living standards and public services of the world's poorest countries be "structurally adjusted"—meaning degraded—has certainly proved that beyond doubt.

But equally, the public health fallout from this misguided and

logically inverted attempt to instill the supposed moral fiber of the market economy into social and political systems—systems lacking the primary communications and sociolegal infrastructure that European peoples developed over centuries to enable their own market economies to work[21]—has also emphasized the extent to which McKeown was wrong. He was wrong in failing to foreground the importance of politics, ideologies, states, and institutions in producing the kind of societies that distribute their material wealth, food, and living standards in a health-enhancing way for all concerned.

The problem, of course, with emphasizing the importance of politics, the conflict of ideas, the role of the state, conditions of citizenship, local government structures and services, civil institutions and social capital in accounting for the relationship between public health and social and economic change is that this makes for a devilishly complicated story. Those who have endeavored to convey the full complexity of what has been involved have typically been constrained to reduce the scope of their work to the history of a single city to be able to cope with the demands of rigorous examination of all the relevant evidence. These complicated stories have the virtue of being intellectually satisfying, in that they demonstrate the nature of the connections between so many different factors and do not have to leave out certain percentages of dependent variables that are "unexplained" in error terms.

At their best, these studies comprehensively account for the dependent variable (mortality change) in a particular time and place. A number of such studies have been completed for different cities around the globe in varying circumstances, and they would repay careful comparative systematic examination by the international public health community.[22–25] It is possible to derive lessons and implications from these carefully contextualized studies, even though those lessons relate as much to the role of political, ideological, and institutional factors as to measurable living standards, specific health measures, or particular policy interventions.[26,27]

Furthermore, as guides, first, to the more general ethical principles that should inform health-enhancing development strategies and, second, to the institutional designs that should be integral to public health interventions, 2 extremely important and promising new approaches have emerged during the last 2 decades in reaction to the perceived problems of the neoliberal, free-market prescriptions. These are the ideas of Sen regarding functioning and capabilities[28] and the rapidly developing concept of social capital as it applies to issues of development and health.[13,29–35]

These approaches may at last be providing the foundations for a discussion of the "practical and ethical challenges" that will significantly advance the public health agenda, a discussion that McKeown's contribution has so vigorously animated. Indeed, it is possible to foresee the construction of a powerful, progressive new public health synthesis through the combination of these 2 approaches and the recently established "population health" perspective.[12,13,36] ■

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