LETTERS

RETHINKING MCKEOWN

Thirty years ago I spent a summer's day in Birmingham, England, discussing health and disease with the then virtually unknown Thomas McKeown. At that time medical technology had reached spectacular heights, with open-heart surgery, new antibiotics, and miraculous vaccines dominating the media headlines. McKeown's thesis that social factors were the primary historical determinants of health status was widely regarded as eccentric. No wonder he was able to spend so much time with a junior colleague from the other side of the planet. The gentle Thomas McKeown would be thrilled to know that a generation later, his views were being debated in the *American Journal of Public Health.*

In my view each of the authors of the May 2002 Health Policy and Ethics Forum on McKeown[1–3] misses his essential message, namely that "health has advanced significantly only since the late eighteenth century and until recently owed little to medical advances."[4(p9)]

McKeown's central thesis is dependent on a time scale spanning centuries. In the case of Western societies the social determinants of health to which he referred applied mainly to the period 1700 to 1930, following which technical developments became the dominant influence. Although McKeown's data have since been shown to be not wholly accurate, his thesis that it is primarily social and economic change, and to a lesser extent technical advancement, that has reduced disease is surely true. Perhaps a simple anecdote will best support this statement.

During the early 1960s, accompanied by my pregnant new wife, I traveled to Papua New Guinea to work as a children's medical officer. At that time village social life was very traditional and was supported by a subsistence agricultural economy. Patterns of health and disease were also traditional, with endemic malaria, malnutrition, tuberculosis, diarrheal and respiratory diseases, neonatal tetanus, polio, intestinal worms, yaws, and high maternal mortality due to hemorrhage and infection. Infant mortality was more than 50% in some isolated settlements.

Although we lived literally in the middle of this village, neither my wife, our new baby, nor I succumbed to any of these lethal conditions. Neither did any of my White colonial expatriate colleagues. Why? Because we could afford good food, clean water, mosquito screens, shoes that prevented hookworms from entering our feet, and antenatal care, and of course we had been vaccinated against polio, tetanus, and mumps. We also had health-related knowledge and technology—we knew the importance of handwashing and avoiding mosquito bites at dusk, and we had safe water supplies and safe systems for disposal of sewage. In other words, we had inherited the economic advantages, social behavior, and medical technology that combined to radically reduce the risk of malnutrition and communicable disease. This inheritance was not, of course, available to traditional Papua New Guineans. ■

James Lawson, MBBS, MD, MHA

About the Author

Requests for reprints should be sent to James Lawson, MBBS, MD, MHA, School of Public Health, University of New South Wales, Sydney 2052, Australia (e-mail: james.lawson@unsw.edu.au).

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