What's New About the "New Public Health"?

From its origins, when public health was integral to societies' social structures, through the sanitary movement and contagion eras, when it evolved as a separate discipline, to the "new public health" era, when health promotion projects like Healthy Cities appear to be steering the discipline back to society's social structure, public health seems to have come full circle. It is this observation that has led some to ask, "What's new about the 'new public health'?"

This article addresses the question by highlighting what is new about the health promotion era—including adapted components of previous eras that have been incorporated into its core activities—and its suitability in addressing established and emerging public health threats. (*Am J Public Health.* 2004;94:705–709)

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THIS ARTICLE CONSIDERS 6 major approaches to public health practice implemented between ancient times and the contemporary era, defined more by important milestones than by convention. These approaches are (1) public health as health protection, mediated though societies' social structures; (2) the shaping of a distinct public health discipline by the sanitary movement ("miasma control"); (3) public health as contagion control; (4) public health as preventive medicine; (5) public health as primary health care; and (6) the "new public health"—health promotion (Table 1).

The hallmark of the health protection era was enforced regulation of human behavior in order to protect the health of the individual and the community. Such enforced regulation was usually mediated by ruling elites through society's religious, political, cultural, and quarantine practices. Hand-washing rules, theologically sanctioned quarantine of leprosy sufferers (e.g., in Leviticus 13), and certain health-related societal responses to the 1346 Black Death plague in Venice and Marseilles exemplify this public health approach.[1,2]

The miasma era first evolved in England, in part as a result of the adverse public health impacts of the industrial revolution.[3] Edwin Chadwick's *Report on an Inquiry into the Sanitary Condition of the Labouring Population of Great Britain* demonstrated the overwhelming influence of filthy environmental conditions on adverse health outcomes, and it facilitated the formalization of England's Public Health Act in 1848.[4] Chadwick's report detailed environmental conditions in Britain, together with data to correlate sanitation trends with variations in mortality rates and economic status, thus laying the foundations of modern epidemiology and surveillance.[5,6] Although Chadwick's opinion that most diseases result primarily from sordid environmental conditions was eventually proved to be incorrect, his approach to the safeguard of the public's health is, for the most part, as valid today as it was 160 years ago. For instance, dengue, which was once close to elimination in the Western Hemisphere, now plagues all of South America, primarily because of the rapid growth of cities with poor water supply, sewage disposal, and sanitation.[7]

Following his landmark study of the etiology of tuberculosis in 1882, Robert Koch proposed that fulfillment of the following "germ theory" postulates were necessary in order to demonstrate the parasitic nature of a disease: "The organism must be shown to be constantly present in characteristic form and arrangement in the diseased tissue, the organism which, from its behavior appears to be responsible for the disease, must be isolated and grown in pure culture, and the pure culture must be shown to induce the disease experimentally."[8]

The contagion era facilitated improved understanding of the pathogenesis of infectious diseases like cholera. Such understanding stimulated improved water filtration practices in large urban water supplies and resulted in major decreases in morbidity and mortality from intestinal infections. In addition, advances in bacteriology provided a solid foundation for contemporary measures to control the outbreak of communicable diseases and laid a scientific basis for vaccination.

The preventive medicine era extended the contagion control era in several ways. First, it took appropriate account of the concept of disease vectors. Second, it recognized that not all microbes were dangerous; indeed, some were necessary for healthy bodily function. Third, it highlighted the role of nutrient deficiencies (e.g., of iodine and vitamins) in impairing optimal health. It was during this era that public health activities became centered on "high-risk" population groups such as schoolchildren, pregnant women, and the elderly.[9] The establishment in 1948 of Britain's National Health Service formalized the principles of the preventive medicine era and facilitated their widespread adoption through physicians' enhanced ability to shape political and public perceptions of health policy issues and by incorporating a professional (medical) bias into the perspectives of key politicians and policymakers.[10]

The key elements of the primary health care era, as formalized by the 1978 Alma-Ata Declaration, were (1) global cooperation and peace as important aspects of primary health care; (2) recognition that primary health care should be adapted to the particular circumstances of a country and the communities within it; (3) recognition that

TABLE 1—Six Eras in the Evolution of Public Health

Public Health Era	Dominant Paradigm	Analytic Approaches	Action Frameworks	Legacies Incorporated Into Contemporary Public Health
1. Health Protection (antiquity–1830s)	Diseases may be prevented by enforced regulation of human behavior, mediated through societies' social structures.	Interpretation/promulgation of religious and cultural rules that are thought by the ruling elites to protect the health of the individual and the community.	Enforcement of spiritual practices, community taboos, customs, and quarantine.	Quarantine of illegal migrants; enforcement of some environmental protection laws; aspects of spirituality in prevention and coping with disease; some occupational and transport safety laws.
2. Miasma Control (1840s–1870s)	Addressing unsanitary environmental conditions may prevent diseases.	Demonstration that poor health and epidemics resulted directly from unsanitary physical and social environments.	Centralized action to improve environmental sanitation; public health legislation relating to minimum standards for drainage, sewage, and refuse disposal.	Aspects of Healthy Cities initiatives; potable water and sanitation programs; legal framework for implementing public health activities; foundations of modern epidemiology and surveillance.
3. Contagion Control (1880s–1930s)	Germ Theory: positivist approach to demonstration of infectious origins of diseases.	Demonstration of the presence of disease-causing microorganisms in infected media, their isolation, and experimental transmission.	Interruption of disease transmission through improved water filtration processes; vaccination; standardized disease outbreak control measures.	Evidence-based public health practice; ethical vaccination practices; foundations for international cooperation in health; foundations for modern chemotherapy.
4. Preventive Medicine (1940s–1960s)	Improvements in public health through focus on the prevention and cure of diseases in "high-risk groups."	Definition of, and interventions aimed at, main avenues for disease transmission. Medical dominance, with focus on treatment of communicable diseases and primary care of "special populations" (e.g., pregnant women and factory workers).	Environmental interventions directed at disease vectors such as mosquitoes; identification and use of "useful" microbes; enhanced medical care for "high-risk groups"; foundations of modern clinical pathology.	Focus on "high-risk groups" in the planning and implementation of public health programs; improved understanding of the pathogenesis of communicable and noncommunicable diseases.
5. Primary Health Care (1970s–1980s)	Health for All: effective health care geared toward the community, for the community, and by the community.	Largely preventive health care approach, underpinned by emphasis on equity, community participation, accessibility of services, and social determinants of health.	Emphasis on global cooperation and peace; adapting health services to countries and communities; links between health care and socioeconomic development; intersectoral cooperation in health promotion and disease prevention; equity in health care.	Concepts underpinning multicultural health and Healthy Cities initiatives, health inequalities, and community participation in health promotion activities.
6. Health Promotion (1990s–present)	Advocacy for health; enabling individuals and communities to attain optimal health.	Individuals and communities may be assisted by educational, economic, and political actions to increase control over, and improve, their health through attitudinal, behavioral, social, and environmental changes.	Encapsulated by the key action areas of the Ottawa Charter: build healthy public policy; create supportive environments; strengthen community action; develop personal skills; and reorient health services.	

health care reflects broader social and economic development; (4) primary health care as the backbone of a nation's health strategy, with an emphasis on health promotion and disease prevention strategies; (5) achievement of equity in health status; and (6) involvement of all sectors in the promotion of health.[11]

The health promotion era was formalized by the 1986 Ottawa Charter, which advocated the need to increase opportunities for people to make healthy choices with regard to specific

disease-precipitating factors by providing them with health information and education and enhancing their life skills. The charter affirmed that health promotion policy combines diverse but complementary approaches, including legislation, fiscal measures, and organizational change. It classified the concerns of health promotion into 5 key areas: to build healthy public policy, to create supportive environments, to strengthen community action, to develop personal skills, and to reorient health services.[12]

By the early 1990s, there was general agreement within the public health community that health promotion, based on the Ottawa Charter principles, constituted the "new public health."[13,14] Yet analysis of the health promotion framework reveals the legacies of previous eras, thus prompting the question, "What's new about the 'new public health'?" In addressing this question, I demonstrate that original health promotion innovations, and the legacies of previous eras, are "new" in the sense that the latter have been revised in the light of advances in knowledge, increasing concerns about human rights, and emerging threats to health.

LEGACIES AND INNOVATIONS IN HEALTH PROMOTION

The term "health promotion" describes the health education interventions and related organizational, political, and economic interventions that are designed to facilitate behavioral and environmental changes to improve health. Health promotion is generally viewed as having 3 core components: health education, prevention, and protection.[15,16] The term "health promotion" itself is a legacy of the preventive medicine era; it was first used by Dr Henry Sigerist, who described it as one of the several major tasks of medicine.[17] Its current use is new not only in its being a distinct professional discipline, but also with regard to its mission.

Quarantine practices exemplify the manner in which health protection activities have been incorporated into the new public health. While quarantines continue to serve their basic function, confining diseased individuals as a means of halting infectious disease transmission, the historic legacy of the practice as intensifying stigma and stifling individual autonomy[18] is currently being superseded by more humane and less stigmatizing measures. Furthermore, scientific and legal advances have made more targeted measures possible, as the nature of a given threat to public health becomes better defined (e.g., the response to the recent outbreak of severe acute respiratory syndrome [SARS]). Also, article 7 of the World Health Organization (WHO) International Health Regulations provides clear guidelines on when to declare the end of epidemics in defined communities, thereby limiting the risk of perpetual stigmatization of regions from which epidemics arise.

These improvements have significantly facilitated the diminution of stigma and promoted voluntary compliance among quarantined individuals and groups. Individual autonomy vis-à-vis quarantine has also been enhanced in the new public health. For example, Australia's recently introduced Quarantine Amendment (Health) Bill 2003 stipulates that people ordered to be quarantined in Australia on health grounds now have the right to request independent medical assessment, thus protecting them against arbitrary detention.

The use of legislation to effectively implement contemporary public health activities such as tobacco control is a legacy of the miasma era. Current centralized systems of environmental protection also owe a lot to Chadwick's initiatives. His broad attribution of the cause of ill health to environmental and social factors, rather than the specifics of biology, constitutes the foundation of current concerns with "social determinants of health." However, unlike in Chadwick's time, when legislation suggested that environmental sanitation was essentially a responsibility of government, it is now seen as a responsibility shared by individuals, community groups, and governments. Currently, most government agencies charge individuals and communities for environmental sanitation services such as garbage disposal, and stiff penalties usually apply to those found to have breached environmental protection laws.[19]

The contagion era provided the impetus for evidence-based public health practice, especially through improved understanding of the microbiology and pathogenesis of communicable diseases. These advances laid a scientific basis for vaccination. In the new public health, social marketing and persuasion have transcended legal enforcement as the key to improving vaccination coverage. The latter approach was tried during the contagion and preventive medicine eras, with strident opposition from anti-immunization lobbies. Interestingly, current "consumer participation" strategies are not entirely free of opposition.[20]

Robert Koch, and to a lesser extent Edwin Chadwick, were rigid adherents to the "monocausal" doctrines they espoused. Consequently, their towering influence complicated efforts to revise erroneous aspects of their theories in the light of new knowledge.[6,21] General acceptance of the concept of social determinants of health, as well as the multidisciplinary nature and generally horizontal hierarchy of the contemporary health promotion workforce, has diminished the potential adverse impact of their rigid stances.

Physicians of the preventive medicine era made innovations in the fields of epidemiology, statistics, pharmacology, nutrition, bacteriology, and pathology, from which contemporary public health has benefited immensely.[6,22] The era's focus on high-risk groups is currently being reframed in efforts to address the generally inferior health status of prisoners and indigent populations.[23,24] However, contemporary health promotion rightly accords greater attention to social determinants of health than was the case during the preventive medicine era.[25] In addition, the dominance of the medical profession in public health, which characterized the preventive medicine era, is being superseded by a multidisciplinary approach, with sociologists, health economists, and health promotion specialists now sharing the limelight with public health physicians.

The health promotion era appears to be a continuation of the primary health care era, couched in phrases that appeal more to rich nations and donor organizations. Although the key concepts

of the Alma-Ata Declaration are essentially coterminous with the Ottawa Charter, the Alma-Ata Declaration emphasizes issues that are of major significance to developing countries (e.g., affordable health care, food security, and an emphasis on global peace), whereas such issues are presented as subscripts in the Ottawa Charter. Ironically, while technical experts appointed by the WHO to review the implementation of the Alma-Ata Declaration in developing countries assessed the framework as unwieldy and instead suggested a selective approach,[26] the core principles of health promotion currently endorsed by the WHO—empowerment, equity, collaboration, and participation[27]—are even more imprecise.

CONCLUSION

Unlike other paradigms that gained acceptance by demonstrating a more robust and appropriate framework than those they displaced, contemporary health promotion suffers from a "crisis of legitimacy." Critics view it as providing a functionalist framework that detracts from the need for longer-term social, economic, and political change, as succinctly advocated by the Alma-Ata Declaration.[27] Apparently in response to this criticism, health promotion leadership has tried to accommodate key players and concepts of all previous eras under its umbrella—a "total public health" approach.[25] However, rather than help consolidate its position, this approach has blurred the dominant paradigm and mission of health promotion, as evidenced by a lack of generally agreed upon definition or philosophical underpinning and a lack of unanimity as to whether or not health promotion is the new public health.[29,30] Consequently, most countries currently operate parallel systems of public health and health promotion, unlike in most previous eras, when the dominant paradigm and public health were generally coterminous.

What is new about the new public health is not the originality of strategies to ensure healthy conditions, but the manner in which health promotion discourse has adapted core doctrines of previous eras to address the public health threats of our era. New public health eras usually arise when the dominant public health framework becomes obsolete as a result of changing health patterns and advances in health knowledge. Currently, public health theorists and commentators appear to be losing confidence in the capacity of the health promotion paradigm to effectively address major contemporary public health threats, such as health inequalities and terrorism.[31,32]

Reform of the contemporary health promotion framework, and a possible progression into a more responsive era that would better address new and emerging threats, should be considered from several perspectives. First, there is a need to define the philosophical basis of contemporary public health, thereby facilitating more effective monitoring of public health functions and a more secure basis for advocacy of public health funding.[33,34] Second, there is a need to determine who exactly is a public health worker or specialist. This would better define workers' roles and responsibilities, and facilitate cohesion within the discipline. Although the International Union for Health Promotion and Education's strategic directions for 2002 through 2007 (available at http://www.iuhpe.org) indicate that implementing healthy public policies is "an overriding concern" for health promotion, the new public health generally values social change advocates (vital players in such implementation) less than workers in established specialties such epidemiology and public health medicine. There is a need to acknowledge public health workers and activists who "lead from the front," rather than overrelying on the hierarchical structures of previous eras.

Third, previous characterizations of public health as "global" prior to the primary health care era are inaccurate, reflecting more the views of former empire states than the realities outside the spheres of major influence of these defunct empires. The failed implementation of primary health care as an instrument of global public health highlights the difficulties in developing a truly global public health framework. As an international framework, the health promotion paradigm has not fared better—most of its supposedly successful concepts have proved unworkable outside the affluent, largely homogenous societies in which they were pilot-tested.[35,36] Indeed, public health is essentially an expression of the ways different societies address questions of social order and nationhood. By first addressing the structures of power and socioeconomic development within the history of national and regional cultures, the suitability of implementing specific public health paradigms might become clearer.[37]

Finally, because of the health promotion paradigm's functionalist orientation, it probably could not ensure healthy conditions for people in the 21st century.[28,38] Today's world is characterized by intractable problems of poverty, global inequality, emerging diseases, and persistent conflicts[39]—issues that require more radical public health frameworks than that of the new public health. A historical–structural framework should provide a more resilient basis for contemporary public health workers to prevent diseases and save lives locally using practical, cost-effective techniques. At the same time, it should facilitate global prophylaxis against communicable health threats. It is not necessary for such frameworks to be uniformly implemented worldwide, as the primary health care and health promotion eras have unsuccessfully attempted to do. These are the challenges that await the next "new public health." ■

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