The Distinction between Public Health and Community/Social/Preventive Medicine

EDITORIAL

A GREAT deal of confusion exists with regard to the meaning of the terms "public health," "community medicine," "social medicine," and "preventive medicine." The terms are often used interchangeably, a practice which adds to the confusion. Attempts to clarify the meaning of these terms are not simply exercises in semantics, for there are important issues at stake. Both explicitly and implicitly, these terms carry major implications for public health policy. In every country of the world, the direction of policy has been molded, for better or for worse, by the theoretical orientations inherent in their use.

Two basic concepts are at issue: public health on the one hand, and community/social/preventive medicine on the other. The latter three terms have different historical roots, but reflect a more or less identical orientation.

The term "preventive medicine" stems from a period in the United States when public health was almost exclusively concerned with the prevention of infectious diseases and was dominated by the medical profession.

"Social medicine" is a product of France, Germany, Belgium and other European countries. Firmly based in the medical profession, it reflected a concern with the role of social factors in the etiology of disease, and the need for government action in the areas of disease prevention and medical care. The term was widely adopted in Great Britain in the 1940s.

"Community medicine" became prevalent in the United States as a substitute for "social medicine," since the latter term sounds too much like "socialism." Furthermore, use of the word "community" implies activity at the local level rather than the national action abhorred by the conservative leadership of the medical profession. In view of the growing trend toward political conservatism in Great Britain, it is perhaps no accident that the term "public health" has been officially dropped in that country in favor of "community medicine."

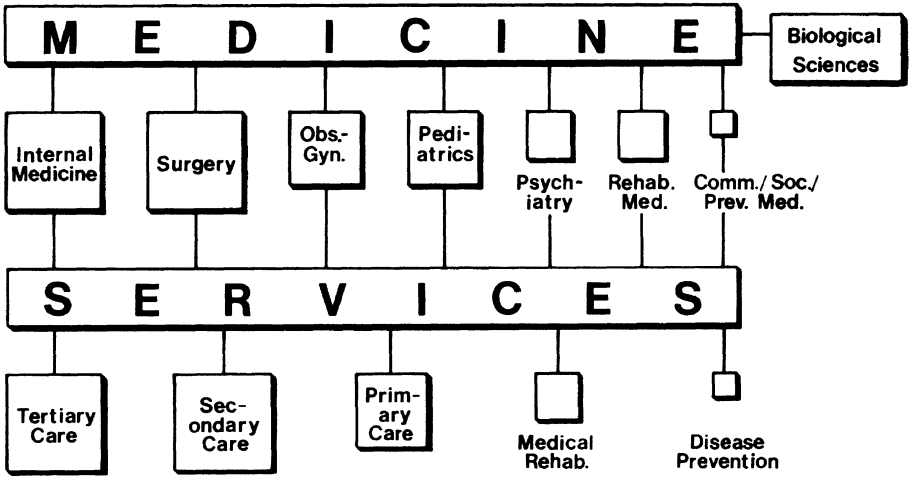
The common denominator of all three of these terms is "medicine." This is the key word: community, social and preventive medicine are considered to be, and in fact are, a subdivision of the overall discipline. Indeed, as indicated in Figure 1, they constitute a very minor subdivision of medicine, as measured by every parameter: financial support, numbers of personnel, prestige, political influence, etc.

The concept of public health, on the other hand, is that of a major governmental and social activity, multidisciplinary in nature, and extending into almost all aspects of society. Here the key word is "health," not "medicine"; the universe of concern is the health of the public, not the discipline of medicine.

The multidisciplinary character of public health is crucial to the concept. As Figure 2 indicates, many professional disciplines are involved: epidemiology and biostatistics; health economics, sociology, political science, and other social sciences; the biological and physical sciences; public health engineering, nursing, dentistry, and nutrition; community/social/preventive medicine; health education; and health administration, i.e. the organization of personnel and facilities to provide all health services required for the promotion of health, prevention of disease, diagnosis and treatment of illness, and physical, social and vocational rehabilitation. Other profes-

FIGURE 1

The Community/Social/Preventive Medicine Concept



sional disciplines, such as veterinary public health and public health social work, are not included in Figure 2 for lack of space.

The two concepts—community, social and preventive medicine on the one hand, and public health on the other—are clearly contradictory. One considers public health to be a subdivision of medicine; the other considers medicine to be a subdivision of public health.

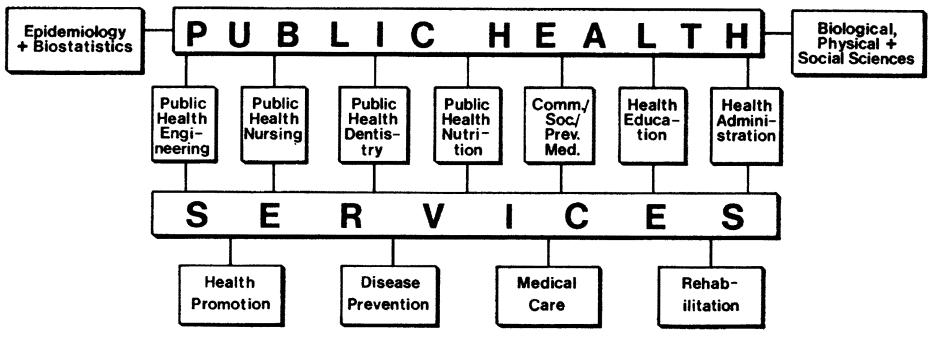
CONSEQUENCES OF THE COMMUNITY/SOCIAL/PREVENTIVE MEDICINE CONCEPT

Since the concept of community/social/preventive medicine defines public health as a minor subdivision of medicine, and since clinicians who provide tertiary care are the most prestigious and powerful group in the medical profession, certain results occur. The following consequences of the concept are by no means theoretical; they exist as hard and unfortunate realities in most countries of the world today:

1. Medical care services are skewed to tertiary and secondary hospital care, with inadequate attention to primary care.
2. Preventive services are generally neglected and receive little financial support.
3. The emphasis in disease prevention is placed on secondary prevention, which is the province of the physician, instead of primary prevention, which is the province of the community. This occurs despite the fact that primary prevention is far more effective. Enormous amounts of time, effort and money have been spent in general medical examination programs in which the costs have far outweighed the benefits.

FIGURE 2

The Public Health Concept



4. Medical rehabilitation services are inadequate, and vocational and social rehabilitation programs remain neglected and undeveloped.
5. Health promotion—which is concerned with improvement in the economic and social conditions of the population, i.e. employment, income, housing, working conditions, education, rest and recreation, participation in community activities and decision-making, etc.—is almost never considered.
6. Ministers of Health, the Surgeon General, and other directors of national health services are often drawn from the ranks of cardiac surgeons, pediatric surgeons, anesthesiologists and other clinical specialists with no education or experience in the science and practice of public health.
7. State, regional and local directors of health services are likewise often drawn from the pool of clinical specialists with no background in public health.
8. So-called schools of public health exist in which the faculty consists entirely or almost entirely of physicians, and none but physicians (or perhaps a few token members of other disciplines) may be accepted as students.
9. Some schools of public health are subordinate to medical schools, while several have been dismantled in an attempt by leaders of the medical profession to force them back into the community/social/preventive medicine mold.
10. The World Health Organization, strongly influenced by physicians oriented to the community/social/preventive medicine concept, has failed to take significant action to meet the urgent worldwide need for national, state and provincial schools of public health.
11. A number of foundations with large financial resources have developed major programs to train "clinical scholars" and "clinical epidemiologists". These programs have the potential of making it possible to replace public health-oriented personnel in the leadership of the health services with physicians having a primary loyalty to clinical medicine.
12. One of these foundations is actively recruiting physicians from the Third World for training, not in the epidemiology of the infectious and noninfectious diseases which are the major sources of illness, disability and death in developing countries, but in so-called clinical epidemiology, i.e. the scientific evaluation of clinical procedures, with trainees performing a clinical trial of a diagnostic or therapeutic procedure on return to their country. There can be no doubt about the value

of such training for clinicians, who by and large comprise a "virgin" population in terms of exposure to the methodology of scientific investigation. But to promulgate such activity through blatant misuse of the term "epidemiology" is at best a dubious practice. To do so in the Third World, with its terrible burdens of famine, endemic malnutrition, infant diarrhea, malaria, and a host of other infectious and noninfectious diseases, is the ultimate absurdity.