Shifting Paradigms in Public Health

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From Holism to Individualism

Springer

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For Anchal

You whom I gladly walk with, touch,
Or wait for as one certain of good,
We know it; we know that love
Needs more than the admiring excitement of union;
More than the abrupt self-confident farewell,
The heel on the finishing blade of grass,
The self-confidence of the falling root,
Needs death, death of the grain, our death,
Death of the old gang; would leave them
In sullen valley where is made no friend,
The old gang to be forgotten in the spring
The hard bitch and the riding master,
Stiff underground; deep in clear lake
The lolling bridegroom, beautiful, there.

–Auden, W.H. *Poems*, 1934: 66

Foreword

The world has never before been as rich as it is today. Yet, substantial populations of the world are bereft of resources to ensure a modicum of health. Nearly 1.3 billion people, overwhelmingly in the formerly colonised countries of the South, live on less than a dollar a day, and close to 1 billion cannot meet their basic calorie requirements. More than 800 million people lack access to health services, and 2.6 billion people to basic sanitation. Although people are living longer today than at any time in the past, around 1.5 billion people are not expected to survive to age 60. Indeed, life expectancy in some countries of sub-Saharan Africa is only around 40 years.

One familiar reason given for the widespread poverty and ill health in poor countries is, of course, overpopulation, which is a red herring. Despite population growth, global per capita food production increased by nearly 25 % between 1990 and 1997; the per capita daily supply of calories rose from less than 2,500–2,750, and that of proteins from 71 to 76 g. In other words, not one person in the world needed to go to bed hungry. Yet, given the fact that the overall consumption of the richest fifth of the world's population is 160 times that of the poorest fifth, 840 million people, 160 million of them children, are undernourished. Close to 340 million women are not expected to survive to age 40.

The overpopulation argument also elides the fact that there occurs a net transfer of close to 80 billion dollars annually from the countries of the South to those of the North. Indeed this figure has increased substantially over the last three decades. During this period, marked by the demise of actually existing socialism and of Keynesianism, and the rise of the neoliberal policies of Reagan and Thatcher, inequalities within and between countries have risen sharply: the income gap between the world's richest and poorest has more than doubled. In 1960, 20 % of the world's population in the richest countries had 30 times the income of the poorest 20 %; today, they command 74 times more. The same richest 20 % of the population command 86 % of world GDP, while the poorest 20 % command merely 1 %. More than 80 countries have per capita incomes lower than they were a decade or more ago; 55 countries, mostly in sub-Saharan Africa, Eastern Europe and the former Soviet Union, have had declining per capita incomes.

These changes in the global economy have been accompanied by dramatic reversals of the health gains made in the immediate aftermath of the Second World War as formerly colonised nations rushed to their trysts with destiny, and as countries of the 'free world' built their welfare states. In some countries of sub-Saharan Africa, the average age of death has actually declined in the last decade. Sharp declines in life expectancy have also been recorded in countries of the former Soviet Union.

With the initiation of macroeconomic policies commonly known as structural adjustment programmes (SAPs) under the aegis of the World Bank and the International Monetary Fund, infant mortality rates and child mortality rates increased in several countries of Latin America and Africa, along with increases in the levels of undernutrition and morbidity. Public health services, reeling under fund cuts, a sine qua non of SAPs, collapsed. Indeed, so devastating were the consequences of these reforms that UNICEF was compelled to call for structural adjustment 'with a human face'. Similarly, infant mortality rates have stagnated in India and in China in the post-economic reform period. But it is when looking beyond the deceptive averages that the full extent of the damage to health emerges: a sharpening of health inequalities.

While the situation in the so-called Third World is bleak, how have neoliberal policies affected health outcomes in the developed world? These economic policies have also ushered in increasing poverty in these countries, rich as they are. Many of them have affected cuts in social security and eased labour laws to facilitate hiring and firing. How, then, have the poor in these countries fared? *The Black Report* by Peter Townsend, Margaret Whitehead and Nick Davidson, published in 1980, put health inequalities squarely on the agenda in the United Kingdom, much to the discomfiture of complacent Thatcherites. *The Black Report* showed a substantial increase in mortality differentials by class: for example, that the unskilled working class, despite an overall decrease in mortality rates, had higher mortality rates than ever before in the twentieth century. Over this period, while disease patterns changed, technologies radically improved and more was spent on medical care that was accessible to the entire population of the country; what did not change were the social differentials in death rates. These inequalities in health widened sharply during the Thatcher years, along with a widening of class differentials in heights among schoolchildren. Here was evidence, again, that substantial GDP growth accompanied by inegalitarianism is bad for health.

Among the many explanations proffered for this state of health affairs, three deserve some scrutiny. The first is the myth about the genetic determination of diseases. Unfortunately, led by the media and the medical technology industry, even otherwise intelligent people believe that a range of diseases and behaviours have genetic roots and propose technical interventions at the individual level. Thus, the frequent tendency in public health is to focus on the proximal to the exclusion of fundamental causes of disease. However, secular mortality trends indicate that social change can result in sizeable changes in disease risk within populations over a short period of time. At the same time, mortality and morbidity trends indicate that interventions targeted at individuals have little impact. Focusing on individual or

genetic causes also serves to distract attention from the social roots of prevailing patterns of morbidity and mortality.

The second explanation is that the poor behave reprehensibly and are therefore responsible for their own state of ill health. This so-called behavioural school has great appeal – as is evidenced by well-funded information programmes that, for example, emulate Marie Antionette, and exhort the poor to eat good food. Studies have revealed that individual behavioural or, if you will, 'lifestyle' factors accounted for about a third of the differentials in death rates among different social groups, while a substantial proportion, about two-thirds, could not be explained by such factors. In other words, there were larger structural factors governing and contouring behaviours themselves.

The third explanation, on somewhat less sticky ground ideologically, is that of social capital. Yet, even this is inadequate as an explanation, both empirically and conceptually. Social capital means different things to different people, and explaining everything runs the risk of explaining nothing at all. Thus, it is ripe with possibilities of methodological problems: sometimes it is a cause, sometimes a dependent variable and, all too frequently, a confounding variable. That the Putnam avatar of the concept of social capital found such enormous appeal in the World Bank, setting the development and health agendas globally and contributing to increasing income and health differentials, tells its own story.

All these explanations suffer also because they are committed to the philosophical tradition of methodological individualism that Dr. Vijay Kumar Yadavendu critiques in this excellent work. He explores the philosophic basis of dominant contemporary public health approaches, tracing their origins and development over the last 100 and 50 years, and argues that public health has seemingly lost its raison d'être, a population perspective. The problem with the philosophical – and methodological – underpinnings of public health is not something that public health practitioners or medical students are often even aware; indeed, most would claim that theirs is an empirical, value-free subject. The book thus also fulfils a yawning gap in the training of students in both public health and medicine. We live in a world profoundly troubled with history and impatient with it; this work brings back a historical perspective, revealing that the challenge to public health is as much philosophical as political.

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Mohan Rao

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For the drawbacks in the book, if any, I alone shall be responsible.

Vijay Kumar Yadavendu

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