

## Why Health is a Planning Issue

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## ***Why Health is a Planning Issue***

***Lori Letts & Beth Moore Milroy***

Health is moving back onto the planning agenda. It used to be an issue closely associated with planning early in the century. Then it was scooped away as the preserve of medical care providers and rarely discussed in planning. Now it is appearing again as a planning issue.

In this research note we attempt to outline some of the reasons why health seems to have followed this cycle. In its simplest terms, the argument is that at the turn of the century the state of health was associated with everyday life in Canadian cities. It later receded as medical practitioners drew health out of that context and into a framework of hospitals, medicine, technology and services. Today's environmental issues have helped to refocus attention on health, and in the process to begin to recontextualize it in community settings.

### ***View of Health over Time***

One way to follow how health has been treated as a subject over time is to examine the actions and activities that have contributed to improving people's health. Thomas McKeown (1971a) does this for the case of Britain from the mid 1800s to the present. After describing the changes in death rates and corresponding increases in population size over the period, McKeown makes the case that the steady population growth can be explained by three main factors that occurred sequentially.

First among these are the improvements made to the standard of living between 1840 and 1870, and especially those related to nutrition. Better agricultural practices led to better food supplies. Infant mortality rates dropped, and adults who came into contact with communicable diseases were less likely to die.

The second factor was sanitation. Around 1870 many measures were introduced in Britain such as clean water supplies and sewage disposal systems. Especially in urban areas, these were significant in reducing the spread of communicable diseases. These changes were being made without a clear understanding of germ theory which is now accepted as explaining the spread of those communicable diseases (Albino & Tedesco, 1987, p. 210; McKeown, 1971b, p. 12; Rosen, 1958, p. 288). While the association between disease and the plight of the working class poor living in industrial slums was established through surveys by the early 1800s (Rosen, 1958), the cause for this association was not clearly understood. The predominant theory of the 19th century was that foul air, or miasmas, perhaps from decaying animals or vegetables, was the source of disease (Albino & Tedesco, 1987; Rosen, 1958). Based on miasmatic theory and the survey results, sanitary reforms were initiated. Throughout the entire 19th century, individual researchers were developing a body of knowledge that would eventually lead to the development of the germ theory. However, it was not until the last 20 years of the 19th century and into the beginning of the 20th century that specific microorganisms that caused disease were identified. The validity of the germ theory could no longer be denied (Rosen, 1958).

McKeown (1971a) also notes that around the 1870s Britons changed their reproductive behaviour, giving birth to fewer children. Fewer children in each family also contributed to better nutrition and healthier living conditions.

The third and final factor that McKeown identifies as being important in lower-

ing mortality rates was the prevention and treatment of disease in the individual from the mid 1920s to present. This contribution by medicine came after germ theory was widely accepted, and after immunization and other methods of preventing and treating specific diseases in individuals were developed. Consequently, McKeown concludes that the contribution of the medical system to improved health in society was less significant than changes in reproductive behaviour, improved nutrition, and a decline in environmental hazards. Health promotion in urban contexts was already significantly contributing to better health before the medical services we know today proliferated and became the focus of thinking about health and disease.

Based on this brief review of the contributors to improved health, a review of the definition of health over time can be conceptualized. The most significant indicator of how health was viewed may be the implementation of sanitary measures without proven cause. The medical model focuses on the individual rather than the interaction between the environment and the individual, and defines health as a lack of disease. If health was viewed as a lack of disease only, it is unlikely that changes such as sewer systems and clean water supplies would have been initiated. However, from a more global definition of health, focus would turn to "the environmental and social context of disease, and the importance of behaviour in disease control" (Albino & Tedesco, 1987, p. 208). It seems then that early in this century and before, health was viewed within the environment of living, and that behavioural, environmental and social factors were accepted as playing a role in the determination of health. Health promotion played a significant role in improving the well-being of people at that time.

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Over the last 70 years, a greater understanding of biological processes and the ability of medicine to treat certain diseases has occurred (Rachlis & Kushner, 1989). It has been demonstrated by McKeown (1971a) that these changes are not the primary reason for improvements in health over the last 150 years. Despite this, the medical model of health has become well accepted by society. Perhaps this is attributable to the drama associated with these medical advances, especially in cases of acute illness. The focus of the medical model is on the treatment of an individual within the health care system. Individuals are treated for their individual illnesses. Illness is seldom considered within the context of the environment in which the person lives.

As the medical model became accepted, more funding was given to this area by government. Comprehensive, accessible, universal, and portable health care have become highly valued services in Canada, something of which most Canadians are very proud. However, when governments began funding health care services, hospital services received assistance first, and funding later expanded to include services outside hospitals (Rachlis & Kushner, 1989). This system of funding further allowed a continuing emphasis of health care on a lack of disease, since most hospital programs are devoted to the treatment or cure of disease. The existing health care system might actually better be called a sick care system (Hancock & Duhl, 1986).

### ***Recontextualization of Health***

Limitations of the medical model are now recognized, and have probably contributed to the growing recontextualization of health. The medical model of diagnosing, treating, and curing disease

is not applicable to many chronic diseases which cannot be cured, or for which there is no known treatment. As well, implementation of the medical model is expensive, as shown by the large amounts of government spending devoted to the provision of health care services. For these reasons, other approaches to health have been examined.

In 1974, the Minister of Health and Welfare Canada, brought forward a discussion paper that advocated the consideration of human biology, environment, lifestyle, and the health care organization all as contributors to the health of Canadians. This conceptualization opened the door for a broadened definition of health from a lack of disease to a state of physical, mental, and social well-being (Epp, 1986). The relationship between health and environments, both natural and built, is promoted by the redefinition of health. While the response to the Lalonde report was not immediate or resoundingly positive, other initiatives have occurred since then that indicate that health is being considered within a broader environmental context, and recognize that health is determined by several factors. The Ontario Ministry of Health published three reports in 1987, all of which discuss the importance of health promotion, and a redefinition of health (Minister's Advisory Group on Health Promotion, Ontario Health Review Panel, Panel on Health Goals for Ontario). Healthy public policy has become a part of health planning and has also impacted on other areas of planning.

Initiatives that have begun to act on the concept of health in the context of living can be identified. The healthy cities movement has provided opportunities for municipalities to become involved in healthy public policy. The Canadian Healthy Community Project is a joint effort of the

Canadian Institute of Planners, the Canadian Public Health Association, and the Federation of Canadian Municipalities. This project provides support and guidance to communities and regions that wish to adopt healthy public policy (Berlin, 1989). It recognizes that the physical, social, and natural environment of the city in which people live can impact on the health of its residents and therefore the health of the city. The efforts of the Sole Support Mother's Group which was started six years ago by residents of Regent Park in Metropolitan Toronto to begin a garden and nutritional education program for residents also indicate that health can be improved outside of traditional medical care services.

### ***A Return to Planning***

Forces that recognize the limitations of the medical model and the opportunities offered by considering health in a broader context have resulted in the recognition that health is contextual. That context includes money and environments. Planning is involved in directing money and resources towards problems within the organizational systems in which we live. Therefore, health is again a planning issue. Planners must not only consider health as an outcome influenced by decisions made and policies considered within the urban context, but must also set the health of the community as a goal in itself.

### ***Notes***

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