Editorial

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Public health, public persuasion

This year marks the 200th anniversary of the birth of Edwin Chadwick, whose *Report on the Sanitary Conditions of the Labouring Populations* paved the way for Britain's first Public Health Act to be passed into law in 1848.[1] Living at a time of rapid social change — the population of England and Wales was in the process of doubling, from 9 million in 1801 to 18 million in 1850 — Chadwick witnessed the Dickensian nightmare that accompanied the Industrial Revolution. Although it was not until the 1880s that "germ theory" provided a rational explanation of infectious disease, physicians and social reformers in Chadwick's day recognized that the health status of a population is related to environmental factors such as clean water, safe working conditions and decent housing.

Although Chadwick based his *Report* on epidemiologic evidence gathered by Poor Law officers, physicians and others, he suppressed some data and emphasized others to support his "sanitary idea" — that improvements to water systems, drains and the management of waste must be the first priority in routing out disease.[1] But if the *Report* was calculated to sidestep the more radical and politically unacceptable idea that poverty was the root cause of disease,[1] it also demonstrated that the success of public health initiatives rests not just on data, but also on the art of persuasion.

Since Chadwick's time, we have adopted new models of health and disease, and hence new approaches to public health. We have tended to hope that technologic solutions alone would be sufficient. And sometimes we have run afoul of our own success: in countries where epidemics of some childhood infectious diseases are receding into memory, it is again becoming necessary to "sell" the public on the need for mass vaccination. And, as in Chadwick's time, we are witnessing vast social upheavals that will test the limits of public health. The freer exchange of goods around the globe, the burgeoning of international travel, environmental deterioration and the displacement of populations by armed conflict will require better disease surveillance, innovative public policy and greater international cooperation. For example, the World Health Organization is within reach of its goal of eradicating polio by the end of the year 2000. But fulfilling that goal involves the daunting political process of negotiating "Days of Tranquility" in war zones to allow the vaccination of children to be carried out in areas where reservoirs of wild polio virus remain.[2]

In Canada, the challenges facing us range from the banal to the exotic. Funding cutbacks have disproportionately affected the delivery of public health services, while the reporting of malaria transmission in Canada[3] and the first outbreak of West Nile fever reported in North America (see page 1036) remind us that tropical diseases of which we have little experience are just an airplane ride away. No less than in Chadwick's day, we need good systems of public health surveillance and delivery. But, most important, we need strong leadership and the will to practise the art of public persuasion. — *CMAJ*

References

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2. Hull HF. Fighting stops for polio immunization. www.who.int/inf/polio.html (accessed 2000 Mar 7).
3. MacLean JD, Ward BJ. The return of swamp fever: malaria in Canadians. *CMAJ* 1999; 160(2):211-2. Available: www.cma.ca/cmaj/vol-160/issue-2/0211.htm