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HEALTH AND CARE—FROM A EUROPEAN PERSPECTIVE

Lifeworld-led care: Is it relevant for well-being and the fifth wave of public health action?

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Abstract

A recent paper has made the case for a "fifth wave" of public health action. The paper articulated the first four waves as focusing on civil engineering, the germ theory of disease, welfare reforms and lifestyle issues. This article will focus on well-being and will expand on the authors' articulation of a current need to "discover a new image of what it is to be human" to begin to address the challenges of promoting well-being. This article will consider an alternative way of viewing human beings within a "caring" context and how this alternative view may aid this potential fifth wave of public health action. This alternative view has emerged from the work of Husserl who suggested that any human view of the world without subjectivity has excluded its basic foundation. The phenomenological understanding of "lifeworld" is articulated through five elements, temporality, spaciality, intersubjectivity, embodiment and mood that are all discussed here in detail. A world of colours, sparkling stars, memories, happiness, joy, anger and sadness. It is this "lifeworld' that when health care or as argued in this article as public health becomes overly focused on decontextualized goals, and measuring quality superficially can be neglected.

Key words: *Lifeworld, well-being, public health*

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A recent paper has made the case for a "fifth wave" of public health action (Hanlon, Carlisle, Hannah, Reilly, & Lyon,. 2011) through analysing current public health issues and reflecting on the history of public health action. The paper articulated the first four waves of public health activity as focusing on:

1. Civil engineering or the great public works period.
2. The germ theory of disease and refinement of the scientific approach in hospitals.
3. Restructuring of institutions, welfare reforms, new housing, social security and the development of "health services", and
4. A dominant focus of activity on the "risk" theory of disease causation, and lifestyle issues, smoking, diet and physical activity.

The paper presented its case for a fifth wave through discussing the complex current challenges of obesity, inequality and loss of well-being.

It is clear that each historical wave of public health action has arisen in response to geographical and cultural needs and has drawn upon emerging philosophies and ideas in society at that time (Hanlon et al., 2011, Szreter, 1997). The "waves" of action are articulated as metaphors for each phase of improvement in public health with maximum change being affected during the peak of the waves with a trough or decline in affect between each one. Each one of the waves emerged from current contextual issues in society with the first wave emerging from concerns over the health of the public following changes in the organization of society during and after the industrial revolution in Northern Europe and North America (1830–1900). Overcrowding, lack of sanitation and clean water and poor living conditions created perfect conditions for the transmission of infectious diseases along with increased alcohol consumption and crime within rapidly growing urban environments (Hanlon et al., 2011). Social

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reformers were key actors in this first wave of public health action.

The second wave was concerned with the rise of scientific rationalism found in medicine (and the development of hospitals), engineering and municipalism. The idea of the "expert" in a narrow specialist field emerged and the body became viewed as a machine (1890–1950) with different "components" being treated by different experts. Scientific discovery and medical science drove this second wave.

The third wave was influenced by the materialist philosophies of Marx and Engels who argued that material changes drive changes in society, and "health" was recognized as the compound result of the conditions of every day life. Examples of reforms during this period are the idea of universal education, social housing reforms and the establishment of health services. Political reformers were key drivers within this period (1940–1980).

By the second half of the 20th century, the results of the first three waves of activity became clear with death rates declining (McKeown & Record, 1962). However, Northern Europe and North America became part of a transition to post industrial society where service industries replaced manufacturing and a dominant knowledge-based economy developed. Consumer choice increased, fertility rates fell and rates of divorce increased. Work and gender roles changed dramatically with the knowledge economy having little use for the tradition roles played by men in the work place with seismic shifts occurring in what was available as a job or working life within many communities (Karasek & Theorell, 1990). In the fourth wave, "risky" behaviours, such as smoking, diet, exercise, alcohol and drug consumption, became the focus of public health activity as chronic diseases caused the majority of death and disability in the western world (Hanlon et al., 2011). Indeed, this focus on what causes our ill health rather than what promotes our well-being has influenced the way we consider physical and mental health where most research is not focused on prevention but on causation and treatment (Heller, Muston, Sidell, & Lloyd, 2001).

This article will focus on well-being and will expand on Hanlon et al.'s (Hanlon et al., 2011, p. 34) articulation of a current need to "discover a new image of what it is to be human" to begin to promote well-being (Easterlin, 1980; Eckersley, 2004; Lane, 2000). This article will consider an alternative way of viewing us as human beings within a "caring" context (Todres, Galvin, & Dahlberg, 2006) and how this alternative view may aid us in the potential fifth wave of public health action.

Loss of well-being

Understanding well-being and its determinants allows for a whole new endeavour that of well-being promotion that builds on the work of the positive psychology movement (Csikszentmihalyi, 2004). This movement is concerned with empowering people and communities to see well-being as achievable and something that they can influence. The well-being of a person can be seen in terms of the "well-ness" of the persons' being. A person consists of his or her "beings" and "doings" (Sen, 2002) the elements of this can vary from being adequately fed, in good health and escaping early morbidity and mortality, to more complex achievements such as having security, self-respect, happiness and potential (Nussbaum, 1988). These complex achievements can also be articulated in existential terms as "dwelling" or feeling peacefully at home and "mobility" relating to one's potential thoughts, experiences and actions (Todres & Galvin, 2010). It is important to note however, that problems of social justice and inequities in health relate strongly to extensive disparities in well-being, including the freedom to achieve or strive for increased well-being or "well-being freedom" (Sen, 2002).

The World Health Organisation (2001) has predicted that depression (as a gross measurement of well-being) will soon be one of the leading global causes of disability. It is likely that this increase is due in part to improved detection and diagnosis. However, it appears that despite increasing economic growth in Europe, Australia and the USA, rates of depression and anxiety are increasing. It would appear that our "consumerist society" is not having a concomitant positive impact on our well-being (Carlisle, Hanlon, & Hannah, 2008). Indeed, it may be that through our societal obsession with consumerism, our well-being may begin to decline (Easterlin, 1980; Eckersley, 2004; Lane, 2000; Layard, 2006,).

The first four waves of public health activity have focused primarily on structural changes within the organization of society and more recently the potential to blame or hold accountable individuals for their health behaviour. What seems to be missing is a view of human beings as "assets" with the potential to harness their qualities of passion and effort as a possible force for public health improvement (Hanlon et al., 2011; McKnight & Kretzmann, 1996). Interestingly, one can find some resonance with the first wave of public health action that was led by social reformers who were themselves clearly assets at that time and in that context in terms of improving public health. However, overall how we begin to understand our human experience of the

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world and how we enable each other to "flourish" has been markedly lacking from the previous four waves of public health action articulated here (Hanlon et al., 2011). As mentioned in a recent editorial, Dahlberg (2009, p. 131) stated that "using a phenomenological lifeworld approach we can see how a patients' suffering can be related to biology but that at the same time we need to attend to the experiences of the person to (effectively) support well-being". Equally, when considering how to promote well-being across communities and populations, we can describe causative factors for increased risk and illness but how can we develop an understanding of the experience of living in that context and how changes can be made that can positively influence well-being or the potential to achieve well-being? How do we influence well-being freedoms?

The fourth wave of public health one could argue has resulted in a negative "micro measurement" approach to public health intervention that focuses on individual biology or behaviour, rather than arguably more influential macro influences on well-being such as social, welfare and economic issues (Venkatapuram & Marmot, 2009). This micro evaluation focus is currently being encouraged through public health-related research calls and the approaches the funders are favouring (Whitehead, 2010). This approach is essentially opposed to that suggested in Hanlon et al.'s (2011) paper which suggests that the legacy from our biomedical approach to health is that we can find a cure for everything, given enough time and resources rather than focusing on finding a way forward that puts well-being first. A key characteristic of the first four waves of public health action is the relative unimportance of the human spirit and capability. We appear to behave as if "experts" and "organisations' are the key regardless of the great potential of our human capacities for energy, learning, passion and effort. The idea that Sen (2002) presented on well-being freedoms or disparities in the potential for people to achieve well-being is relevant here as one could argue that as we all have the potential for energy, learning, passion and effort, so it is possible for this potential to be limited or blocked by our circumstances, thus impacting negatively on our well-being.

The lifeworld

The "lifeworld" view has emerged from the work of Husserl (1970). As well as a philosopher, Husserl was a mathematician who became increasingly concerned regarding how quantitative measures can forget or ignore qualities of the human experience. Husserl suggested that any human view of the world without subjectivity has excluded its basic foundation from the beginning. He articulates our world as textured, embodied and experienced by us and through us. A world of colours, sparkling stars, memories, happiness, joy, anger and sadness. It is this "lifeworld" that when health care or as argued in this paper public health becomes overly focused on decontextualized goals, victim blaming, and measuring quality superficially can be neglected or even forgotten leaving us open to the risk of dehumanizing research and practice.

Five elements of "lifeworld" have been articulated, through building on Husserl's consideration of what makes up the human experience of life (Boss, 1979; Heidegger, 1962; Merleau-Ponty, 1962). These are temporality, spatiality, intersubjectivity, embodiment and mood. They will be considered here individually in relation to well-being and will then be discussed in relation to the suggested six emergent qualities of this new fifth wave of public health action.

Temporality

Temporality refers to time as it is experienced by us as humans. As we increasingly try to fit our lives into the pressures of our "clock" time, the way that we experience time can become a negative pressure rather than offering us a feeling of possibility. These feelings of possibility can emerge through memories of the past and the potential offered by the rhythms of the seasons for instance. The way we experience time can become oppressive and overly rigid and dominant which has a negative impact on our well-being rather than offering us options and possibilities both for the here and now and the future (Todres et al., 2006).

Spatiality

Spatiality refers to our environment as humans, our world and our experience of living in that environment. It has been clear through all of the phases of public health action that the way we interact with our environment and the nature of that environment have a positive or negative impact on our well-being. Our own personal topography can impact on our health or health behaviour for instance or put our personal safety at risk, just as it can also promote our well-being. Our "space" can present us with opportunities for socialization and purpose, or natural images, colours and textures, arts and sport for instance all of which have the potential to enhance our well-being (Hemingway & Stevens, 2011). Or indeed it can limit our potential through

offering no opportunities for socialization and little access to the "natural" environment.

Intersubjectivity

We are part of the world and are continuously interacting with it and others in it. Our capacity for language extends our understanding and shared meanings in our world. Through intersubjectivity, we locate ourselves meaningfully in our interpersonal world, who am I close to, who am I worried about, who am I looking forward to seeing? What am I looking forward to doing? Intersubjectivity also articulates how we are in relation to culture and tradition that impact on how we view ourselves and others. Forms of intersubjectivity can humanize or dehumanize us such as kindness or violence and can have a positive or negative impact on our well-being.

Embodiment

Being human, we live within our bodies and we experience the world through them in a positive or negative way (Merleau-Ponty, 1962). Interestingly, embodiment has been articulated as a key concept within an ecological perspective on public health (Lang & Rayne, 2001; McLaren & Hawe, 2005; Rayner, 2009). Embodiment in public health and epidemiology is the means by which humans biologically incorporate the physical and social environment in which they live throughout their lives. An underpinning assumption of the term embodiment is that one's biology cannot be understood without considering psychosocial and sociocultural aspects of individual development and societies history (Krieger, 2001). If applying an anthropological perspective, embodiment is relevant to the distinction between abnormalities in structure and function of organs (disease) and the lived experience of sickness and the way in which sickness acquires social significance within particular cultures and contexts. Embodiment pertains to how we experience the world that includes our perceptions of our context and its possibilities or limits.

Mood

Mood is intimate to how we are as human beings and is both impacted upon and impacts upon ones spatial, temporal, intersubjective and embodied horizons and our ability to realize potential. Anxiety reveals a very different experience of the world than joy and sorrow do. Mood is a potent messenger of the meaning of our situation (Todres et al., 2006) and as such will influence and be influenced by our physical and mental well-being and is influenced by the other four dimensions outlined here.

The "fifth wave" of public health action

Within the articulation of a potential "fifth wave" of public health intervention (Hanlon et al., 2011), the authors suggested six emergent qualities of this new wave of public health. They will be considered here in relation to well-being and the "lifeworld" view. The description of the six qualities will each be introduced by a key quote from the earlier paper.

We are not dealing with simple systems

> Recognise that the public health community is dealing not with simple systems that can be predicted and controlled but complex adaptive systems with multiple points of equilibrium that are unpredictably sensitive to small changes within the system. (Hanlon et al., 2011, p 34)

As human beings, we are complex as are our groups, tribes or communities. Within this complexity lie our strengths and through them we express our unique human qualities and our desire to both experience the here and now and influence the future. We need to work with and through this complexity to understand what it is we need to flourish. In order for the promotion of "well-being" to become the dominant discourse within our "sickness" and "sickness causation" focused actions, we need to come to a shared definition that may be context specific, however should be specific enough to build policy and practice upon. Todres et al. (2006) when discussing the core perspectives of lifeworld led care mentioned "grounding" that is an understanding of others' experiences of living through and within complex circumstances that can help us to understand our adaptive systems. Our well-being is densely connected with many systems as we move through our lives such as community, culture and state to name but a few. Our lived experience of these systems is equally as important as outcome-based quantitative evaluation. Indeed, if these experiences were valued equally, then the design of our health and other state systems could be guided by the real experience of the end user. This could give our public health efforts the potential to be supported or driven by real "actors" as assets within any given context as we can all share an understanding of what we are trying to achieve. As human beings, we can intuitively share the experiences of others that help to motivate us to participate and share in the efforts or actions needed

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to promote well-being through using a narrative that makes sense to us.

The need to rebalance our mindset

> Rebalance our mindset: from 'anti' (antibiotics, war on drugs, combating inequalities) to 'pro' (wellbeing, balance, integration) and from dominion and independence (through specialist knowledge and expertise) to greater interdependence and cooperation, the capacity to learn from and with others. (Hanlon et al., 2011, p. 34).

The dimensions of "lifeworld" presented here expose the potentially de-humanizing impact of a public health approach that focuses solely on "experts" giving advice to those who need "fixing". It is clear that to deal with the complexities of the human condition and experience, we urgently need to learn from and with others to find a vision for the future. Less of a focus on "labels" and "experts" and more of a focus on 'listening" and the way in which we as human beings experience our world and our potential well-being as articulated here resonates with a philosophy focusing on inter-dependence, inter-subjectivity and cooperation. Indeed focusing on "expert advice" may never increase our well-being freedoms as it does not enable us to find our own way forward.

The need to rebalance our practice models

> Rebalance our models: from a mechanistic understanding of the world and of ourselves as mechanics who diagnose and fix what is wrong with individual human bodies or communities, to organic metaphors where we understand ourselves as gardeners, enabling the growth of what nourishes human life and spirit, and supporting life's own capacity for healing and health creation. (Hanlon et al., 2011, p. 35)

The dimensions outlined here could help inform our "cultivation" as they offer an emerging idea of what is important to us as humans and therefore what we need to be well and flourish. Approaches that utilize the stories and dramatic representations of experiences through narratives, and the arts can help us to understand others' world and their capacity for healing and being well.

The need to rebalance our orientation

> Rebalance our orientation: integrate the objective (measurement of biological and social processes) with the subjective (lived experience, inner transformation) and inter-subjective (shared symbols, meanings, values, beliefs and aspirations.) (Hanlon et al., 2011, p. 35)

This article has explored a suggested philosophy for viewing us as human beings and our experiences within a public health and well-being context (Todres et al., 2006). Of itself, this lifeworld-led approach seeks to explore the lived experience, and inter-subjectivity of human life through the dimensions articulated here. As human beings, we have evolved to find shared meanings, values, beliefs and aspirations; however, the notion of experts who find causes and fix our problems in our western societies has become the dominant paradigm. This means our shared language and understanding of our issues and our potential to solve problems has become marginalized and under valued, thus limiting our well-being freedoms (Sen, 2002).

Innovate to feed our future

> Develop a future consciousness to inform the present, enabling innovation to feed the future rather than prop up the current unsustainable situation. Develop different forms of growth beyond the economic to promote high levels of human welfare." (Hanlon et al., 2011, p. 36)

The dimensions articulated here, temporality, spatiality, intersubjectivity, embodiment and mood relate specifically to this area and suggest that to flourish, we need to better understand our part in what is happening to us and to others. We need to focus not just on the causes of our loss of well-being but crucially on what it means to us as human beings to be well, which it would appear does not relate directly to traditional measures of economic growth, once our fundamental survival needs are met (Carlisle et al., 2008; Easterlin, 1980). It would appear that if one looks closely at income inequality research, the most likely explanation is that it is what individuals are able to "be" and "do" at each level of their social hierarchy that produces the gradient in ill health rather than the simple fact of their being in possession of different amounts of income (Sen, 2002). How we experience our world as humans impacts on our physical and mental well-being, these experiences are subjective; however, we need to understand the elements of our subjective experiences in order to promote well-being. Inevitably, otherwise we will focus on gross economic measures or disease as they are easily measurable.

Scale up through learning

> Iterate and scale up through learning – a design process where we try things out, learning and share this learning. The major challenge of scaling up, which requires us to develop promising new approaches, should be taken as a natural process of growth, driven by a desire to adapt and learn rather than a mechanistic process that managers in large bureaucracies have responsibility for rolling out." (Hanlon et al., 2011, p. 36)

Theories and models that are based on the dissemination of expert knowledge to implement no matter what the context such as suggested by the Randomised Controlled Trial model that dominates biomedical interventions have clear and multiple disadvantages within the public health context (Hunter, 2009; Potvin, Gendron, Bilodeau, & Chabo, 2005). These interventions ignore the context and do not attempt to accommodate the means through which programmes are adapted and transformed to become a social movement (Hunter, 2009). When written up for publication, these adaptations and transformations are often ignored, therefore giving the reader the impression that implementing change is linear and simple when in reality it is more likely to be complex and convoluted (Hemingway & Stevens, 2011). Our public health actions should build on experiences, assets, shared values, beliefs and culture (McKnight, 2010; McKnight & Kretzmann, 1996) within any given context.

Conclusion

This article suggests that the "lifeworld" is very relevant to moving public health action into an era where its focus is the promotion of well-being. One could argue that it is impossible to promote well-being without considering the dimensions outlined here. If we persist in viewing public health interventions as independent of their contexts where the prescribed elements of the programme are more important than local human experiences and beliefs, we are at risk of ignoring the human assets when arguably these are the very strengths upon which a solution needs to build. How can we promote well-being freedoms within and across communities without knowing what it is like in human terms to live there? The dimensions of lifeworld outlined here, temporality, spaciality, intersubjectivity, embodiment and mood offer us a way of viewing well-being and public health action that is positive and relevant to the human spirit, purpose and meaning. These dimensions are not disease or problem based, they enable us to focus on the lived experience of well-being and are relevant to all of us as human beings.

Hanlon et al. (2011) suggested that in public health, we need to think of ourselves as "gardeners" growing what nourishes our human life and spirit. The "lifeworld" dimensions outlined here could help moderate traditional ideas of progress (Carlisle et al., 2008; Easterlin, 1980, Sretzer, 1997) and inform our "cultivation". They offer insights into what is important to us living with finite resources. It may enable us to harness our own and others' passion and enthusiasm through understanding and sharing human experience and offer all of us the freedom to be well.

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