PUBLIC HEALTH 126 (2012) 448–453

Available online at www.sciencedirect.com

Public Health

journal homepage: www.elsevier.com/puhe

Original Research

Can humanization theory contribute to the philosophical debate in public health?

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ARTICLE INFO

Article history:
Received 4 April 2011
Received in revised form
10 November 2011
Accepted 13 January 2012
Available online 29 February 2012

Keywords:
Philosophy
Inequities
Fifth wave

SUMMARY

This paper will explore the humanization value framework for research, policy and practice with regard to its relevance for public health, specifically the reduction of inequities in health. This proposed framework introduces humanizing values to influence research, policy and practice. The framework is articulated through eight specific constituents of what it is to be human. These dimensions are articulated as humanizing and dehumanizing dimensions that have the potential to guide both research and practice. The paper will then go on to consider these dimensions in relation to the emergent qualities of the potential 'fifth-wave' of public health intervention.

The humanization dimensions outlined in this paper were presented as emerging from Husserl's notion of lifeworld, Heidegger's contemplations about human freedom and being with others, and Merleau-Ponty's ideas about body subject and body object. Husserl's ideas about the dimensions that make up 'lifeworld', such as embodiment, temporality and spatiality, underpin the suggested dimensions of what it is to be human. They are proposed in the paper as together informing a value base for considering the potentially humanizing and dehumanizing elements in systems and interactions. It is then proposed that such a framework is useful when considering methods in public health, particularly in relation to developing new knowledge of what is both humanizing and dehumanizing within research and practice.

Introduction

This paper will explore the value framework for research, policy and practice as proposed by Todres *et al.*[1] with regard to its relevance for public health, specifically the reduction of inequities in health. This proposed framework introduces humanizing values to influence research, policy and practice. The framework is articulated through eight specific constituents of what it is to be human. These dimensions are articulated as humanizing and dehumanizing dimensions that have the potential to guide both research and practice. The paper will then go on to consider these dimensions in relation to the emergent qualities of the potential 'fifth wave' of public health intervention, as outlined by Hanlon *et al.*[2]

For the benefit of this paper, humanization/dehumanization is defined through the eight dimensions outlined within the value framework under exploration.[1] Inequities in health are defined as measurable differences in health between social and economic groups that are preventable and therefore judged to be unfair and unjust.[3]

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doi:10.1016/j.puhe.2012.01.014

The humanization dimensions outlined in this paper were presented as emerging from Husserl's notion of lifeworld,[4] Heidegger's contemplations about human freedom and being with others,[5] and Merleau-Ponty's[6] ideas about body subject and body object. Husserl's ideas about the dimensions that make up 'lifeworld, such as embodiment, temporality and spatiality, underpin the suggested dimensions of what it is to be human.[4] They are proposed in the paper[1] as together informing a value base for considering the potentially humanizing and dehumanizing elements in systems and interactions. It is then proposed that such a framework is useful when considering methods in health and social care, particularly in relation to developing new knowledge of what is both humanizing and dehumanizing within research and practice.

Public health research has historically relied on calculating 'risk' and health and illness across population groups. We all fall into different groups so we are all labelled and fragmented in this way. This labelling and calculation of risk enables us to problematize, label and target from a distance as experts.[1] Whilst being excellent at describing problems, this strategy of using 'risk', 'need' and 'sickness' labels has the potential to fragment and disassociate community issues from their context, individuals from their problems, and, one could suggest, policy makers from the social determinants of health. Public health practice has historically moved from a biomedical orientation to a social orientation that now includes the involvement of multiple actors and agencies. The theoretical foundation and development of public health practice has been based on biomedical science, behavioural psychology and public policy or administration,[7] which has arguably limited its ability to develop theoretically and philosophically cogent concepts to guide research and practice. Pioneering public health practice within recent years is increasingly understood to be where situations traditionally regarded as social problems are re-interpreted within a health framework such as drug abuse, teenage pregnancy and inequities in access to education.[7] Indeed, we now label key issues that impact on inequities in health as the social determinants of health,[3,8] and these include economic circumstances, stress and lack of control, circumstances in childhood, social exclusion, working life, unemployment, social support, addiction and food supplies.[8] This 'joined-up thinking', so vital to the study of inequities in health, has grown out of a theoretical base dominated by biomedical science, the focus of which is labelling, measuring and calculating risk, thereby negating and avoiding the need for the development of an intimate understanding of the lived experience of inequity and how we help individuals, communities and policy makers to develop capacity to positively influence these issues. It is important to realize within this debate that there are determinants of health that only have meaning at the population or the cultural level. Clearly, the income gradient and its impact on health is one such determinant, as are consumerism or materialism as dominant aspects of culture within a society. This paper suggests, however, that along with this understanding of overall gradients and outcomes, we need to understand the impact at the level of individuals and communities to ensure that we value and build on the potential strengths and 'answers' that we, as humans, offer.

During the last 10 years, there has been discussion within the public health academic literature focussing on the need for theoretical innovation in the fields of population and public health research.[2,7,9,10] Yet, despite the essential role played by theory in shaping what we see, or do not see, what we deem important or irrelevant, and what we consider achievable or unachievable, the theoretical frameworks or philosophies that inform public health research and debate are few.[9,11–14] If we accept that health is an essential resource at the core of individual and community life, we need theoretical tools that allow us to develop an in-depth understanding of everyday life. Interestingly, a recent article discussing a possible 'fifth wave' of public health intervention[2] suggested that, thus far, a key characteristic of previous waves is the relative unimportance of the individual and the human spirit. The authors suggest that 'in the modern world we have created, we appear to behave as if organizations do the work, regardless of human capacities, consciousness, energy, passion and effort'.[2] The dimensions of humanization discussed here[1] have been suggested as a framework for understanding the human experience of life specifically in order to aid an in-depth understanding of what it is to be human within that context. This paper will consider humanization and public health in conjunction with other relevant theories as they relate to each dimension.

Dimensions of what it means to be human[1]

Insiderness/objectification

To be human is to experience life in relation to how you are; your feelings, mood and emotions are all a lens through which you experience the world. Such individual subjectivity is key to our sense of ourselves as human beings. We have overwhelming evidence that disparities in income across population groups cause differences in life expectancy concomitant with less income, less life.[3] However, as we have not routinely listened to hear what the experience of life is like for different groups, our ability to intervene successfully and influence policy is now limited. An approach that does not focus on problems but potential and assets within communities and individuals[15] emphasizes the importance of subjectivity in relation to contexts and individuals to enable us, as humans, to use our creative assets (our consciousness, energy, passion and effort)[2] to tackle issues important and relevant to our everyday lives. Interestingly, this 'asset'-based approach,[15] emerging as it has from community development and appreciative enquiry, may enable us to move from description to action, providing insights into potential for change in the seamlessness of people's everyday lives, rather than seeing individuals and communities as fragmented risks and problems, which does not lead us to a shared vision or potential way forward.

Agency/passivity

As humans, we make choices and are generally held accountable for our actions. We do not commonly see ourselves as passive or totally determined, but we have the