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Editorial: three years of DHH

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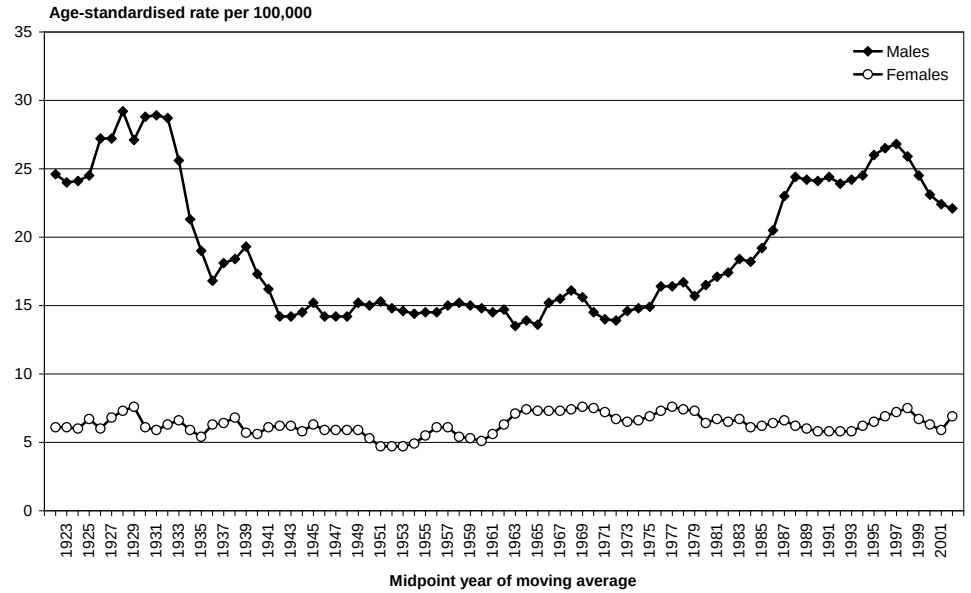
I am happy to report that the readership of DHH has steadily been increasing with a sharp rise showing in volume 3, 2016. I hope that with the continued support and contribution of our readers and associate editors the trend will continue.

During the last three years the DHH has attracted articles profiling human health in relation to human behaviour from prevention of infectious diseases to stress, and suicide prevention in order to integrated dynamics of health in medical (clinical) and non-medical health care planning. Past issues are archived and can readily be accessed by clicking on the "past issues" tab.

Ploughing through past issues, I believe that DHH has achieved its goal of highlighting the importance of understanding and incorporating dynamics of human behaviour into research and policy development. Failure to do so has often led to short-term interventional policies responding to symptoms rather than preventing adverse outcomes.

It is disappointing that, after decades of dedicating resources and research, suicide prevention strategies still provide the perfect example for failing to account for dynamics of human behaviour. In October of this year the New Zealand coronial office's press release announced the highest suicide rates since 2008. The reaction to this news was the usual flurry of outrage, followed by calls for a new approach and more resources. Whereas a few years earlier when the suicide rate appeared to dip, various medical and government's agencies took credit for the reduction in the suicide rate. One could be forgiven for déjà vu! Indeed, this cycle has been repeating itself since records began (Shahtahmasebi, 2005, 2008) , also see Figure 1.

Figure 1. Death from suicide by sex, New Zealand, 1921-2003.



Source: reproduced from (Shahtahmasebi, 2013)

The second article in this issue discusses rising suicide rates in more detail. It is, disheartening to observe that those who are in a position to make changes and have a positive impact on suicide rates have adopted a deliberate policy of ignorance. To those suicide "experts" and decision makers I would say that the case of 'ignorance is bliss' does not apply. The public has been promised new approaches and more resources to reducing rates at each cycle but resource allocation and action have been under the same philosophy that suicide is the result of mental illness and depression. This approach has helped sustain the cyclic trend rather than break it, providing an unacceptable outcome of 'more of the same' but a much higher costs at each cycle, i.e. more dedicated resources with more lives lost unnecessarily.

It is further demoralising to observe that this pattern of policy making failing to acknowledge dynamics of behaviour is not restricted to suicide prevention.

The problem with the current interventionist care systems (be it health, social economic, or environmental) is that they only attempt to address visible symptoms rather than the cause. In doing so the intervention often masks the cause and over time the symptoms may appear as causes of the adverse outcome. This is the feedback effect through which public norms for incidence, prevalence, and outcomes may shift with public expectations. For example, despite decades of redirecting and allocating resources and technological advancements heart disease and cancers are still top killers (http://www.who.int/mediacentre/factsheets/fs310/en/index2.html), yet, professional and public expectations are that these are treatable through interventional techniques such as surgery and organ transplantation.

There is something not quite right with the health care system. Why is this?

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