New challenges for public health

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Folkhälsopolitik och planering måste ta hänsyn till förändringar i samhället och de roller som olika aktörer har i samhällslivet. Man kan tala om tre "industrier" i samhället som påverkar folkhälsan: Hälso- och sjukvårdsindustrin, Informationsindustrin och Livsstilsindustrin. Dessa måste användas som partners i folkhälsoarbetet.

Hälso- och sjukvården betraktas ofta separata från folkhälsoarbetet och som konkurrent vad gäller resurser och budget. Hälso- och sjukvården och andra sektorer, andra "industrier" måste integreras i det samlade folkhälsoarbetet. Sju områden nämns där fokus måste skiftas för framgångsrikt folkhälsoarbete.

Ilona Kickbush har sedan länge innehaft chefsbefattningar (Director) vid WHO och varit ledande i att driva frågor kring hälsofrämjande arbete. Hon var länge chef för Division of Life Style and Health vid Europakontoret i Köpenhamn, och hon är sedan några år vid huvudkontoret i Genève med ansvar för bl a Health Promotion och Health Education.

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Introduction

While we are meeting here (june -95) another major meeting is taking place in Halifax, Canda: the meeting of the G7 group of major economic powers. It is getting considerable press coverage at present, with the consensus view emerging, that the group is not very useful and does not produce results.

A recent foreign affairs commentary in the New York Times took up this point and proposed a very different composition of the group, which at present includes the US, Britain, France, Japan, Italy, Germany and Canada. The inclusion of China, Russia, India, Brazil would seem most appropiate, taking into account both population sice and geographical distribution.

To me the parallels to the public health debate are obvious. They spring even more to mind when one regards the subcaption of this piece:

Put in new players for a new era

This I believe to be the key message and challenge for a new public health.

Too often I get the impression that public health exists in a vacuum - the organisational infrastructure of many public health departments or the curricula of some schools of public health do little to counterbalance this impression. Even the so called renaissance of public health and many of the contributions under the heading "new public health" do not think "*outside the dots*" at is has become fashionable to say in management theory, neither in the terms of its knowledge base or the building of a new conceptual base, nor in terms of its organisational base within our societies. The innovations that have occurred have been frequently introduced (with much opposition) in the name of health promotion, and have not been able to move center stage yet in the public health/health policy discourse, even though lip-service is continously paid to them.

But a significant number of public health professionals feel that "today more than ever public health institutions world wide need to redefine their mission in light of the increasingly complex milieu in which they operate". The magnitude of the problems as such should be an impetus for a renaissance.

In a way it already constitutes a renaissance to be talking again about public health to the extent that we do (new or old) in view of the fact that for quite some time it was a term that was considered outmoded - others took its place in a long succession; community medicine, social medicine, primary health care, health promotion, to name but a few. The demise or eclipse of public health was linked to many factors; the increasing power of clinical medicine, the upsurge of behavioural

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epidemiology (at one point Milton Terris was forced to exclaim: "there can be no epidemiology without public health"), the rise of the environmental movement, the dominance of health research by an individualistic, the bio-medical paradigm imported from the United States. Partly the very success of public health and the health service systems of European countries after the second world war had led to a demise of the discipline and system that had brought about many of the significant health gains of this century. And what remained of it is often threatened by the new climate of cost cutting and economistic reform.

It would seem therefore that "today more than ever public health institutions world wide ... need to redefine their mission in the light of the increasingly complex milieu in which they operate." (Julio Frenk, Mexico)

The questions that need to be asked (so he says) evolve around three areas:

- the role of public health institutions in society
- the scope of their actions
- the basis of their knowledge

I will contribute thoughts to each of these three areas in the following text.

I would venture that at this point most proposals for "a new public health" are still inherently traditional, separating public health from what really matters and therefore marginalizing it rather than placing it in the center of any health care reform debate where it should be.

The mission of public health

In order to structure our thinking let's start from the mission of public health.

I have come to most prefer the following by the US Institute of Medicine 1988:

fullfilling societies interest in assuring conditions in which people are healthy

This definition is short, precise and a large order: in present language it means acting on *determinants of health*.

Margaret Whitehead and Göran Dahlgren have described many of the factors that determine health, in particular inequities. The recent Canadian publication "Why are some people healthy and others not" explores this issue further in many of its complexities. I would like to highlight two issues they emphasize:

- at the micro level the importance of factors in the social environment: it seems to be the quality of the microenvironment (both social and physical) that is critical to health. This reconfirms the "settings aproach" to create supportive environments that the WHO has promoted throughout the ten years following the Ottawa charter.
- at the macro level it seems that the equality of income distribution is more significant for population health than the average income. It is the gap that counts - and WHO reports (most recently the 1995 world health report) show that this gap is widening. It is to be expected that given the present economic climate this will continue to be the case, both within and between countries.

These findings do not fit comfortably at all with the present priorities in public health research (the knowledge base) or the scope of public health action or the role of public health institutions. There are some notable exeptions: the recent health policy of Quebec and the recent health policy of the city of Copenhagen, both focusing on social environments and social support.

To build the next step of the argument let us look at how an Institute of Medicine (IOM) defines as the aim of public health:

"to generate organized community effort to adress the public interest in health by applying scientific and technical knowledge to prevent disease and promote health."

Now I would fully concur with the focus on *organized community effort*, but I put forward that a very changed environment calls for public health responsibility and action that goes beyond "preventing disease and promoting health".

When public health was first established the medical care sector (what we now call health services) was negligable, both in quantitative and qualitative terms.

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Also the demographic composition of our societies was markedly different.

Today the "health sector" accounts for 10% or more of the GNP in most developed countries, with a range of other sectors (ie the building industry) dependent on its continuing growth. It is one of the largest single sectors with significant employment effect, particularly for women. In such an environment public health cannot be solely concerned with prevention and health promotion, while the minds of politicians, the media and the public are dominated by the curative sector in terms of distribution, financing, access, quality etc.

We cannot continue to see public health as a "separate subsystem of service provided by the state", that (because of that outlook) get increasingly marginalized, i.e. the Clinton health plan hardly mentioned public health.

Instead we must begin to understand public health as a much broader *organized social response* to the production of health and the consumtion of health services.

The conceptual base

These two at first instance paradoxical directions:
- more action on the determinants of health
- more concern with the health care system

come together in the conceptual notion of *health gain*. This to mind is one of the key intellectual concepts on wich to build a new public health. It moves the debate from the assumption that we create health by eliminating disease to a public health paradigm based on the creation/production of health.

This obviously health gain is not a purely economistic category - and this is crucial for the further debate on public health - in order to underline this I have proposed three basic questions that outline the intellectual and operational challenge implied in such a concept:
- what creates health? where is it created?
- which investment produces the largest health gain?
- does this investment help reduce health inequities and does it ensure human rights?

Such an investment example was recently displayed in a full page ad in the New Yorks Times, financed by a group of business representatives in response to proposals by the republican congress.

This investment concern already hints at another component that needs strengthening in public health practice. The IOM report says that the organized community effort that is public health is adressed by by private organizations, by individuals as well as by public agencies

It indicates that the health of the public is not just a government concern, implemented by government agencies but a joint societal effort, where in particular the contribution of the private sector needs to increase significantly - as in the area of workplace health.

The context - the issues

If the above is accepted then a new public health is based on a knowledge base that builds on the truly interdisciplinary study of
- the determinants of populations health and its distribution
- the organized social response to these determinants.

It is clear that we are very weak on both counts, and this is reinforced if we look at the changing environment as it presents itself.

These environments or threats as some would see them can be defined and classified in very different ways depending what school of thought one adheres to, on the whole though they present the elements that we need to tackle with a new public health paradigm:
- They can be seen as "health issues" such as AIDS, smoking, drug abuse or accidents.
- They can be seen as wider environmental and ecological issues such as toxic waste, environmental degradation. Not only do these problems constitute an addition to the problem range of the public health agenda they also contribute to its change of focus and style of operations - working with AIDS organizations or the environmental movement requires a different style than food safety regulation.
- They can be seen as social issues that increasingly enter the health arena such as violence, teenage pregnancy, social isolation and call for new types of interventions and a new epidemiological base.
- They can be seen as larger societal challenges that will influence the health of populations not only nationally but at a global level.

But, as outlined earlier the public health agenda in

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the 1990:ies also includes the overall systems challenges of health policy, particularly in view of increasing privatization a focus on guidance and planning of health care provision (often reinforced through the new purchaser, provider splits), assessment and control of medical technology, the ethical issues arising from the health care system and progress in biomedical research, the appropriateness and quality of care, the issues of dying and death and many more.

Fulfilling societies interest in assuring conditions in wich people are healthy must also be seen in the wider frame of the changing demographic situation. It calls on us to explore public health measures of relevance for older persons and move the debate from life expectancy to health expectancy and health potential. This means that foresight goes beyond stopping people from falling into the water (as we consider it a major public health success that people get older) to ensuring wellbeing, quality of life and quality of caring as each individual and each society ages.

The *scope* of public health has therefore expanded considerably: this means a new public health does not "restrict" itself to functions as would have been outlined classically in disease control and sanitation and the standard setting in terms of safety standards for hygiene, food safety, air pollution.

The three key industries

Public health now has to include the dimension of regulating and standard setting as well as partnership development with at least three major industries:

1. *The health care industry* which will continue to grow, totally restructure itself and continue to be one of the key markets of the future, last not least in terms of export to the middle income economies.
2. *The information industry*, which is the megagrowth market of the present and which encompasses and helps create and structure how we live and what we think, just correlate the tought of 2 billion teenagers world wide by the year 2001 and a global network of the MTV type.
3. *The "life-styles industry"* of products (foods, drinks, cigarettes) as well as the sports and leisure industry and the many health related services such as fitness institutes, weight watchers etc.

Some examples

Hospitals/health service institutions will compete along the lines of the largest health gain component, they will increasingly enter the area of community health, as is already the case in the USA, where community based projects and assessments allow hospitals to keep a tax free status, increasingly areas that were seen to be uniquely responsibility of the state will be seen to move into the private sector or into a public/private mix.

The information industry will aim to satisfy the publics interest in health matters through massive expansion of its health programmes, in the USA first pilots are being run on a 24 hour health channel, health matters are ideal for interactive television programming, health information (on self medication, self care, prevention etc) will increasingly be offered through private information services.

The lifestyle industry will aim to expand its markets scope, this can open the way to interesting alliances as with sport organisations, arts councils an the like as practiced in Australia, or extreme conflict as the ongoing war with the tobacco industry documents.

These three growth sectors are amplified by the lobbies of those dependent on these markets: advertising agencies, television and print media for advertising revenue...

Where to from here?

We need to break through the public health bubble and exercise the public health virtue of foresight rather than get caught up in what is basically a conservative debate.

I venture to propose that what is presently happening in the media industry will happen increasingly in health, meaning the interlinkage of seperate functions or "industries" to a new type of service and product - as computer hardware firms buy up soft ware producers, link with telephone and cable companies and go global as "mega media" - so will the health indystry:

The pharmaceutical industry for example will redefine its product to be "health" rather than a pill which can be bought at a chemists or in a pharmacy - as IBM buys Lotus they will get involved in direct health care provision (hospital chains), home order systems (for self medication), health advice on line (interactive television, 24 hour health line etc).

The pharmaceutical industry will get involved in direct health care provison, home order systems health advice on line

These type of developments reinforce the statement by Henderson:

> "it would seem that we can no longer deal conceptually with curative medicine and public health as two separate and distinct programmes. With finite resources choice have to be made and a balance struck between preventing disease and treating it."

We do have the first outlines of a road map to tackle these issues. The Ottawa charter and health promotion have early on laid the ground for a thinking based on determinant of health and oriented towards health investment and health gain. The strategies that the Charter outlined stand the test of time, now nearly ten years after, and in many cases it is only now that countries show signs of serious political implementation: as the intersectoral politcal forum that your minister will establish for population health. Let me remind you of those agendas:

- *Healthy public policy:* the refocusing of a public health community that had got sidetracked into individualistic behavioural epidemiology on a determinants of health debate. This debate has now seriously statted in Canada.
- *Supportive environments:* highlighting the role of social factors in health and through that the importance of the social sciences to any future oriented public health thinking (political science, organizational sociology, social psychology approach has emerged out of this.
- *Community action:* highlighting participation and involvement as a key factor in change for health and recognizing the need for community action and advocacy.
- *Personal skills:* highlighting the need for broader health skills and life skills rather than just health knowledge.
- *Reorienting health services:* highlighting the need to reorient the health sector..

The challenge for the discipline

The challenge can be summarized in seven categories of change (*table 1*).

The managing of this change process for the discipline and for the operational dimension requires a new type of public health leadership, a leadership that sees its skill in setting a health gain agenda, advocating for it and mediating between the major partners to achieve it. This means working with at least 5 key sectors (*table 2*).

That outlines the *new players in the new era.*

The public health *programme* is to *maximize health gain.*

Here the schools of Public health fail us: these are the skills that are not taught. public health says Winslow, one of its founders in the United States, is both a science and an art. the crisis of public health has come about because at our peril we have forgotten its essence:

We teach a reductionist and fragmented public health science and we rarely give students the opportunity to learn the art.

Table 1. Current challenges for public health. Areas of change.

change of context:	new social and epidemiologicalbaseline
change of scope:	global, interrelated, social environments
change of institutional focus:	health system, other systems
change of goal:	health gain
change of partners:	private, business, NGO public private mix
change of site:	from the individual to the setting and social environment
change of style:	participatory, multisectoral communications oriented

Table 2. Key sectors for public health work.

- citizens, consumers, NGOs
- health care industry, providers (public and private), professional organisations
- public health/scientific community
- policy makers, parliamentarians
- private sector: communications, lifestyle industries, leisure, tourism