

Changing Global Scenario and Public Health for the Next Millennium

Keynote address

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I would like to begin by tracing the comprehensive history of public health, so that we will have a common understanding of the reasons that deviations have occurred in its practice. I will then discuss the constraints and various global changes that pose challenges to the public health system and practice. Finally, I will suggest measures that respond to these challenges and constraints.

To appreciate the role of public health in national development, we need to examine Winslow's 1923 definition of public health: "Public Health is the science and art of preventing disease, prolonging life, and promoting health and efficiency through the organized community efforts for the sanitation of the environment, the control of communicable infection, the education of the individual in personal hygiene, and the organization of medical and nursing services for the early diagnosis and preventive treatment."

This definition never mentions curative services at all, perhaps because public health originated during the Industrial Revolution of the nineteenth century, when hygienists advocated solutions for health problems caused by environmental and lifestyle factors. This first phase of public health is known as the Environmental Phase.

Later, with the development of the concept of germs in the 1870s, when novel interventions seemed to emerge from the introduction of new immunization practices, public health entered its second phase, the Individualistic Phase. Its focus shifted from concern with the environment to concentration on groups of people.

The third phase, the Therapeutic Phase, was triggered by the discovery of medications, such as insulin and the sulfonamide group of drugs, in the early 1940s, which tremendously increased indi-

vidual therapeutic intervention and widespread belief in new technical and scientific approaches. Power and resources shifted from community-based, environmentally oriented, preventive programs to hospital-based curative services. This trend became deep-rooted due to the development of cure-based academic hospitals and more pronounced because of scientific and technological developments in medicine. The dominance of therapeutic medicine, which involves large financial investments, inevitably paved the way for the dichotomy between the urban and the rural, as well as the rich and the poor. This focus on therapeutic intervention also gradually led to the myth that good health primarily results from medical intervention and hospital services, and it created a lack of clear understanding that health is governed by, and is a reflection of, the social and living conditions of the community. Therapeutic intervention claims to offer immediate and individual gratification to patients, providers, and politicians, as opposed to the long-term benefits of preventive health that may, or may not, materialize. Additionally, the emphasis on curative medicine finds greater favor with less-informed societies and is reinforced by the growth of medical and pharmaceutical industries and medical associations, which greatly influence governments.

In the mid-1970s, research showed that health improvement is best attained by behavior modification and environmental change. This realization led to the fourth phase of public health, known as the New Public Health. The New Public Health focuses broadly on environmental factors and physical, social, and psychological elements, as well as a healthy lifestyle, thus, requiring that health be placed in the mainstream of development. The intrinsic connection between health and poverty in the individual, as well as the bond be-

tween health and development in nations, is recognized. It seeks to bring health into the developmental framework, to ensure the protection of health in public policy. Above all, the New Public Health is concerned with action – a concern that not only seeks a blueprint to address many critical issues, but, also, to identify strategies that can be implemented.

Various global events, such as the 1992 United Nations Conference on Environment and Development, the 1994 International Conference on Population and Development, the 1995 World Summit for Social Development, and the 1995 Fourth World Conference on Women have emphasized the need for human health to be the central concern in sustainable development.

The New Public Health adopts a developmental approach to health, where health is viewed as the goal and outcome of all national development sectors, particularly housing, education, industry, agriculture, transportation, and local government. It promotes stronger health programs characterized by relevant aspects of development, such as school health and healthy villages and cities. Evidently, public health must deal with issues that traditionally have not concerned the health sector. This New Public Health, as opposed to Classical Public Health, considers all aspects of health, including preventive and curative services.

Many elements of the New Public Health are contained in the 1978 Alma Ata Declaration, which reaffirms the World Health Organization's (WHO) definition of health and its status as a human right. It advocates action by other social and economic sectors, in addition to the health sector, to achieve the goal of health for all. For the first time, the goal of health, "the attainment by all peoples of the world, by the year 2000, of a level of health that will permit them to lead a socially and economically productive life," is defined. The declaration views primary health care as the principal vehicle for attaining this goal.

The Global Strategy of Health for All by the Year 2000 was adopted as a policy by the Thirty-fourth World Health Assembly in 1981. Later, the Alma Ata Declaration was endorsed by the United Nations General Assembly, and WHO continues to

advocate the global strategy of Health For All (HFA) 2000. The principal pillars of public health, equitable access to effective care, health-friendly public policy based on community participation, and collaboration are promoted, all constituting important elements of the New Public Health. These pillars are reflected in the 1986 Ottawa Charter for Health Promotion, one of the first WHO documents to explicitly use the term, "New Public Health," in its subtitle.

We have seen how public health has evolved as an independent discipline, continuously adapting and responding to new health problems and benefiting from advances in scientific knowledge and technology. In addition to the term, the New Public Health, other descriptions of evolving public health concepts include the renaissance of public health, modern public health, or revitalized public health. However, rather than elaborating, I will simply use the term "public health" to describe the comprehensiveness of this health discipline. As the twentieth century closes, we face formidable challenges, with the world evolving as a global village. Urbanization, ecological imbalance, changing social structures, and globalization, resulting in increasing interaction and dependency among local, national, and international events, constitute the new operational field of public health. Telematics in cyberspace has strengthened this globalization, which, manifested through World Trade Organization (WTO) and TRIPS, could negatively impact developing countries in their efforts to improve equity of health care.

After globalization, the second challenge is the emergence of new diseases and new epidemics like STD/AIDS, in addition to re-emerging diseases, such as malaria and tuberculosis. Demographic, socioeconomic, and epidemiological transitions, resulting in the double burden of infectious and non-infectious diseases, intensify public health challenges.

The third challenge involves privatization of health care, a market-oriented problem. If not clearly anticipated, this trend, usually accompanied by uncontrolled sophistication of health technology, will detrimentally affect the poor. In this new climate, public goods (for example, communicable disease control) will receive inadequate funding without

governmental regulation. Today, a major concern is the spiralling cost of health care and the availability of resources. In developed countries, the primary concern is cost containment, while in developing countries, the chief problem is increasing the health budget. Advocates in all countries understand that the potential for significant, new funds directed to health sectors is very limited. The Saitama Summit, 1991, revealed the impact of health resource constraints in the HFA 2000 strategy and the necessity to plan within those restrictions. Public health has great interest in financing health care, in optimally mixing public and private resources, and in ensuring more value for money, as well as equitably sharing resources among curative, preventive, and proactive health care.

The fourth challenge is improving the quality of care through the implementation of quality assurance, including accreditation and certification as part of primary health care. Improvement of community welfare has resulted in increased demand for quality health care. Advocacy efforts directed toward policy-making officials are indispensable if we are to secure their commitment to quality assurance.

The fifth challenge is developing healthy public policy; that is, policies in multiple fields that support the promotion of health. As mentioned earlier, this emphasis focuses on public health's concern with environmental factors in a broad sense and places health in the mainstream of development.

The sixth challenge is effective decentralization, which necessitates transformation of vertical programs into an integrated general program, using bottom-up planning. Changes are also needed in leadership patterns, budgeting systems, accountability, and laws/regulations.

The seventh, and perhaps most important challenge, is the focus on the poor, vulnerable, and marginalized groups. Evaluation of HFA 2000 clearly demonstrated increasing inequities occurring within countries and among different countries. Public health should be a part of poverty alleviation measures. Some member countries have had successful programs, such as the Grameen Bank in Bangladesh and the Samrudhi program in Sri Lanka.

Having discussed public health challenges, we now need to examine the constraints of implementation. A decade ago, two inquiries, one in the USA and the other in Britain, investigated the role of public health in light of prevailing criticism. The inquiries' results indicated a general disarray in the field, with ambiguity and uncertainty concerning the mission of public health and capacity for leadership. These findings had a direct bearing on the Alma Ata Declaration. On one hand, the Declaration conceives and promotes primary health care, defined as "the first level of contact of individuals, the family, and community with the national health system," presumably a clinical activity. On the other hand, it enumerates, as part of PHC, "proactive and preventive services" and "education concerning prevailing health problems and the methods of preventing and controlling them," presumably a public health activity. The declaration, in effect, states that these two types of activities are inseparable and must be cooperatively performed. Problems occur, however, when providers of the first level of contact within the national health system are not the same as those with the tasks of researching, planning, and providing preventive and educational services. And, historically, these two departments do not communicate.

Many reasons cause the disagreement between providers of individual care and practitioners of population-based medicine, including the segregated training of medical schools and schools of public health. Medical schools have overwhelming power to emphasize individual curative medicine as the center of the health universe, thus relegating public health to the periphery. Service payment techniques and budget differentials between the two services further aggravate this phenomenon.

Another constraint concerns research. Public health research is not contributing to pertinent public policy. Too often, many schools of public health emphasize extreme specialization and publication in international scientific journals. Health policy development at national, regional, or local levels, even though it is relevant, is not rewarded by academic peers. In fact, schools of public health have tended to become centers of excellence rather than centers of relevance. How should public health respond to these challenges and constraints?

In August 1999, WHO organized an international conference entitled "Towards Unity For Health" in Phuket, Thailand, which aimed to promote unity in service provision based on people's needs. Unity is to be achieved through sustainable integration of medicine and public health, as well as coordinated inputs from five major stakeholders: policy makers, health managers, health professionals, academic institutions, and communities. According to presentations on "Towards Unity for Health," collaboration among stakeholders appears to need strengthening.

Continuous encouragement to medical schools to address important aspects of quality that extend beyond academic excellence should occur. In other words, the ability of training institutions to respond to the needs of society needs emphasis. For example, WHO is supporting an institute of health science and a medical school in Nepal for its endeavors to develop an integrated model of socially accountable medical education. The medical school is working closely with health services, families, and communities to improve the health status of clients of its teaching hospital, as well as citizens of the entire community. This effort's impact will be evaluated by the analysis of such indicators as the maternal mortality ratio and the infant mortality rate. WHO is also working with medical and nursing schools in Indonesia, Thailand, and Sri Lanka concerning similar projects. I am currently proposing a priority international project on this theme in our region, which will hopefully derive lessons from our experiences.

Regarding the existing dichotomy between medicine and public health, let us learn from Mother Teresa: "It is the individual that matters. If we care properly for every unique individual, then we will get things right." Since societies are composed of individuals, caring for individual needs and society are complementary actions, requiring an integrated approach among the health sector, other sectors, and the community. I, therefore, urge you to develop models in your countries that integrate medicine and public health of all populations. By developing such models, we must seize opportunities provided by advances in communication and information technology caused by globalization. Telemedicine is also an important tool

that could greatly facilitate the implementation of those models.

Convergence of medicine and public health is indispensable for our efforts to overcome the dual disease burden of infectious and non-infectious diseases. Many breakthroughs are anticipated, such as new vaccines and drug development for the prevention of cardiovascular diseases, cancer, and chronic degenerative diseases. However, without properly integrating medicine and public health, we won't fully benefit from these advances. The two disciplines must collaborate, since further daunting challenges must be confronted. Curative treatment, the main domain of medicine and medical care, will be overburdened if public health does not work effectively through disease prevention and health promotion. Health promotion, alone, cannot be effective without the support of a healthy public policy. However, considerable effort in this field by public health specialists must be expended to convince other sectors to develop health-promoting policies. Although it is encouraging that some member countries have undertaken environmental impact assessments, health impact assessment must be added so that both the environment and health are protected from detrimental effects of development.

As mentioned earlier, one of the constraints that inhibits unity of medicine and public health is how the community rewards public health practitioners, both financially and otherwise. Policy makers could compensate this deficit by reserving strategic posts in the health system for public health specialists, as exemplified by measures in developed and many developing countries. Improvement in remuneration and career development are other possible strategies.

Many international meetings on reorganization of medical education have convened to address issues of better public health practice. However, few accomplishments have occurred thus far. The prevailing value system in the community gives greater weight to medicine than to public health, which has an overriding influence.

To achieve more relevant outcomes of health development research activities, we have established four scientific working groups to deal with the fol-

lowing issues: policy formulation, priority setting, research information, and research management. These working groups were recommended by the 1998 First Joint Meeting of the Advisory Committee on Health Research (ACHR) and Medical Research Council (MRC), with the expectation that the four groups would create guidelines for all five stakeholders of health and, most importantly, for better convergence of medicine and classical public health.

Finally, we all recognize that the health systems adopted by countries are extremely important in determining public health performance. Various types of reforms have been undertaken to make the health systems more equitable, affordable, effective, and efficient without sacrificing quality. Health system reforms concerning financial backing, coupled with effective decentralization, are the most frequently attempted endeavors undertaken to cope with scarce health resources. These reforms have resulted in a shift from classical universalism, where the state is responsible for

providing primary health services to the entire population, to the new universalism, where the main role of the state is to regulate health services.

Clearly, health budgets in developing countries need to be significantly increased. Yet, allocation of the limited available resources is usually biased toward medical care, resulting in less cost-effective interventions as compared to public health interventions. These allocations are, therefore, inefficient. Thus, as the Director-General of WHO aptly said in May 1999, "In several regions of the world, we need more money for health; but equally important, we should have more health for our money."

To conclude, I would like to emphasize the importance of health systems development, including health sector reform, in shaping the system and practice of public health in our region in the next millennium.