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New players for a new era: responding to the global public health challenges*

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Introduction

Many of the institutions and approaches established after World War II are no longer functional for the challenges of the twenty-first century.

In relation to the Group of Seven (G7), a recent foreign affairs commentary in the *New York Times* took up this point. It proposed a very different composition of the group, which at present includes Canada, France, Germany, Great Britain, Italy, Japan, and the USA. The composition could be as follows: '(1) China. (2) Japan. (3) The US. (4) Germany. (5) Rupert Murdoch, because he is... putting together the first truly global telecommunications network and he scares everybody in every market. (6) Bill Gates of Microsoft, because through his software he is building the first truly global marketplace, ... he is doing more to enlarge the global market for goods and services than any trade minister. (7) Mother Teresa, because she understands that promoting economic efficiency – a G7 speciality – is not the same as building a caring society.' Other lists in the article include countries such as India and Brazil, and the new global organization, the WTO (World Trade Organization), and most innovatively one list adds Michael Jordan, the US basketball player 'because his personal GNP is bigger than half the countries of the world, and because he is so cool and would definitely liven up that stupid group photo they take every year of seven white guys in suits'. This membership would definitely increase the interest of my 12-year-old son in the dealings of the G7.

This creative speculation about significant membership in world bodies highlights two questions:

- Who really matters – and who should participate in defining the problem?
- What really makes a difference in terms of solutions?

The vacuum

To me, the parallels to the public health debate are obvious. Too often, I get the impression that public health exists in a vacuum – the organizational infrastructure of many public health departments or the curricula of most 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', as it has become fashionable to say in management theory.

This applies to the knowledge base, the conceptual base and the organizational and policy base of public health within our societies. The innovations that have occurred have frequently been introduced (often with much opposition) in the name of health promotion, but have not been able to move centre stage yet in the public health–health policy discourse, even though lip service is continuously paid to them.

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 centre of health development and health care reform where it should be. Most importantly, most proposals do not address the challenges public health must face in view of increasing globalization.

Looking at the bright side, we can argue that 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 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, bio-medical paradigm. Partly the very success of public health has led to a lack of visibility and/or demise of the discipline and system that has brought about many of the significant health gains of this century. And what remains is often

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threatened by the new climate of cost cutting and economic 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 mission of public health

Let me start from the mission of public health. I have come to most prefer the following definition by the US Institute of Medicine (IOM) in 1988: 'fulfilling 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 the determinants of health.

The Ottawa Charter for health promotion reiterates this: 'The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in these basic prerequisites.'

As we go systematically through these points and analyse what is happening in most countries around the globe we can note:

- a growing inequity in health as measured in life expectancy and healthy life expectancy within countries and between countries, as outlined in the World Health Report 1995 by WHO[1] with its focus on poverty;
- a growing unwillingness to invest in public housing, infrastructure, education, basic preventive services, and basic public health;
- an unwillingness to look at the organization of work – its division during the life cycle, between generations, between men and women and globally; and
- a drawing back from international initiatives and foreign aid.

Anyone who has read the history of public health feels trapped in a time machine and transported back to the nineteenth century rather than forward in *Star Trek* to the twenty-first.

The key challenges

Health policies are not yet reacting to the fact that we are on to a new revolution – a total restructuring of our societies and the way they function: 'how people live, love, work and play' to paraphrase the Ottawa Charter. And as with the industrial revolution 100 years ago, it is a global revolution, based on new types of interdependences. There are several ways to look at the key challenges; to a certain extent they reflect a hierarchy of decision-making.

(a) The US Institute of Medicine recently put forward six factors that will most influence health over the next 20 years:

(i) human demographics and behaviour;
(ii) technology and industry;
(iii) economic development and land use;
(iv) international travel and commerce;
(v) microbiological adaptation and change;
(vi) breakdown of public health measures.

Do schools of public health include these issues in their curriculum? Do our own health policies refer to these factors? Do health professionals push for a public debate on matters that are as important to our future as sewer systems were to nineteenth-century cities?

(b) WHO has identified seven key areas for health promotion action that will be discussed at the upcoming WHO conference in Indonesia in 1997 on 'Moving health promotion into the 21st century':

(i) habitat;
(ii) families;
(iii) work;
(iv) ageing;
(v) violence;
(vi) markets;
(vii) communications.

In nearly all of these areas, WHO is launching or implementing major programmes and projects to develop global responses – but still many key donors remain focused on infectious diseases.

(c) The United Nations Research Institute for Social Development (UNRISD) has identified six consistent trends that are shaping institutional change:

(i) the spread of liberal democracy;
(ii) the dominance of market forces;
(iii) the integration of the global economy;
(iv) the transformation of production systems and labour markets;
(v) the speed of technological change;
(vi) the media revolution and consumerism.

The aim

To build the next step of the argument, let us look at what the same IOM report defines as the aim of public health: '*to generate organized community effort to address 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 negligible, both in quantitative and qualitative terms. Also, the demographic composition of our societies was markedly different.

Today, the 'health sector' accounts for 10 per cent or more of the GNP in most developed countries with a range of other sectors (i.e. 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 services provided by the state'; that would lead to increasing marginalization (i.e. the Clinton health plan hardly mentioned public health). At the same time, the health services agenda must not be allowed to overshadow the population health agenda. A difficult balancing act indeed. And even more crucial for developing countries which face serious investment decisions.

We must begin to understand public health as a much broader organized social response to both the production of health and the consumption of health services – particularly as a basis for development policies.

The IOM report says that the organized community effort that is public health is addressed: '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, but a joint societal effort where, in particular, the contribution of the private sector needs to increase significantly, yet be held accountable in new ways.

The conceptual base

These two, at first instance paradoxical, directions – more public health action on the determinants of health and more public health concern with the health care system – come together in the concept of health gain. This, to my mind, is one of the key intellectual concepts on which 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.

Obviously, health gain must not be treated as a purely economic 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 advertisement in the *New York Times*, financed by a group of business representatives in response to proposals by the Republican Congress (see Fig. 1).

The issues – the scope

If the above is accepted, then a new public health has its foundation in a knowledge base that builds on the truly interdisciplinary study of:

- the determinants of population health and its distribution;
- the organized social response to these determinants.

It is clear that public health at present is weak on both counts, and this is reinforced if we look at the changing issues public health needs to confront.

These issues 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 of a Rubik cube that we need to tackle with a new public health paradigm.

(a) They can be seen as 'health issues' such as AIDS, smoking, drug abuse and/or as wider environmental and ecological issues, such as toxic waste, environmental degradation. Not only do these problems constitute an additional 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 or they can also be seen as social issues that increasingly enter the health arena – such as violence, teenage pregnancy, social isolation – and that call for new types of interventions and a new epidemiological base.

(b) The next analytical level starts from actual cause of death, along the lines of the model outlined by McGinnis and Foege for the USA on the basis of 1990 data. It juxtaposes the diseases with the actual causes of death (Table 1). This approach allows a clear action agenda and is more easily outlined to the public.

(c) The World Health Report 1995 outlines the issues in terms of killers, disease incidence, and burden and disability:

- the biggest group of killers remains infectious diseases and parasitic diseases (16.4 million lives every year);
- disease incidence – diarrhoea in children under five years old (1.8 billion episodes a year, 3 million children die); sexually transmitted diseases (297 million new cases every year);
- disease burden – goitre (655 million sufferers); chronic lung disease (600 million sufferers);
- disability caused – biggest cause of disability: mood disorders (59 million); blindness (27 million); leprosy (2.5 million).

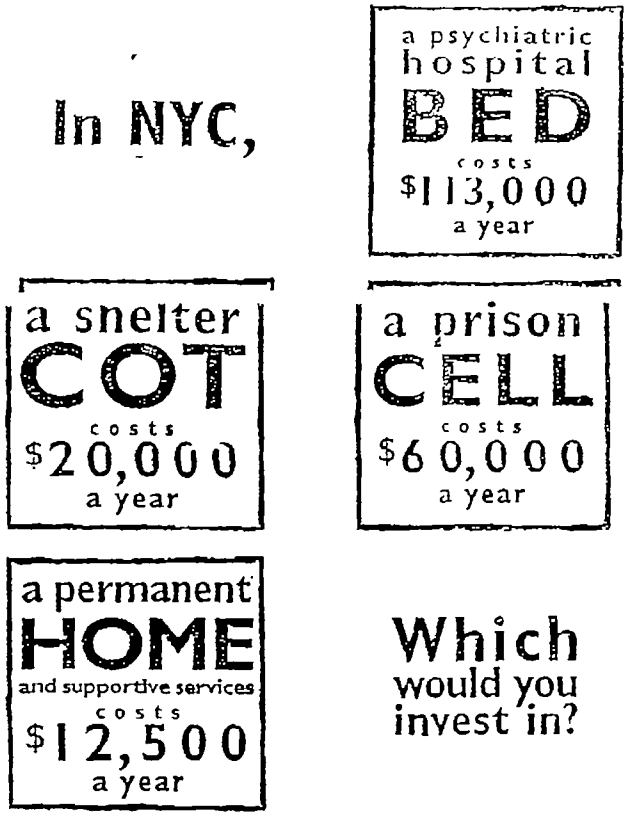

Figure 1 Part of an advertisement in the *New York Times*, financed by a group of business representatives.

WHO, together with many partners, has shown that a difference can be made and has been made in global health. Table 2 highlights some improvements achieved in the last 15 years. But the new and pressing challenges call on us to move faster and be more determined: we need to prepare for the new challenges while the old are still with us.

But, as outlined earlier, the public health agenda in the 1990s and beyond 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, and the issues of ageing, dying and death.

The scope of public health has therefore expanded considerably: this means a new public health cannot '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, as essential as all these measures are. It becomes part and parcel, if not the driving force, of a new type of development agenda.

The measures, the policies and the economics of health creation need to be driven by an organized community effort, from the local through to the global level.

Table 1 Number of deaths in the United States in 1990

Actual causes of death	
Tobacco	400 000
Diet–inactivity patterns	300 000
Alcohol	100 000
Certain infections	90 000
Toxic agents	60 000
Firearms	35 000
Sexual behaviour	30 000
Motor vehicles	25 000
Drug use	20 000
Total	1 060 000

New players

This leads me back to where I started. Now, as with the G7, it is obvious that these challenges cannot be met by public health or even the health care system alone. We must aim to create public health approaches and alliances that will respond to the new and global health challenges and that open up means for real solutions: we must start thinking of global health not just in terms of minimum health care, a moral obligation to save children from dying, or a possible market place for health care products. Instead, we must begin to understand global health in terms of health security that transcends national boundaries.

Table 2 Some selected global health targets by the year 2000

Indicator (Global)	1980	1993–94	Targets by the Year 2000
Life expectancy at birth	61	66	Over 60 years in all countries (26 countries still to reach 60 years)
Infant mortality	82	68	50 per 1000 live births or under, in all countries
Under-5 mortality	117	92	70 per 1000 live births or under in all countries
Dracunculosis prevalence (Guinea-worm)	12 million	3 million	Eradication of dracunculosis
Leprosy prevalence	10.5 million	5.5 million	Elimination of Leprosy
Malnutrition (children under 5)	–	35 8%	Reduction by at least 50%
% of world population having access to:			
• Safe water	52%	71%	85%
• Sanitation	24%	56%	75%
Average rate of children immunized against six diseases. diphtheria, pertussis, tetanus, measles, poliomyelitis and tuberculosis	20%	80%	at least 90%

Population health is increasingly being influenced globally by developments in the private sector. Three major players stand out, and in many cases form a highly influential triad:

1. The health care industry, which will continue to grow dramatically, totally restructure itself and continue to be one of the key markets of the future, last but not least in terms of export to the middle income economies. Hospitals/health service institutions will increasingly compete, strengthen their accountability and health gain orientation through managed care, and will increasingly enter the arena 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. Areas that were seen to be the unique responsibility of the state will be seen to move into the private sector or into a public/private mix – both in the developed and the developing world.
2. The information industry, which is the mega growth market of the present and which increasingly helps create and structure how we live and what we think (just correlate the thought of 2 billion teenagers world-wide by the year 2001 and a global network of the MTV type). Not only will this industry structure global patterns of consumption, it will aim at satisfying the public's interest in health matters through massive expansion of its health programmes. In the USA, first pilots are being run on 24-hour health channels, 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, as will on-line information services for health professionals (telemedicine, health on-line). Epidemics today are 'made' by global media – plague, Ebola, BSE.
3. The 'lifestyles industry' of products (foods, drinks, cigarettes), as well as the sports and leisure and tourist industry, and the many health-related services, such as fitness institutes, weight watchers, etc., will continue its rapid expansion. Already, tourism is the world's largest industry: it has 10 per cent of the global workforce, 10 per cent of world GNP and 10 per cent of all consumer spending. The cigarette is the most widely distributed global consumer product on earth, the most profitable and the most deadly. The average profit margin on a cigarette has been about 35 per cent. Owing to diversification, about 10 per cent of everything on the shelf in American supermarkets is a product of one large tobacco company. A whole generation of kids is confronted with a development that has transformed sports into entertainment and it has been a shoe company that has pushed world-wide a new range of sports activities, body image and self-esteem (including women).

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?

There is no choice but to break through the public health bubble and exercise the public health virtue of foresight.

I venture that what is at present happening in the media industry will happen increasingly in health, meaning the interlinkage of separate functions or 'industries' to a new type of service and product. As computer hardware firms buy up software producers, link with telephone and cable companies and go global as 'mega media' – so we will see a similar development in the health care industry.

For example, a major American communications company is now entering the arena of medical self-help videos to be sold for US$20 in drugstores, mass marketing chains and through Health Maintenance Organizations (HMOs). (Note: the company invested US$20 million in the project and will spend US$15 million on a national advertising campaign.)

The pharmaceutical industry, for example, will redefine its

product to be 'health' rather than a pill which can be bought at a chemist or in a pharmacy – it 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.), and health software development.

Is public health prepared? Is the answer control, standard setting, joint ventures or laissez-faire? What forms of co-operation must be sought?

The road map

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 determinants of health and oriented towards health investment and health gain. The strategies that the Charter outlined have stood the test of time. In many cases, it is only now that countries show signs of serious political implementation. 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 started.
- 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 and the like); the public health strategy called 'the settings 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 towards a health gain perspective.

Let me highlight two strategic areas where a new public health needs to focus activities and sharpen its approaches – although they also seem juxtaposed at first:

- more action on the social health components, particularly through local strategies; and
- more action on global issues.

They come together as part of a sustainable development agenda. Naisbitt has called this the 'global paradox'.

With its 'settings' projects, WHO has shown foresight in aiming to find new approaches to strengthen commitment to health where it is created: projects such as 'Healthy Cities' have led to spin-offs such as 'Healthy Islands' and 'Healthy Villages' – each type of project in turn respecting and building on the specific regional context. This year's World Health Day has been designated to 'Healthy Cities' – and the amount of energy that has been generated at city level using local resources shows that creative public health strategies can get political and popular commitment throughout the world.

Similar experiences have been gained with settings projects that are organization-based, such as health-promoting schools, hospitals, workplaces, even prisons. They, in turn, look at the changing nature of institutions and the contribution of health as a way forward to better institutional performance. Health promotion has availed itself of organizational development strategies tested in the private sector, showing the value of crossover and experience exchange between public and private sectors.

These projects and approaches have an added value that is often neglected, but constitutes the core of WHO's definition of health as social wellbeing. A key feature of modern societies is social disintegration and the helplessness of formal structures and institutions to respond. Settings projects act as mediating structures for civil society – and provide a counterbalance at the local, national and global level through integration, participation and open communication channels. We will learn over the years that frequently the process is as important as the targeted outcome, particularly in relation to larger social goals. An example is the statement from one of the Eastern European countries involved in the health-promoting schools project, stating: 'This project is important because it allows us to invest in our children and young people and provides them – together with their teachers – with a space to practice democratic behaviour.' Naisbitt calls this 'the spread of governance without government, globalization from below'.

Let me move then to the other component of the global paradox, the globalization of industry and trade, of communications and travel. WHO in revisiting the 'Health for All Strategy' is aiming to define the key components of what constitutes good global governance for health. Five principles are beginning to emerge:

1. Focus on health and its determinants, with the aim to reduce the enormous health gaps that persist and have been widening across the globe.
2. Understand health as a global commons and resource. No longer is 'my' health safe if I don't care about 'your' health; AIDS, Ebola, the BSE scare and many similar issues, particularly in the environmental arena, demonstrate this.
3. Ensure health security in view of increasing economic pressures – tobacco, primary health care provision.
4. Invest where it matters – women, schooling, country-based services.
5. Work in partnerships, create alliances.

We have seen the first positive signals of these messages being heard: health is becoming more important in the agendas of the development banks, it has moved up on the agendas of

the global summits – but we are still far removed from a new global contract on health which strengthens the elements laid out in Alma Ata towards a concept of joint stewardship of a global commons. It cannot be acceptable that in the space of a day passengers flying from Japan to Uganda bridge 37 years difference in average life expectancy, and even the train ride from Vienna to Budapest bridges an average of seven years.

The harsh reality is that about $260 is spent per capita per year on marketing products, while some countries have an average of $4 per capita per year to spend on health. These imbalances need to be addressed through a global public health strategy that seeks a systematic dialogue with the three key industries that I have mentioned earlier. A number of 'responsible partnerships for global health' through a global health promotion alliance could be considered.

But we also need to make proposals for new rules of the game: already a number of countries are using the model of dedicated taxes to increase the resources for health promotion, usually focused on the tobacco tax. Another model that could be considered in order to address global imbalances is a dedicated tax on advertising and marketing, a portion of the proceeds of which could support public health and health promotion projects world-wide.

It is a great challenge indeed to work on new norms, rules of conduct, accountability and decision-making. How difficult this is is illustrated every day in the debate over regulating the World Wide Web, counteracting the onslaught of the tobacco industry, keeping up with the pace, size and diversity of the changes under way in nearly every sector of life.

The key problem is surely to stay on the political agenda in a period of time where 'the political economy of the post-modern age is centred on the production and distribution of public attention' (Greenpeace).

The challenge for the discipline

The challenge for public health can be summarized in seven categories of change:

- Change of context: global new social baseline.
- Change of scope: multisectoral, interrelated, social environments.
- Change of institutional focus: health system, other systems.
- Change of goal: health gain outside health system/health care.
- Change of partners: alliances, private, business, NGO (non-government organization), public/private mix.
- Change of site: from the individual to the setting and social environment; global?
- Change of style: participatory, multisectoral, communications oriented, policy.

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 five key sectors:

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

I would like to propose that we start thinking global public health 'outside the dots' with new players:

- Why not an alliance between the international civil aviation authorities (or some major airlines), the pharmaceutical industry and WHO to fight those 16 million deaths owing to infectious diseases and the 300 million odd cases of sexually transmitted diseases? Twenty cents on each international ticket, not as a tax but as a voluntary agreement.
- Why not a major campaign to increase women's literacy combined with skills for health and banking in an alliance between the WHO, the World Bank, UNICEF, and a group of telecommunications networks that are out to conquer the most populous countries? This would include making women more knowledgeable about health care provision, sexual health, and self-medication.
- Why not a global safe sex campaign for teenagers on those networks they are just dying to see linked to those products they are just dying to wear, promoted by those people they are just dying to be (that is where Michael Jordan comes in)? In the year 2001 there will be 2 billion teenagers world-wide.
- Why not an alliance of responsible politicians together with WHO, the World Bank, the health industry, the communications industry on 'the economies of health and well-being' following through on The World Health Report 1995 and the World Development Report 1993[2] – reported on with the same big bang as G7? Such a group would put forward a Club of Rome type of report outlining what ill health costs the world (all of us) and what health security threats it involves. It would cost a meagre US$500 million to eradicate polio. It takes about US$100 to 200 million in advertising and promotion to launch a new cigarette brand.
- A health alliance between the seven most populous countries in the world to tackle common problems and to learn from each other how to bring health promotion to scale, focusing on application of what we know (and would include much of the above).

The paradox

Let us face up to it: much of health research is not about the real world. It likes to focus on interventions; it loves controlled environments. But our environments are not controlled.

The health theme permeates advertising, soap operas and sitcoms to the extent that the most recent trend is to say that the product is not healthy. High profits are made in private health, while we face the extreme difficulty of generating a real interest in public health.

It is these kinds of factors we need to face up to when we look at public health in the twenty-first century. We must combine the art of the possible and the art of innovation. And we must set ourselves challenging goals.

Let me end with a quote by Oscar Wilde: 'A map of the world that does not have Utopia on it is not worth looking at.'

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