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Priority research strategies for a new public health and health promotion

Ilona Kickbusch, Yale University

Health has become one of the central dimensions of quality of life. We are beginning to understand how a wide range of policies affect health and how lifestyles shape health behaviors. For example we cannot fully comprehend healthy child development or healthy ageing without taking into account a wide range of determining factors that reach far beyond the health sector. While genetic research and the life sciences are opening up new avenues and hopes for new types of preventive strategies and treatments they do not provide answers in relation to the health effects of social restructuring and new forms of social organization. Seminal trends such as changing family patterns and gender roles, changing nature of work, loss of social cohesion and integration and new forms of social organization all impact on peoples health and are experienced by them as stressors in everyday life. A new type of health research can contribute to help us find answers to some of these challenges, in particular why, in many countries, increased well being and overall social health have not necessarily followed economic growth and why inequality gaps persist and have even increased in some countries.

Ulrich Beck (1992) in his extensive work on 'risk society' has stated that the central political challenge to late modern societies is to find a social consensus in attempting to answer the question "How do we want to live?" Increasingly health issues are a key component of the answer to this question both in developed and developing countries and as a consequence the expectations towards the public health sector have changed. The new complexities, new risks and insecurities that come with rapid social change are increasingly seen in terms of their health dimension and the public health sector increasingly addresses social issues such as violence, drug abuse and social adjustment and is concerned with empowerment and social capital. The famous sociologist Anthony Giddens (1991) has used the term "life politics" to describe this new type of policy that is concerned with the quality of life and does not allow agencies and institutions to maintain the "old" divisions between policy sectors. We see this clearly in areas such as healthy food and nutrition which implies action ranging from agriculture, to food safety measures, to consumer protection and health education. We also see it in the area of HIV/AIDS where the health sector needs to interact with social groups that have been socially marginalized – like drug users or sex workers – and needs to interface with the welfare authorities as much as with the police and the criminal justice system. Because of this development the public health sector is increasingly searching for ways to introduce health promotion and health protection in other areas of policy and to devise new mechanisms for assessing health impact of

policies and sectors other than health. Programs such as health promoting schools or health promoting hospitals and work places document this reorientation.

Another type of public health research is needed to generate answers to questions such as these by providing a clearer understanding of what creates health, which type of policies and interventions best maintain the health of populations, which strategies are most successful in involving other sectors and how to best increase peoples control over their own health and its determinants. Its results would better inform political decision making and priority setting in assigning resources for health.

What makes and keeps people healthy: The priority domains

A new public health paradigm starts out from the question: *what creates health?* It follows a set of basic assumptions:

- It focuses health as a resource to individuals, communities and society as a whole
- It takes its strategic starting point from the underlying factors that promote health and influence the susceptibility to a whole range of diseases
- It sees health as a responsibility of many sectors of government and society and sees investments in health as investments that contribute to quality of life
- It is deeply committed to closing the health gap and addressing the wide range of existing health inequalities
- It considers inter sectorality and participation as crucial components of any health strategy.

Its premise is – as stated in the Ottawa Charter for health promotion – that “health is created in the context of everyday life.” This is a necessary and appropriate response to two major developments in health at the end of the 20th century: the *epidemiological shift*, especially increased longevity and lifestyle related health problems and the increasing concern with the *limits of the explanatory power* of the risk factor model. For example even in relation to cardiovascular disease, one of the best researched conditions, risk factor research allows us to account for only about 40% of the occurrence. In consequence there has been a steady reorientation of public health strategies

- from addressing risk behaviors to taking action on the *underlying factors that influence susceptibility to a whole range of diseases* – such as the economic, social and physical environment, and
- from addressing disease to focusing on resources for health, a perspective that was initially developed by A. Antonovsky (1987) and is called a “*salutogenic approach*”.

This new orientation has been called “the third public health revolution” (Lester Breslow 1985,1999) and has as its key guiding principle the question “*What makes and keeps people healthy*”. It was reinforced 1986 when the World Health Organization (WHO) adopted a document which has become the strategic center piece of “a new public health”, the *Ottawa Charter for Health Promotion*. It identifies five key action areas: healthy public policy, supportive environments, community action, personal skills and the reorientation of the health system.

This reorientation has significantly influenced health policy in a wide range of countries.

The most recent example of a health policy based on the research on social determinants is the “Green paper on health objectives for Sweden” published in 2000 by the National Committee for Public Health (a parliamentary committee established in 1997) which to all effects constitutes an intersectoral “life politics” agenda. It identifies six priority areas:

1. strengthening social capital
2. growing up in a satisfactory environment
3. improving conditions at work
4. creating a satisfactory physical environment
5. stimulating health promoting life habits
6. developing a satisfactory infrastructure for health issues.

In following this line of thinking the US Institute of Medicine Report calls for a “*socio- ecological model*” of health research that addresses generic social and behavioral determinants, considers multiple levels of influences and explores critical pathways through which health is created and maintained. It starts from the premise that differences in health and well being are affected by a dynamic interaction between biology, behavior and the environment and that such interaction unfolds over the life course of individuals, families and communities. It is further influenced by factors such as gender, age, socio economic differences and race.

Such research by necessity needs to be highly interdisciplinary. Its challenge would be the development of strong theoretical models which could be tested systematically in a range of intervention studies similar to the large risk factor intervention studies in the 1970ies. Research programs that move in this direction have been established in a number of countries – in particular the United Kingdom, Canada and the United States (IOM 2000, Keating and Hertzman 1999, Berkman and Kawachi 2000, Blane et al 1996,).

Four proposed priority research areas

21st century health research must be bold in framing priorities and willing to move into new territory. Four strategic priority areas for new public health research can be developed from a socio ecological perspective:

- To study the interface between social, biological and educational dynamics
- To study the interface between health and social organization
- To study social ecological interventions, critical pathways and investment strategies
- To study the health/wealth interface at the macro economic and societal level.

A special consideration should also be given to the issue of methods. We need to explore the expansion of research and intervention methodologies, the facilitation of interdisciplinary research, the interface between quantitative and qualitative research methods and the ethical questions arising from the interface of social and health research.

Studying the interface between social, biological and educational dynamics

New health research must address health in its complexity and focus on sustainable gains in health and well being across the lifespan. It must follow the dictum that a small shift in a large number can bring about significant population health gain. It must address the specific risks and benefits of rapid social change as they effect the health and quality of life of populations. Our evidence base is not yet geared towards measuring life span health in the context of everyday life, and it has led us to underestimate the cumulative/long term (negative or positive) effect of many small interwoven factors of social organization and social change. The focus on risk behavior has also led to the neglect of social, mental and emotional health factors as well as to the neglect of the health and well being of children and young people, who seem to be the population group paying the price of modernization.

Suggested priority areas:

- healthy development of young children/ early child development, the influence of early child development on life-long health, including in particular longitudinal surveys of children and youth that address a broad range of health outcomes: physical, social, psychological and emotional,
- Ageing well - Determinants of healthy ageing, in particular studies on resilience,
- Pathways for health competence, health literacy and successful coping .

studying the interface between health and social organization

Priority in both health promotion intervention and health promotion research should be given to the building of healthy communities and healthy workplaces, strengthening the wide range of networks for health and increasing individual and community capabilities to lead healthy lives. Supporting social capital and creating social opportunity is a crucial challenge for health and social policy in modern societies. It seems essential that we move out of the stage of isolated projects and programs but move towards long term and large scale intervention approaches as was accepted from the seminal risk factor intervention studies.

Suggested priority areas include:

- Impact of supportive environments and settings on health status and quality of life (in particular the social capital created at the interface of schools, families, communities),
- understanding communities and meso institutions as participative health learning environments, with a focus on identify communities and regions that are doing well and a comparative focus on different language groups ,
- modernization of work, a changing labor market and health,
- gender and health (with a special focus on the insecurity of young men).

Studying social ecological interventions, critical pathways and investment strategies

New public health research must study “best investments” policies in support of health. This means more systematic study of the health contribution of different sectors in government and society, for example education, labor and traffic policy provide crucial support to health. The increasing debate on health impact statements seeks to find ways to measure and include the effects – both positive and negative -of these other policies on health. Costs and resource implications would need to be calculated across sectors given the very high level of positive and negative externalities of all policies. Such research needs to explore the rationale and needs of sectors other than health, and hold the health sector accountable for its own contribution to societal well being. New public health research would assist in developing new models of accountability and accounting new reporting formats such as a health equity index (as recently proposed in the UK) or a social stress and modernization index. In the United States a social health index has tracked developments over the last 30 years using eleven indicators. This index shows clearly that during a period of extraordinary economic growth, the social health of the population has actually decreased significantly. Indeed measures that take account of the interface between public health and social and economic policy are of particular importance. The measurement of externalities has been suggested by a UNDP study on “Global public goods” which would show the effect of externalities between sectors and between national and transnational health effects.

Suggested priority areas include:

- Healthy public policy, i.e. legal and policy interventions with high health impact in particular in relation to the health and social integration of young people,
- multilevel/multifaceted/multi disciplinary interventions (i.e. tobacco control),
- methodologies to study the cost effectiveness of interventions and new forms of health impact assessment ,
- the contribution of the “active citizen” and health movements (AIDS groups, women’ health groups, patient groups) to population health.

Study the health/wealth interface at the macro economic and societal level

The new public health research would study the close relationship between health and wealth, which must be better understood in order to create wider societal commitment to reducing health inequalities. This builds on a perspective developed in recent publications on population health. Already in 1994 Evans and Stoddart argued that in times of tight resources the health dollar is best spent by being oriented towards the production of health, thus overcoming what has been called the health policy paradox: *“A society that spends so much on health care that it cannot or will not spend adequately on other health enhancing activities may actually be reducing the health of its population.”*

Keating and Hertzman (1999) have followed this line of thought and suggested that in late modern societies, health will again play a central role in wealth creation, and that nation states – as was the case during the industrial revolution -will have to invest significantly in human and social capital in order to remain competitive on a global scale. The work of Amartya Sen (1999) and others (Report on Macroeconomics and Health 2001) have shown this to hold for developing countries.

Suggested research priorities include:

- Compare the impact of various investments and policies on population health, i.e. which investments create the largest health gain (for example investment in women’s education and empowerment),
- Compare health and wealth developments in countries of the PAHO region and analyze similarities and differences,
- Try to assess the specific health resources that buffer the impact of rapid social change

As Keating and Hertzman state:

“The wealth of nations in the Information Age may depend heavily, perhaps primarily, upon their ability to promote the developmental health of their populations. This, in turn requires them to create the capacity for providing the necessary developmental resources which is a significant challenge during a period of rapid social and technological change we are now experiencing. To achieve this level of persistent social adaptation, it may become advantageous to construct “Learning societies” capable of organizing and acting on behalf of human development.”

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