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The challenges and promise of European public health

Professor Aydin, Ladies and Gentlemen,

Slide 1 Titles

It is with the greatest pleasure that I accepted your kind invitation to speak at the opening of Medipol University here in Istanbul. This is one of my favourite cities, and the economic, social and educational dynamism here in Turkey is enormously impressive. I wish your University the best of good fortune over the years ahead.

Sir, you proposed that I should speak on public health issues, and I have taken as my title: “The Challenges and Promise of European Public Health”.

When I was elected WHO Regional Director for Europe, all my knowledge and experience told me that the health challenges we face now make public health a vital force for health promotion and protection, and moreover a force that needs to be nurtured and strengthened right across the European Region. I shall try to explain and elaborate on this statement during my talk.

Slide 2 Definition of public health

I shall take for my definition of public health that of Sir Donald Acheson, who, as the Chief Medical Officer of England and Wales, was a member of the WHO Executive Board. Sir Donald famously wrote that: “Public health is the science and art of preventing disease, prolonging life and promoting health through organized efforts of society”.

This definition has since achieved global recognition. It has sometimes been modified a little, but its essence remains.

Public health, then, is both a science and an art, and it is an organized societal responsibility. It is, always, a combination of knowledge and action. This perhaps is the key message that I bring: namely, that public health is a practical business, based on knowledge but also on organization and activity within society.

Early public health concerns were of course mostly with nuisance and the threat of transmissible diseases. Later public health developments included control of water and food (including most particularly the pasteurization of milk), immunization, maternal and child health, and latterly health promotion and disease prevention. These developments were based on science, but were practical in their development and impact.

This focus on knowledge and action is as relevant today as in the past, although in a different disease context. Today, rising living standards and improved life experiences, together with greatly enhanced medical and surgical technologies, have led to much longer lives, although this benefit is unfortunately not shared by all. Today’s main burdens are chronic

noncommunicable diseases (both physical and mental), injuries and violence, and disability. That said, we must remain focused on the combination of knowledge and action that is the essence of public health.

We also know now in ever more detail that public health improvement, important as it is for human reasons, is a vital part of wider human development, for investment in health is an investment in social and economic development and growth.

Slide 3 Themes

I shall take three themes for my talk to you today. Firstly, I shall speak of our need to strengthen public health and health systems. Secondly, I shall look at the interrelationship between health improvement and human development, looking briefly from where health comes and at how we can maximize its positive impact on our human societies. Thirdly, I shall focus on the necessary combination of knowledge and action in public health in our modern context. Lastly, I shall ask for all of you for your help!

I shall start with the strengthening of public health in the European Region. The Region is made up of 53 countries, from Iceland and Greenland in the west to the Pacific coast of the Russian Federation in the east. It comprises almost a billion people. Overall health is improving, but not uniformly and there are wide variations both between and within countries.

Slide 4 Health-related inequalities

Health-related inequalities persist between and within countries, stratifying populations according to ethnicity, gender, socioeconomic status, educational status and geographical area. I will choose just one statistic here to illustrate this phenomenon: in 2007 the infant mortality rate in the poorest countries in the European Region was 25 times that in the richest ones.

Slides 5 and 6 NCD prevalence

Today, as I have said, noncommunicable diseases, particularly cardiovascular diseases and cancer, are the leading cause of mortality and morbidity in the European Region. There is also an increase in the prevalence of mental disorders, which are among the most common contributors to chronic conditions in Europe. Noncommunicable diseases are a serious threat to health and socioeconomic development. For many populations, these diseases create a poverty trap, causing catastrophic health expenditures and poverty. This epidemic of noncommunicable disease threatens to overwhelm health systems in some countries. Yet, although these are sombre facts, investments in prevention and mental health remain low, accounting for just 1% and 5.9% of overall European health expenditure, respectively, well below the average for the Organisation for Economic Co-operation and Development (OECD) countries.

Yet also, in spite of this predominance of noncommunicable diseases, emerging and re-emerging communicable diseases remain a priority area of concern in many countries in the Region, including not only HIV/AIDS and tuberculosis (TB), including multidrug-resistant and extensively drug-resistant TB (M/XDR-TB), but also alarming outbreaks

of potentially global significance, such as pandemic (H1N1) 2009 influenza. This year has seen the re-emergence of poliomyelitis (polio) in Tajikistan, which threatens the Region's polio-free status, which it has held since 2002. The growth of antimicrobial resistance and hospital-acquired infections is also of great concern.

Slide 7 Demographic shifts

Across the Region, in addition to the more general changes associated with globalization, there is a demographic shift, including decreased fertility rates and a rise in the old-age–dependency ratio. These changes are so pronounced within the European Region that they must be key drivers of public health policy. There is an influx of migrants, as well as the international migration of health professionals, leading to shortages of health professionals. Work is changing, with advances in communications, longer working hours, stress in the workplace alongside growing unemployment and insecurity of job contracts at a time of global economic crisis, global environmental changes (including climate change) and most vitally the unequal distribution of health and wealth. These changes coincide with important shifts in the relative roles of health professionals and citizens, as well as increasing pressure to use health systems' resources efficiently and wisely.

This is the background to our present work within the WHO European Region. For the reasons I have explained, we need to strengthen public health systems, functions, infrastructures and capacities, but also increase the capacities and performance of health systems, giving an increased focus to primary prevention and health promotion.

The WHO Regional Office for Europe will take this work forward in the context of the WHO Global Policy Group (GPG) to formulate a common framework for the development of national health policies and strategies entitled "supporting policy dialogue around national health policies, strategies and plans".

Slide 8 Structure of European health policy

A new European Health 2020 policy is being designed and implemented as a collaborative initiative between WHO, Member States and their health-related institutions, and diverse stakeholders whose actions directly and indirectly influence the realization of national and European health potential for 2020 and beyond. The WHO Regional Office for Europe will seek collaboration from scientific partners and relevant professional groups, civil society and policy communities. Diverse stakeholders (scientific experts, policy makers, professional and other networks, nongovernmental organizations (NGOs) and development institutions from across sectors and covering pan-European, national, regional and local levels of administration) are being engaged in order to strengthen existing evidence, know-how and support for action to achieve better health for Europe.

This process is required for:

(i) strengthening public health infrastructure, capacity and functions;

(ii) reinforcing linkages between all components of health systems – most notably between public health and primary care – and expanding them to all government policies; and

(iii) scaling up actions on social determinants of health and the reduction of health inequities both through public health programmes and broader government policies.

In my judgement, this whole approach to comprehensive health improvement and optimal health system performance must rely on a renewed commitment to a strong public health infrastructure.

Slides 9 and 10 Essential public health functions

Core essential public health functions have been well described, for example, by the Pan American Health Organization as part of its Public Health in the Americas initiative, and these are a vital component of the wider health system within society, giving expression to health across the whole political and administrative spectrum of policy-making. Strong public health is vital if we are to promote strategic thinking about health, particularly about the control of noncommunicable and other high-burden diseases. We are too often hampered by the lack of developed and effective public health infrastructure, poor public health services and the lack of capacity in countries to implement public health programmes.

Unfortunately, in many countries the public health role and infrastructures have become institutionally weak. Therefore, as part of the new European health policy, we shall work extensively to improve the strategy for public health development, and public health functions and capacity, in Europe, with a strong emphasis on prevention.

A widely accepted definition of public health functions focuses on health protection, health improvement and health service development. In my view, it is through the interplay between improved public health functions, capacities and systems, and more effective, responsive and efficient health systems, that health will be improved. Technologies for

health improvement at both the population and individual levels have improved and will improve dramatically, and we need strong public health and health systems to take the fullest advantage of the opportunities that these technological opportunities will bring. Public health and health systems are mutually supportive, and must never be thought of as distant from or hostile to each other.

To be a public health leader is very challenging. Public health practitioners must initiate and inform a health policy debate at political, professional and public levels, taking a "horizontal" view of the needs for health improvement across society as a whole. They must create innovative networks for action among many different actors, be catalysts for change, and develop and support the systematic use of tools and instruments that will move from goals to action on the scale necessary to deliver sustainable results. Yet, also, they must be an integral part of the management and development of current and future health systems. These are demanding expectations.

I am delighted to tell you that the recent Regional Committee session in Moscow, Russian Federation supported all this exciting programme of work, and in its implementation I will need and ask for your help, with new and innovative thinking, and expert advice and support across all the countries in the Region.

I would now like to turn to the second of my main themes: the interrelationship between health and human development. I shall consider first the determinants of health and from where health comes, and then how we can maximize the positive impact of health on human societies.

I have said that these determinants include a combination of political, social, economic, environmental and health-system factors. Our new European health policy must encompass all of these.

Slide 11 Slide from European SDH Review

Across Europe, there are persistent differences in the opportunity to be healthy and the risk of illness and premature death between social groups living in the same country. This is true for higher-, middle- and lower-income countries alike. Even between countries with similar development conditions, political history and culture, significant and avoidable differences in health are observed

The report issued in 2008 by the WHO global Commission on Social Determinants of Health, led by Professor Sir Michael Marmot, signalled the ethical imperative of acting on inequalities and set out the evidence showing how the opportunity to be healthy and the risk of poor health and premature morbidity and mortality follow a pattern by number of years in education, job type and security, housing and living conditions, as well as by the level and security of income, degree of social capital, community cohesion and access to affordable and appropriate health services.

Many of these factors are also priorities for other sectors, for civil society and governments overall, and there is strong evidence, including from United Kingdom policy evaluation and researchers, that these inequities are amenable to intervention. Nevertheless, they require solutions that are aligned with an intersectoral approach.

For this reason I have launched an independent review of the social determinants of health and the health divide in Europe. This review will be chaired by Professor Sir Michael Marmot, and bring together a consortium of scientists, academics, policy-makers and representatives of the public health community, drawn from across the whole WHO European Region, to set out the policy-relevant evidence, options and domains for systematic action, and key tools to strengthen the monitoring and analysis of health equity, public health programmes, intersectoral action, broader governance of the social determinants of health and reduction of health inequities within and between countries. An interim report on the nature and magnitude of the current European health divide was presented and discussed by the Regional Committee in Moscow in September 2010, and the review will also underpin the values, goals and objectives of the European Health 2020 policy.

Environmental factors and conditions are also major determinants of health and well-being in our societies. These include water and air quality, the effects of increasing urbanization, and the need to limit exposures to hazardous substances and emissions. The effects of climate change – including rising temperatures, sea levels, and frequency of natural disasters and extreme weather conditions – are also becoming increasingly evident.

Against this predominant burden of noncommunicable diseases, promoting healthier lifestyles and behaviour is of pre-eminent importance, including the fields of smoking, alcohol, physical inactivity, and substance abuse. We have seen success in tackling smoking prevalence, yet an effective package of public health interventions that addresses all of these risk factors must be developed to reduce the

noncommunicable disease burden and the subsequent costs for health systems.

There is also significant evidence showing how investments and decisions made outside of the health sector directly and indirectly influence health outcomes at the population and individual levels. For example, urban planning, agricultural policies, income level and market regulation have all been shown to influence diet, lifestyles and the related levels of obesity in society. As such, reducing the avoidable burden of noncommunicable diseases requires joint planning and action across sectors, to ensure that solutions are effective and sustainable.

As those in the public health community are fully aware, the increased focus on promoting population health, reducing avoidable risks and intervening earlier in preventing and treating illness, is driven not only out of concern for health improvement but also by the need to contain health-sector costs through demand management and efficiency measures. Most countries are experiencing increases in growth in health care budgets as a percentage of the gross domestic product (GDP); as a result, strengthening efforts to implement effective prevention and health promotion interventions is an increasingly important policy goal.

There is also increasing evidence to show how well-planned and -implemented behavioural change programmes – that address social and economic factors in addition to individual knowledge and skills – have greater impact on health decisions and sustainability. This is particularly so in relation to high-risk and vulnerable groups. Therefore, promoting health and influencing behaviour require coordinated actions across

several sectors, specifically to create and sustain the conditions that support healthier choices.

Then, also, the capacity and efficiency of health systems must be considered. All of the Member States in the European Region are concerned with demonstrating value by improving performance and reducing costs while maintaining the values that underpin European health systems: namely, solidarity, equity and participation.

It is generally argued that socioeconomic determinants surpass health-system capacity in terms of their influence on health outcomes, although, as effective technologies develop, the impact of health systems may be expected to increase. That said, what we clearly need is a coherent approach that will address the full spectrum of these factors. Increasing investment in health promotion and disease prevention from its current lamentably low level in some European countries is essential.

How can we maximize the positive impact of health improvement on human societies and development? The Commission on Macroeconomics and Health established a causal link between health and economic development, refuting the notion that health systems are simply a drain on resources. Instead, we now see that investing in health systems and acting across sectors to act on health determinants support both health and economic growth. Health is increasingly acknowledged as having a significant impact on the economic dimensions of society and social cohesion.

Slide 12 Tallinn Charter

The evidence increasingly captures a dynamic set of relationships showing that:

1. ill health has a direct economic cost
2. health systems can produce health
3. wealth is supported by better health.

Such an analysis underpinned the 2008 Tallin Charter: "Health Systems for Health and Wealth", and provides arguments that securing the right mix of public health policy and upstream preventive interventions with actions to reduce health inequalities will result in tangible benefits for health and human development, as well as reducing future costs in health.

This understanding is key to making the case for improved public health and health care services and functions in Europe, and it constitutes a powerful argument for well-targeted investments in both health and health care systems and in interventions beyond the health sector that act on social determinants.

Benjamin Disraeli famously said that: "The health of the people is really the foundation upon which all their happiness and all their powers as a state depend".

This is surely true; yet, if the power of this relationship is to be realized, then governance for health must be improved. Governance is a challenge as we empower ministries of health to lead in horizontal, cross-cutting, policy. Strengthening the governance and leadership roles of ministries of health must be a major focus of our activities, and we need to develop new tools for national health policy work to ensure that public health perspectives and goals are accepted across government: for example,

through horizontal policy boards, a coherent and integrated regulatory framework, embedded performance assessment systems, communication and collaborative mechanisms that work across and within government at all levels, and initiatives to promote accountability and citizen involvement.

Lastly, two tools – health impact assessment and intersectoral targets – have real potential to strengthen policy-making across all sectors.

My third and last main theme focuses on the necessary combination of knowledge and action in public health in our modern context. Knowledge – for example, on the socioeconomic determinants of health – is vital and scientifically derived. Action, however, is ultimately socially and politically determined. The one needs the other.

Considering socioeconomic determinants, it is clear that these are amenable to change but affected by policy decisions in a wide range of sectors. The health ministry may not readily be able to change or even address many of the determinants of health because they lie outside its political mandate and beyond the boundaries of the health system.

Slide 13 Examples of HiAP successes

This is where health in all policies (HiAP) has a key role, with its emphasis on intersectoral governance. How can the health system work proactively with other sectors to identify the impact of their policies on health determinants and health status, and search for practical policy options that both maximize the positive health impacts of other policies and minimize any unintended negative impacts? The overall goal is to

improve determinants and health by implementing intersectoral action and promoting policy coherence. In many cases, HiAP also produces dividends for other sectors.

Slide 14 History of Alma-Ata, Ottawa, HFA, HEALTH21

HiAP builds on a long tradition, going back to the Declaration of Alma-Ata on primary health care in 1978. It develops the thinking underpinning the WHO Health for All policy, introduced in Europe in 1980 and renewed and updated several time since. It incorporates the Health for All experience, along with the 1986 Ottawa Charter's "healthy public policies" action dimension, and emphasizes the central role of governance. It promotes a suite of intersectoral approaches with a view to enabling a dialogue on health-related aspects of all policies, and creating an entry point for work across government to change the determinants of health.

HiAP has itself developed significantly in scope and influence since its introduction through the Finnish European Union (EU) Council Presidency in 2006. Subsequent developments have seen the inclusion of HiAP in the EU health strategy, "Together for health: a strategic approach for the EU 2008–2013". Indeed, collaboration with the EU must and will be a core component of the development of the new European health policy.

To be successful, we will need strong political leadership, evidence that demonstrates the impact of the approach across government, and innovative forms of intersectoral governance structures at cabinet level and between ministries to enable constant dialogue and action: for

example, horizontal public health committees, intersectoral programmes and public health reporting, combined with formal consultation with other sectors.

Slide 15 and 16 Burdens of tobacco and alcohol in Europe

We also need to focus our modern knowledge of the burden and lifestyle factors associated with noncommunicable disease for effective action. We have seen real progress in the development and acceptance of effective control measures in the field of tobacco consumption: for example, internationally with the Framework Convention on Tobacco Control, and nationally in many countries with a variety of measures on the price, advertising and use of tobacco products at work, in bars and restaurants and in public places. Here, also, the Global Strategy on the Harmful Use of Alcohol is very relevant to the European Region

The evidence clearly indicates that, here good science, a clear ethical imperative and strong political support come together, real progress can be made with general public support. After tobacco, we now need to see the same combination of fundamental contributory factors working in other lifestyle areas, such as alcohol, diet and exercise, and indeed more widely in an integrated group of public health interventions to address the totality of risk, as demonstrated, for example, in WHO's 2008–2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases.

There are a number of other international public health instruments in place: for example, in the communicable disease field the new International Health Regulations, and in the environmental field the

WHO Protocol on Water and Health. We need to evaluate their effectiveness, with a focus on the long-term commitments needed to tackle the difficult and protracted public health challenges faced by the European Region. What are the relative advantages of the different types of public health instruments? How can their impact be improved? How can gaps be addressed, and evaluation and monitoring of these instruments be made more effective? I intend to hold a policy dialogue on these issues.

Ladies and Gentlemen,

Slide 17 Summary

I have completed my review of the three main themes I outlined at the start of my talk.

To summarize, the WHO European Region faces a number of challenges in the quest for better health, challenges that national health systems are charged to address. Today, however, their scope for action is often limited by a shortage of human, material and financial resources, weak institutions and limitations in powers and competence.

We aim to help our Member States change this situation. We shall develop a coherent European health policy; promote a renewed political commitment to the development of comprehensive national health policies, strategies and plans; maintain our commitment to strengthen health systems and, particularly resonant here today, renew our focus and rejuvenate our commitment to public health capacity, functions and

services. In all of this, we must ensure a real commitment to and investment in disease prevention and health promotion.

As I said earlier, in all of this I, and we, need your help. I hope that you will all work with us internationally on Health 2020, and reach out to others, inviting their full participation.

It has been the greatest pleasure to speak to you – a most distinguished public health audience – of our future intentions and work, and I hope I have been able to share with you my personal commitment to public health and its functions and infrastructure as vital to the health improvement in Europe that we all seek.

Thank you.