

Future Scenarios for Public Health in Europe

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The public health task is determined by a combination of demography, patterns of ill-health and the availability of policies and interventions which can make an impact on health outcomes. The changing political and administrative environment provides both opportunities and threats for the public health enterprise in Europe. If we are to optimize our contribution public health practitioners must acquire a strategic overview of the issues which need to be addressed. There are tools available which can help in the process of strategic analysis which come from the world of business. Such tools may not seem initially attractive to those working in the public sector, however, they should be judged by their utility in generating understanding and indicating appropriate policy directions. The application of some such tools would seem to indicate a mismatch and a tension between the old and new public health agendas and the institutional arrangements which support them. This paper is intended to stimulate a debate about the most effective way forward whereby a wide range of energies can achieve the greatest synergy.

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Introduction

The World Health Organization (WHO) strategy for health for all by the year 2000 speaks of a state of health which enables people to live socially and economically productive lives (WHO 1981). The WHO perspective has been elaborated in the 38 European targets for health for all (WHO 1985).

The European targets define a new agenda for health. They also reflect a new orientation and approach towards public health practice – one which brings together environmental changes, community participation and personal and preventive measures with appropriate therapeutic interventions (Ashton & Seymour 1988). There has resulted from this new agenda and approach a resurgence of interest in public health. In the parlance of the business community, a new market for public health interventions has emerged. Herein the different forces behind these changes are discussed in light of how they have come to influence the current European agenda for health. Also considered is the potential applicability of incorporating elements of management theory in public health practice.

Forces for Change

McKeown's work and his contribution in highlighting the essentially ecological nature of health and disease

has provided a basis for the new orientation and approach towards public health practice. He argues that in England and Wales it is unlikely that immunization or therapy had a significant effect on mortality from infectious diseases before the twentieth century (McKeown 1976). Most of the reduction in mortality from tuberculosis, bronchitis, pneumonia and influenza, whooping cough and food and water borne diseases had already occurred before effective immunization or treatment was available. Between 1900 and 1935 some specific measures contributed to reduced death rates from infection. (e.g., intravenous therapy for diarrhoeal disease, surgery for appendicitis, improved obstetrical care and passive immunization against tetanus), but the total contribution of medical and surgical intervention to reductions in mortality was small compared with the impact of environmental, public health, political, economic and social measures.

What has emerged over the past 10-15 years as the 'new public health' is built on the idea that the health of populations can only improve in a healthy environment; in a healthy political, economic and social milieu. The new public health takes account of the balance between populations and resources, and raises issues such as the limits of growth and the challenge of producing ecologically sustainable towns and cities (Ashton 1991, Acheson 1991, WHO 1991).

Perhaps the most significant catalyst of the new orien-

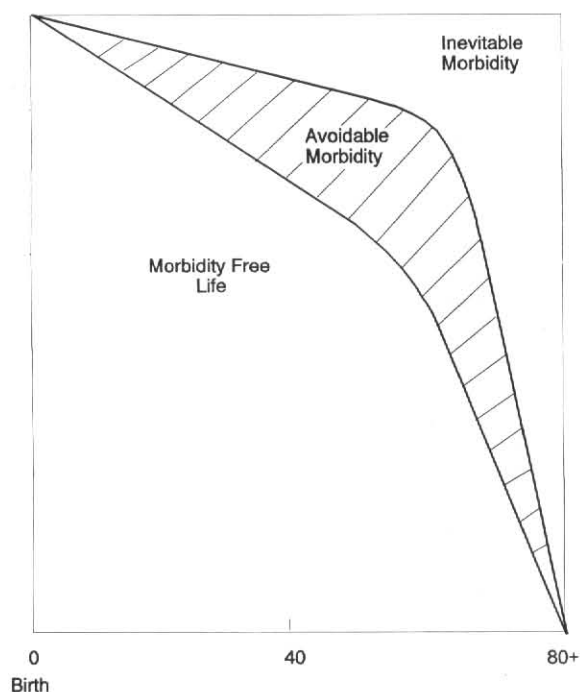


Figure 1. The scope for compressing the morbidity curve and adding life to years.

tation towards and the resurgence of interest in public health are the demographic changes in the populations of developed countries. There has been a dramatic change in reproductive behaviour, family formation and life expectancy. At the turn of the century less than 5% of the population was of retirement age. Today, the figure is approximately 15% and by the year 2000 in some countries it will have reached 20%. People are having fewer children and countries are beginning to see children as a valued national resource to be invested in and brought to as full potential as possible in order for them to contribute to the 'common wealth'.

The age distribution of a population has serious implications for the population's health status. As the proportion of the population in the older age groups increases, the burden of chronic disease is likely to become greater, particularly if little is done to reduce the burden of avoidable morbidity (Figure 1). Similarly, a great deal of ill-health has a skewed social class distribution. The potential for reducing social class inequalities remains considerable, and in some countries, social class inequalities in health have become an important political issue (Ashton 1990). In addition to these factors, or perhaps because of them, it has become increasingly clear to governments that the demand for treatment services is potentially limitless. Health care cost containment is now a high priority. In the ensuing reappraisal, the cost-effectiveness of prevention compared with treatment has become ever more emphasized.

The implications of tackling seriously the current agenda of health need and achieving health gain are twofold. Firstly, the burden of ill-health before age 65 or 70, with its strong social class correlation, must be reduced considerably. Secondly, the need for acute hospital care facilities and tertiary care must be reduced by developing different models of community social/medical care linked to the primary health care system (WHO 1977).

Implications for Practice

As a result of these various forces for change, the skills of public health practitioners have suddenly become in great demand. The core skills which public health practitioners have at their disposal to help in the attainment of improved population health include a variety of tools to assess the health of populations and to evaluate the impact of interventions which they are frequently responsible for bringing about. However valuable those skills may be, public health practitioners are increasingly aware of the need to add management theory and training to their core skills in order to adapt to the demands of the current circumstances. To many people brought up in the world of social and medical care, the very idea of importing concepts from the world of business can seem distasteful. Yet, the alternative is to continue in the tradition where objectives are implicit rather than explicit, and resource use is not set against measurement of need or outcome. In that tradition, the

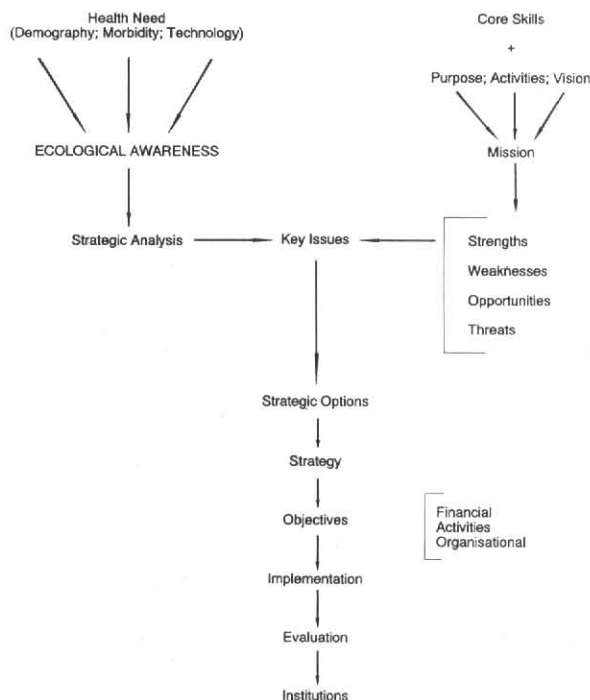


Figure 2. Strategic Planning - a Framework.

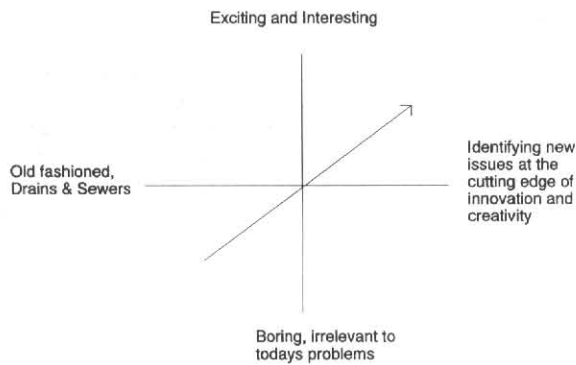


Figure 3. A perceptual map of the repositioning of public health.

professional is in a powerful position, especially in a system which is underwritten by the public sector. The consumer is kept dependent, in the dark and patronized. What is clear from an acquaintance with the world of business and management theory is that there are as many opportunities for insight from experience and from the business school approach to case study analysis as there are from scientific endeavour. The substantive difference between business and public health is the commitment to equitable population coverage irrespective of wealth – equal access for equal need. What is valid from the business approach is for public health practitioners to begin to consider how to: (1) translate available resources into optimal health gain on a population basis; and (2) encourage community participation and empower people rather than make them dependent. This requires strategic planning. Strategic planning as developed in the world of business, involves a process of clarification which runs from mission to action and evaluation of achievement (Figure 2).

Measuring Health Need

Health need is a product of population and morbidity; the technical ability to intervene to protect or improve health and the political will to do so. It is both a relative and an absolute concept and is bound by time and place. In the world of public health the assessment of need usually begins with community diagnosis and the identification of priorities. In recent years WHO and other international, national and local agencies have stimulated a great deal of work in this area with analyses at the international, national and local levels. Further, there is growing emphasis on public participation, whereby individuals and communities can begin to identify their own health needs. In the language of the private sector this work defines the potential market for public health activity; it is a dynamic phenomenon and has changed dramatically since the early 1970s with the rediscovery of the importance of lifestyle and environmental factors in health status as well as the contribu-

tion made by specific medical interventions. Of central importance is a recognition of the dramatic change in reproductive behaviour, family formation and expectation of life (Ashton 1990).

Until quite recently people would be involved with child-rearing from their late teens until they were perhaps 50 and they were probably dead by 60. Nowadays people defer child-rearing often until into their late 20s or early 30s, they often have only one or two children, and the period of child rearing is commonly over by the mid-40s when they still have the prospect of 30 more years of full and active life. During this time they have energy to offer to hobbies, to their families, to new interests and to each other through mutual and self-help.

A further dimension to the demographic change is the scope for pushing back the boundaries of morbidity-free life and of adding life to years. Much of the premature mortality and its associated morbidity is avoidable; heart disease, stroke, accidents, cancers, suicide and depression, alcohol and drug related disorders (including those caused by prescribed tranquillisers). A great deal of this ill-health has a skewed social class distribution and the potential for improvement and for reducing social class inequalities remains considerable in most countries.

Strategic Analysis

To move from an understanding of health needs to a strategic analysis which informs policy it is necessary to consider the environment in which we are working. The environment has changed dramatically in recent years from one which had become hostile to the population-based public health approach to one which now favours it.

It has become clear to governments of all political persuasions in many countries that the demand for treatment services is potentially limitless and cost-containment is now a priority in systems based on private health care linked to insurance as well as to state funded national health services. In the ensuing reappraisal the cost-effectiveness of prevention compared with care has become ever more emphasized and the skills of epidemiology and public health practitioners have suddenly come to be in great demand.

The work of many young enthusiasts over the past 15 years has contributed to what market people would call the repositioning of public health (Figure 3). As a 'business' or as a 'producer' it is now in a prime position – the market has many of the characteristics of a new market and there is a great demand for the product.

New Markets for Old

The configuration of a new market can be viewed as an

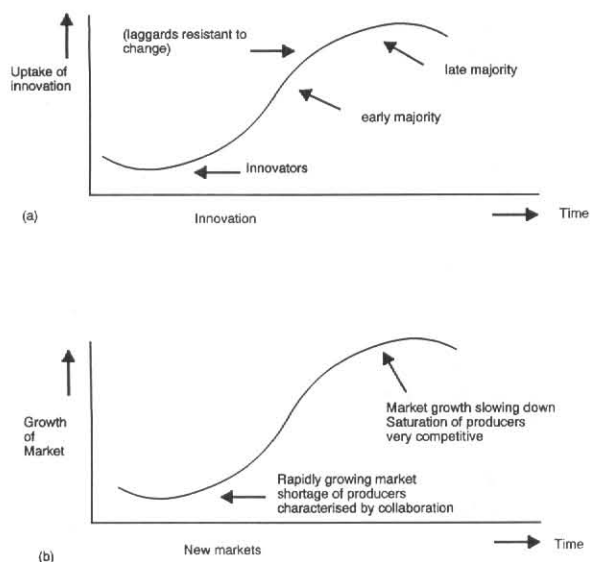


Figure 4. The S shaped curves of new markets and of innovation.

'S' shaped curve and is in some ways similar to that which can be used to describe the process of innovation in organizations (Figure 4). Innovation in organizations is often not an easy matter. According to the diffusion theory of innovation, diffusion takes place as the information about an innovation is disseminated through the appropriate social system and individuals, groups or organizations decide to accept (or reject) the innovation. As more members of the system adopt the innovation an S-shaped diffusion curve is produced, the rate of adoption affecting the steepness of the curve. The early stages of innovation are characterized by an entrepreneurial style with product champions and impatience, the later stages by institutionalization and stagnation unless another group comes along to push against the orthodoxy (Stocking 1985). Institutional inertia is the enemy of innovation. Successful firms have devices that enable them to continue to innovate after their original product champions and charismatic leaders have gone or become complacent (Peters & Waterman 1982). One way to break out of the cycles of inertia is to have models of good practice.

New markets, where there is a rapidly growing demand for a particular product and where there are insufficient suppliers to meet the demand, are characterized by collaboration and mutual self-interest on behalf of the producers. In contrast, mature markets, becoming saturated and with an overproduction of goods are characterized by competition which can be very severe. The situation of public health in the 1990s is complicated by the fact that what we have is a renaissance market for a somewhat different product than before (Figure 5). In this renaissance market we have a complex set of circumstances and players. There are the residual organizational arrangements from the old pub-

lic health (The Rockefeller Schools, the World Health Organization 1948 structure, and the senior members of the public health professions) and there are the new entrants who are more responsive to environmental cues and less committed to traditional ways of doing things; they tend to be more pro-active and entrepreneurial and willing to work in new ways. This mismatch may account for some of the concern which is now beginning to surface. That the established organizations having been accustomed to a) seniority and prestige, b) to compete in a mature market, are having difficulty mixing in with an extensive network of innovators whose ethic is appropriate to a new market and who are happy to share and collaborate. Some of the deeply rooted weaknesses which had become institutionalized in the old public health have recently been well documented by Kerr White (Kerr White 1991).

The Mission

The mission which emerges from the language and documents of the new public health is to ensure that the skills of public health are equitably available to populations on a global, national and local level, that these skills are deployed in keeping with the philosophy of health for all to empower people rather than making them dependent. It is implicit that we should collaborate in this work as a humanitarian mission (Ashton & Seymour 1988, WHO 1981, WHO et al 1986, Ashton 1992, Acheson 1988).

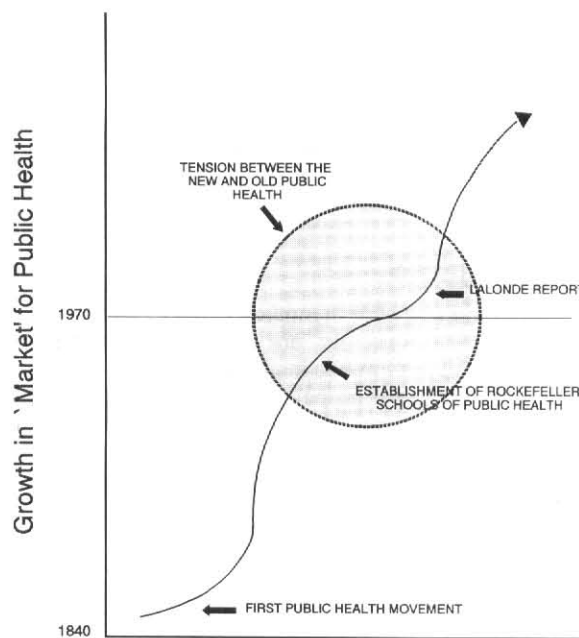


Figure 5. The renaissance market in public health.

SWOT

SWOT analysis is now a well known approach to strategic analysis. It involves the assessment of strengths, weaknesses, opportunities and threats to the achievement of the organization's mission. If we consider public health in Europe from a SWOT perspective the following points emerge.

Strengths

- A high level of public health tradition and development in some countries. Dramatic changes in some countries, (e.g., Spain) over a short-time scale.
- We are in a 'new' market where public health enjoys fashionable attention and is able to command resources at a time when other public sectors are being deprived of them.
- There is buoyant recruitment into the field. Many new schools and courses are being established. There is a great deal of open collaboration among the new players and there are some very good networks already in existence.

Weaknesses

- Resources are very stretched. Major areas are still not being tackled systematically, for example, occupational health and environmental health.
- Variation in country and local levels of public health development.
- No coherence to the activities which have been developing. There is a danger of missing the potential synergy from integrating programmes.
- The lack of dynamic multisectoral and multidisciplinary European public health institutions.

Opportunities

- The continuing crisis in medical care and the changing demographic structure are clear opportunities to press ahead with public health perspectives.
- The enlarging of Europe and the creation of the single market present real opportunities to 'think European' on every aspect of public health: determinants of health; research; teaching; programmes of action.

Threats

- Archaic institutions that wish to control the new.

- The development of a rampant free market ideology overwhelming the social market consensus and possibly resulting in an abandonment of the commitment to equity.
- The ecological crisis and the continuing economic dedication to growth at any price.

Key Issues

Given that we have the health for all strategy as a mission and given the environment in which we are operating which in some ways is hostile to public health (pollution; anti-health forces, etc.) but in other ways is now very much in favour of a public health perspective, can we deliver the goods? There is an extensive menu of them. Public health practitioners have inputs to make on population and environmental questions, on lifestyles, on health care systems and on work, housing, transport, education, agriculture, energy and leisure.

There are not enough of us to go around. Each country and each region of each country needs to think strategically about how it is going to meet the needs for teaching, research and consultancy in all of the fields identified and not least to support the development of primary health care which underpins them. Collaboration and creativity are the keys to success. At the moment many of the players and organizations are issuing mixed messages. They talk participation, collaboration and decentralization but they practice prescription, competition and bureaucratization. It is normal for organization to follow task but at the moment we have an epidemic of schools of public health and often it seems to be for no better reason than the need for packaging. Ultimately people will want to know what is inside the package.

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