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NEW PUBLIC HEALTH AND WHO's NINTH GENERAL PROGRAMME OF WORK

A Discussion Paper

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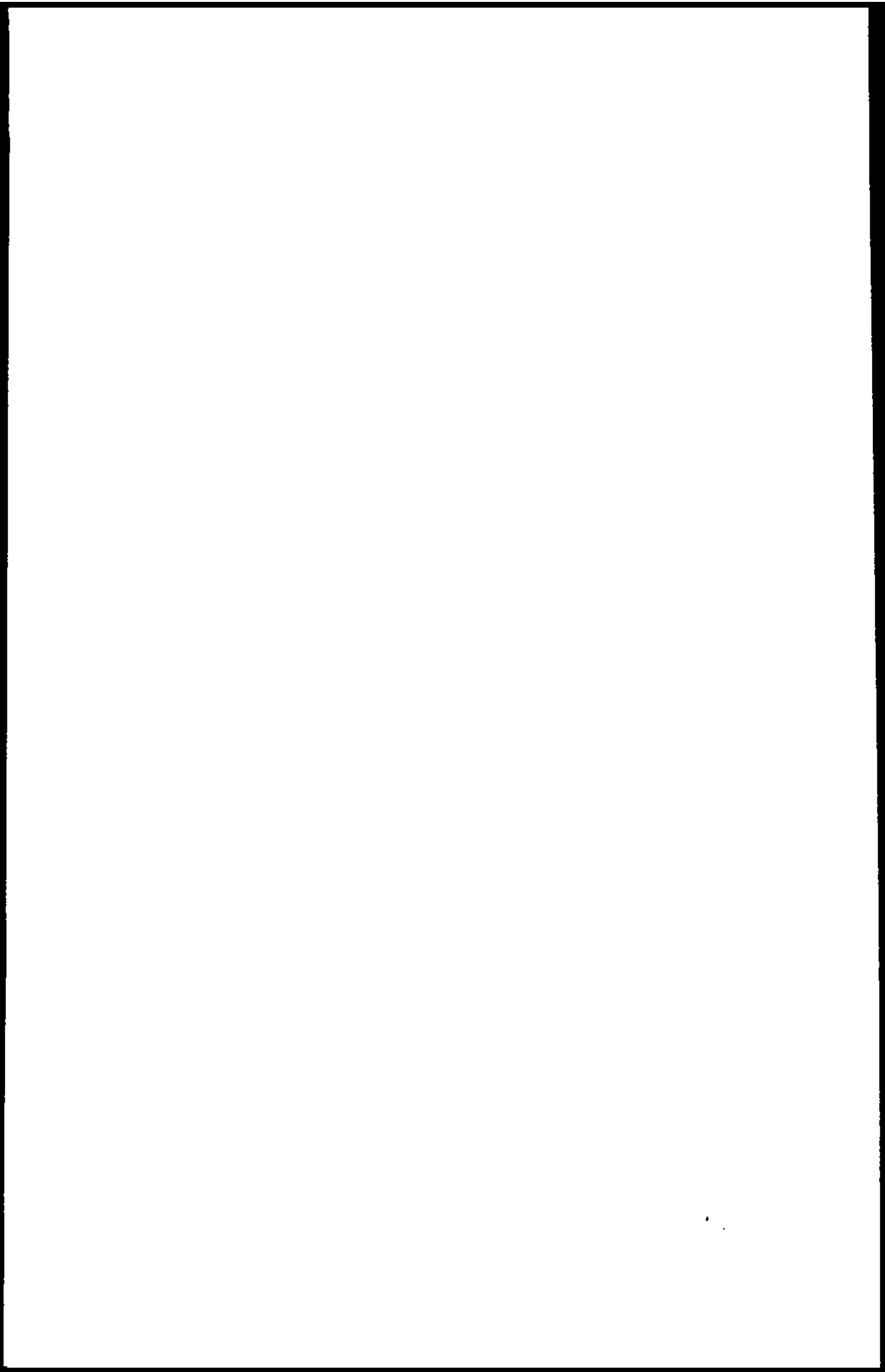

EXECUTIVE SUMMARY

The Problem

Notwithstanding the principles embodied in the Alma-Ata Declaration of 1978 and the "Health for All by the Year 2000" strategy initiated by the World Health Assembly in 1977, there has not been sufficient conformity with these principles to bring about the desired improvement in people's lives.

Other reasons include the pervasive misconception among health planners in many countries that good health is primarily a result of medical intervention and hospital services. Conversely, there has been a growing marginalization of public health (with which the WHO initiatives are often exclusively, though mistakenly, identified). In addition, there has been the problem of time lag between adopting the principles of Alma-Ata and HFA Strategies and relevant changes in curriculums of medical and other health-related institutions. Schools of public health have tended to reinforce the artificial separation between preventive and promotive services on the one hand, and other forms of health care on the other.

Then there have been the worldwide political, social and technological developments which have had an adverse impact on the implementation of Alma-Ata and Health for All principles. There have been significant changes in the economic capacities of the world nations, with some getting poorer, and others richer, and within many countries, a widening gap between rich and poor. Technological advances have been accompanied by an apparent contradiction between sustainable development and a sustainable environment.

Extreme poverty which currently afflicts over one-fifth of humanity has become the most ruthless killer and the greatest cause of suffering on earth. Women constitute the poorest fraction of the population, carry the risk of reproductive disease and death constitute the most illiterate segment, and occupy the lowest status in many societies.

Grave disparities in health conditions remain between and within countries. Health sector expenditure as a percentage of the national budget has declined steadily since 1970 in most developing countries, aggravated by growing national debts and structural adjustment programmes. These countries continue to endure the ravages of long-standing health

problems (e.g., diarrhoeal diseases), or emerging infections (e.g., HIV/AIDS), and re-emerging ones such as tuberculosis, malaria and drug-resistant pneumococcal pneumonia. Then, there are the threats of risk-taking behaviour such as smoking and alcohol abuse.

The costs of individual medical intervention have escalated but the state of health of the people has not improved in relation to expenditure and it has become urgent to revisit the whole question of how best to promote and ensure healthier nations.

The New Public Health and WHO's Ninth General Programme of Work

The New Public Health and the Ninth General Programme of Work (9GPW) are both premised on the principles of Alma-Ata and the Health for All campaign.

Many elements of the New Public Health are contained in the 1978 Alma-Ata Declaration, which reaffirms the WHO definition of health and its status as a human right, and which goes on to advocate "action by many other social and economic sectors in addition to the health sector" in order to achieve the goal of good health for all.

The New Public Health reaffirms those principles, and seeks to contextualize them in the light of contemporary realities and of lessons from he past. The 9GPW is WHO's blueprint for the operationalization of the New Public Health principles.

The New Public Health is concerned with a variety of issues which heave been associated with developmental stagnation in the public health arena. One of these is public health training which has largely become outdated and irrelevant. It is concerned with the health care issues of equity and social justice and improved access to health services. It demands a re-thinking of intersectoral action for health, that takes seriously the notion that health can be improved through improvement in social and environmental conditions. New Public Health takes a developmental approaches to health, whereby health is viewed as the goal and result of the activities of all national development sectors, and particularly the housing, local government, education, industry, agriculture, and transport sectors. It promotes stronger health programmes characterized by greater relevance to various development sectors such as school health,

housing and health, "healthy villages", "healthy food-markets", health in agriculture, health in workplaces/industry, "healthy municipalities", "healthy cities", etc.

Skills, including the ability to analyse the relationship between health and trade agreements, multinational negotiations, population shifts and increased global communication and technology transfer must be combined to address these complex issues. Is it necessary to develop a new category of public health internationalist? Are these the core skills for such a specialty?

Clearly, then, the New Public Health must concern itself with issues which fall outside the traditional concerns of the health sector. *The question is how – beyond advocacy, what can the health sector do?*

Today, the overwhelming concern is the cost of health care and the availability of resources. In developed countries. There is an urgent call for cost containment, if not reduction. In developing countries. There is pressure to raise or even sustain the modest sums needed to provide minimum health care. In all countries, there is tacit understanding that is unlikely there will be substantial new funds coming into the health sector.

The New Public Health has a vested interest in the financing of health care, in possible public and private sector cooperation, and in ensuring good value for money. It is concerned with the equitable sharing of resources between curative, preventive and promotive health care.

The New Public Health is not so much a concept as it is a philosophy which endeavours to broaden the older understanding of public health (so that, for example, it includes the health of the individual in addition to the health of populations), and seeks to address such contemporary health issues as are concerned with equitable access to health services, the environment, political governance and social and economic development. It seeks to put health into the development framework to ensure that health is protected in public policy. Above all, the New Public Health is concerned with **action**. It is concerned not only with finding a blueprint to address many of the burning issues of our time, but also with identifying implementable strategies in the endeavour to solve those problems.

1. The Origins and Evolution of Public Health

1.1 Introduction

1. Despite the timeless definition of health in the WHO Constitution as «a state of complete physical, mental and social well-being and not merely the absence of disease», health is too often narrowly interpreted in the context of curative medicine (often described – perhaps rather presumptuously – as «modern scientific medicine»).

2. It was McKeown's[0] research which underscored the important observation – unsettling to curative traditionalists – that mortality from infectious diseases such as tuberculosis, bronchitis, pneumonia and influenza, whooping cough, as well as food and water-borne diseases had already begun to plummet before effective immunization and treatment had become available. To be sure, medical intervention subsequently also made a contribution to the decline, as when antibiotics started to be used to treat tuberculosis, the measles vaccine, and surgery for appendicitis. Nonetheless, after analysing the factors governing population trends in England and Wales between the years 1801 and 1971, McKeown concluded as early as 1976 that «past improvement (in health) has been due mainly to modification of behaviour and changes in the environment, and it is to these same influences that we must look for further advance».[1]

3. Despite the pledge by the world to promote good health for all along the principles as embodied in the Alma-Ata Declaration of 1978, and the «Health for All by the Year 2000» movement initiated by the World Health Assembly in 1977,[1] there has not been sufficient conformity with these principles to bring about the desired improvement in people's lives.

4. The New Public Health movement and the Ninth General Programme of Work[2] of WHO are largely concerned with a renewed commitment to, and implementation of, these basic principles. This document is intended to serve as a basis for discussion leading to a clearly enunciated and widely accepted definition of public health, the core public health functions, the education and training relevant to these functions, and strategies for action at all levels.

1.2 The historical perspective

5. In November 1952 the WHO Expert Committee on Public Health Administration[3] adapted Winslow's 1923 definition of Public Health[4] to include mental as well as physical health, as:

   «the science and art of preventing disease, prolonging life, and promoting mental and physical health and efficiency through the organized community efforts for the sanitation of the environment, the control of communicable infections, the education of the individual in personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of disease and the development of social machinery to ensure to every individual a standard of living adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realize his birthright of health and longevity.»

6. The second meeting of this Expert Committee in 1953 discussed Methodology of Planning an Integrated Health Programme for Rural Areas.[5] It defined the services necessary for the health protection of a given area. These services, which it called «basic health services» included:

   - maternal and child health
   - communicable disease control
   - environmental sanitation
   - maintenance of records for statistical purposes
   - health education of the public
   - public health nursing
   - medical care.

7. Though the definition of public health did not specifically include curative services, they were included among the basic health services.

8. In a review of basic health services in 1963 it was found that they were «in a serious state of fragmentation, unresponsive to community needs and dysfunctional».[6] Dissatisfaction and concern over the situation provided the impetus for the search for solutions which later became embedded in the health-for-all initiative. Primary health care, defined as the strategy for achieving health for all (HFA), absorbed the elements of basic health services but stressed community participation and political will as additional criteria for action.

9. The fact that there has been no call to revise the 1952 definition of public health can be interpreted as evidence of its comprehensiveness and farsightedness. Even the United Kingdom[7] preparing for its own response to health for all, felt it was sufficient to paraphrase the original as: «the science and art of preventing disease, prolonging life and promoting health through the organized efforts of society».[8]

10. It is also possible that in the intervening years we were too taken up with great advances in the knowledge base of the different public health disciplines, by breakthroughs in analytical methods, by the primary health care/health-for-all debate to recall the broad-based definition, though they have all contributed to expanding our understanding of public health.

11. In recent years, global events such as the United Nations Conference on Environment and Development, Rio de Janeiro, 1992, the International Conference on Population and Development, Cairo, September 1994, the World Summit for Social Development, Copenhagen, March 1995, and the Fourth World Conference on Women, Beijing, September 1995 have each in its way emphasized the need for human health to be the central concern in striving for sustainable development.

12. New public health will incorporate these and other developments which will certainly shift the balance between different existing elements of basic health services, emphasizing intersectoral action and new partnerships for health, rather than introduce something radical.

13. It is reasonable to assume that some form of public health was already practised in ancient civilizations. For purposes of this paper, however, we shall adopt Ashton and Seymour's[9] position that modern public health evolved in three phases in developed countries. The first phase occurred (at least in Great Britain) in response to the squalor and overcrowding resulting from lack of adequate housing, food and potable water which characterized the fate of the recently urbanized masses following the mass migration from the countryside to the cities some 150 years ago. The causes for this migration were predominantly the agricultural revolution which diminished the need for manual labour, and the industrial revolution which tended to draw large numbers of the poor to the cities. The very first official public health initiatives consisted of the appointment of medi-

cal officers of health, sanitary inspectors, and the passage in some localities of appropriate public health laws, such as the Liverpool Sanitary Act of 1846. This phase of public health was directly concerned with environmental issues (environmental phase) – sanitation, clean water, clean cities. As can be inferred from McKeown's work,[1] this environmentally oriented public health initiative was, in fact, eminently successful, especially in developed countries.

14. Then, with the development of the theory of germs in the 1870s, and when new possibilities seemed to emerge from the introduction of novel immunization and vaccination practices, public health shifted into its second phase – the **individualistic phase**. Public health attention shifted from being concerned with the environment to dealing with groups of persons. Simultaneously, school health services were introduced. Community health projects – vaccination, family planning, etc. – were first established in Liverpool. At this time, government also began providing hospitals and social welfare.

15. The third phase, the **therapeutic phase**, was ushered in by the discovery of therapies such as insulin and the sulfonamide group of drugs in the early 1940s. This gave rise to a tremendous increase in individual therapeutic intervention, and a great faith in the new technical and scientific approaches. The trend was also facilitated by the success of «old-fashioned» public health which, by reducing the prevalence of infectious diseases, had in fact weakened the case for substantive public health support by government. There was a shift of power and resources from community-based environmentally-oriented preventive programmes to hospital-based curative services, which was further entrenched by the development of cure-based academic hospitals. This course intensified in line with scientific and technological developments in medicine. This dominance of therapeutic medicine with its large investments and costs invariably paved the way for the dichotomy between the urban and rural and the rich and the poor. To be sure, communities still had to contend with a variety of public health threats during this third phase, but as long as such threats did not directly impinge on the health of the governing elite, they did not receive as much political attention as those public health hazards that were capable of penetrating the upper classes such as the Victorian cholera epidemics and, more recently, HIV/AIDS.

16. It was this focus on therapeutic intervention which gradually gave rise to the «pervasive myth that good health is primarily the result of

medical intervention and hospital services, and to a growing lack of real understanding that health is governed by, and a reflection of the social and living conditions of the community»[9]. And because therapeutic intervention purports to offer instant and individual gratification to patients, providers and the politicians, as opposed to the purported long-term benefits of preventive health which may or may not materialize, cure-based medicine also finds greater favour with less well-informed societies. In addition, the emphasis on curative medicine is reinforced by the growth of the medical/pharmaceutical industry and medical associations that have a powerful influence on governments.

17. The costs of individual medical intervention have escalated around the world but the state of health of the people has not improved in relation to expenditure, and it has become urgent to re-visit the whole question of how best to promote and ensure healthier nations. We have already referred to McKeown's research and conclusions in the mid-1970s that health improvement can best be attained by behavioural modification and environmental change. About the same time, Marc Lalonde, then Canadian Health Minister, published a document entitled «A New Perspective on the Health of Canadians» which asserted unequivocally (as cited in Ashton) that a great deal of premature death and disability in Canada was preventable. Some epidemiologists scoffed at Lalonde's document as «epidemiology going wild and losing its medical and scientific basis». Nevertheless, this publication arguably «signalled the turning point in efforts to rediscover public health in developed countries and ... ushered in a new, fourth phase of public health», the New Public Health.

1.3 Thinking «Upstream»

18. Ashton and Seymour[9] recount a parable in which health workers are equated to life-savers standing beside a fast flowing river. Every so often a drowning person is swept alongside. The life-savers dive in to the rescue, retrieve the «patient» and resuscitate him. Just as they have finished, another casualty appears alongside. So busy and involved are the life-savers in all this rescue work that they have no time (or perhaps have not come upon the idea) to walk upstream and see why it is that so many people are falling into the river. What is necessary, it is argued, is to refocus upstream, and what is needed generally among health workers is more «upstream thinking». Depending upon one's perspective, one may be inclined to think that it

is the people themselves who are jumping in and that their sickness is their own fault; that they are being seduced or pushed into the river; or that they are the victims of genuine accident or act of fate. Whatever one's thoughts, Ashton and Seymour conclude that «it is no longer enough to claim immunity from thought by virtue of being a lifesaver». The recommitment to the «new» Public Health movement is about going upstream to investigate and, where possible, intervene.

1.4 The WHO origins of the New Public Health

19. Many elements of the New Public Health are contained in the 1978 Alma-Ata Declaration,[10] which reaffirms the WHO definition of health and its status as a human right, and which goes on to advocate «action by many other social and economic sectors in addition to the health sector» in order to achieve the goal of good health for all. The Declaration further refers to the unacceptability of «the existing gross inequality in the health status of the people» or lack of equity between developed and developing countries and within countries. It sees the promotion and protection of the health of the people as essential to sustained economic and social development. It places on the governments of the world the responsibility for the overall health of their people, and sets the goal of «the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life», with primary health care (PHC) as the principal vehicle for attaining this goal. This is the first time that the purpose of health has been defined. It also sets a standard below which a basic human right – the right to health – has been infringed.

20. The Alma-Ata Declaration was affirmed at the highest WHO level the following year,[11] and again two years later when the Global Strategy for Health for All by the Year 2000 (HFA/2000) was adopted as policy by the Thirty-fourth World Health Assembly in 1981.[12] Later it was endorsed by the United Nations General Assembly. Since that time, WHO has served as advocate around the world on this subject and has, since the beginning, continued to promote the principal pillars of good public health, namely: equitable access to effective care, health-friendly public policy based on community participation, and intersectoral collaboration, all of which constitute important elements of the New Public Health. These elements are also emphasized in the 1980 Ottawa Charter for Health Promotion which,

in its subtitle «Moving towards a new public health», was one of the first WHO documents to explicitly use this term. Other objectives underlined in the health-for-all strategy encompass three crucial principles: promotion of life-styles conducive to health, prevention of preventable conditions, and rehabilitation, all of which are priorities of the Ninth General Programme of Work and the New Public Health.

1.5 The Saitama Summit and Declaration

21. Notwithstanding the idealistic intentions of numerous WHO declarations and pronouncements culminating in the HFA/2000 strategy, public health worldwide was not achieving all the intended goals when the Saitama Public Health Summit was convened in Omiya City, Japan, in September 1991. Part of the explanation for this were economic factors, identified by Dr H. Nakajima, Director-General of WHO, in his opening address as «vagaries of the world economy (which) have resulted in many developing countries facing not only recession but debt crises»[13]. Saitama brought into the foreground the importance of the finiteness of health resources in the HFA/2000 strategy, and the necessity to plan within those constraints.

22. While declaring its commitment to the standard positions of WHO through Alma-Ata, the Summit also conceded that the failures of the past were in part due to unfavourable economic realities.

23. In his opening address, the WHO Director-General drew an important link between the classical concept of public health versus medical care, saying: «There are two fundamental issues in health for all: the first is health for all people, and the second is health for the individual during his or her entire lifetime»[14]. The argument was developed that the «new» public health takes into account all of health, including preventive and curative services. At the same time it is important to recognize the differing health needs of people throughout the human life cycle from infancy to old age.

1.6 The «New» Public Health – a Renaissance

24. The concept of the «New Public Health» is a comprehensive one, combining all of the new issues that have emerged since HFA/2000. Therefore, attempts to define it have become like the legend of a group of blind men from Hindustan trying to describe an elephant – each according to the side of the creature in closest proximity.

25. Goldstein[10] describes the New Public Health as «the idea that living conditions (physical, social and economic environment) are the main determinants of health. Health services are important, but New Public Health focuses on changing the determinants rather than providing treatment for the sick. What is new about the New Public Health is that it takes seriously the idea that determinants can be modified and develops and implements a practical workplan to do this.» This challenging definition must nevertheless be read within the context that, first: there are only so many resources that can be devoted to health *in toto* and, second: that setting the priorities as to how much should be spent on «the determinants» and how much on «treatment for the sick» is the dilemma. What proportion of the available resources should go into «spring protection» to shield rural water sources from contamination, and what proportion to treat those children already with diarrhoea?

26. However, available resources should not be regarded as limited to those possessed by the health sector. Intersectoral work involves promoting a health component in housing, schools, workplaces, etc., that is part of the work of non-health development sectors. For example, education authorities are or should be responsible for school health programmes.

27. Liverpool University's Ashton and Seymour[9] are more comprehensive in their description which states: «the New Public Health brings together environmental change and personal preventive measures with appropriate therapeutic interventions, especially for the elderly and the disabled». They then go on to add that «Many contemporary problems are therefore seen as being social rather than solely individual problems, underlying them are concrete issues of local and national public policy, and what are needed to address these problems are «Healthy Public Policies» – policies in many fields which support the promotion of health. In New Public Health, the environment is social and psychological as well as physical».

28. Macedo of the Pan American Health Organization sees New Public Health[14] as representing the fact that «the health field, at least theoretically, has been freed from its totally subordinate relationship to medicine. I believe that public health has created its own space (even though this space may not yet be receiving adequate priority or attention), and although our work does include a consideration of what medicine and medical care can do, we are no longer in a subordinate position to medicine either conceptually or operationally.»[10]

This raises the question whether public health should be in competition or in alliance with curative health care. There are major reasons why alliance is the correct answer, including that the greatest insights into what are the determinants of health – and the causes of injuries and diseases – are held by the staff of health facilities and hospitals.

29. In an editorial entitled «What's new in public health?» the Lancet[15] pointedly claims that «public health has been enjoying a renaissance», a return to Winslow's and WHO's definition as paraphrased by Acheson as «the science and art of preventing disease, prolonging life and promoting health through the organized efforts of society».[8] Again, it is a description which is comprehensive. The editorial's «side of the elephant» is the environment. And so it sees as New Public Health's most unique aspect: «seeking to recognize the environmental impact of public health interventions and to propose public health solutions that sustain local and global ecosystems». The editorial continues by describing «sustainable development» for us as: «improvements in health standards are genuine only when resources used in their achievement can be renewed».

30. However, this rosy view of New Public Health is not universally shared. Writing in the *British Medical Journal* from a traditional Department of Clinical Epidemiology at the University of Leiden, Vandenbroucke[16] sneers: «There is a discipline in medicine that over the past 200 years has been known by various names ... Its newest incarnation proudly calls itself «the new public health». In his view, New Public Health is simply a repetition of old rhetoric, and should be regarded with skepticism by «those departments of public health and community medicine that believe that good science should be the basis for public health action». He does not reveal whether and how often public heath action is taken as a direct consequence of the academic deliberations of departments of clinical epidemiology.

31. It is quite clear that attempts to define Public Health or New Public Health will continue to raise passions and draw controversy. *The crisis of public health: Reflections for the debate*[15] gives a good range of the diverse positions. Some authorities go so far as to reject the idea that public health can have any dealing with the individual (Köhler paper presented at the St Petersburg Forum on Public Health, 22–25 June 1995)[17] and Frenk[18] who defines it as the study of health phenomena in human populations. In his context it is the level of analysis (populations) rather than the topics under analysis which defines public health.

32. *How should new public health ideally be defined? Will new public health be always like the «elephant» to «the blind men from Hindustan» each seeing only his part but never the whole?*

33. *Could it be that we are approaching the issue from a wrong perspective? Are we over-compartmentalizing and over-prescribing? Are there not numerous preventive and promotive interventions directed at the individual? And do individual curative interventions not have any impact on public health? After all, our concern is «health» and the health status of people and nations. In this instance, health status not only «reflects conditions within the health system but perhaps more the benefits of the social, economic and physical environment.*[19]
By using health status, would it allow us to organize our responses according to the real problems, no matter what sector they emanate from? Is this not the essence of intersectoral action for health? Is this ultimately the essence of new public health?

2. Health-for-All Strategy – Gains and Gaps

34. The adoption of the goal of health for all also required that progress in its implementation be monitored. There clearly are problems. The third report of the health for all strategy on monitoring[20] says that «Quantitative information on indicators was critically affected by two factors: insufficient returns from the countries, and insufficient processing of information at regional level. As a result, the information on many indicators ... was insufficient to enable the calculation of reliable global estimates ...». In fact, most of the 1994 calculations of indicators were based on data sources from outside WHO. Within these constraints, it is still possible to identify gains and gaps in the implementation of HFA/2000.

2.1 Gains and gaps

35. In his official annual report on the state of world health entitled «The World Health Report 1995»,[21] the Director-General reports that life expectancy increased overall, although it stagnated -and may soon even regress – in some least developed countries. The overall immunization levels of 80% or better were achieved for the five most frequent childhood infections. However, deep pockets of unimmunized children remained, so that measles still killed more

than 1.2 million children annually. Polio edged closer to eradication, but then again there were parts of the world where no data was forthcoming. Infant mortality improved globally, as did the mortality of children under age five, and control of diarrhoeal diseases has made steady progress.[22] Here again, conditions in some specific counties have deteriorated.

36. Grave disparities in health conditions remain between and within countries. Health sector expenditure as a percentage of the national budget has declined steadily since 1970 in almost all but the industrialized countries, reflecting world economic decline generally; the deleterious effect of gigantic national debts; and structural adjustment programmes that have entailed a shift in government spending from «social» to «productive» activities[13]. However, it has also been a question of priorities, since, while defence spending has decreased overall in developed countries, it has increased in some developing countries during that same period.

37. The World Health Report highlights some new and continuing threats to health. Diarrhoeal diseases continue to be a major killer of infants and children. Then there are the new as well as re-emerging infections: HIV, tuberculosis, malaria, drug-resistant pneumococcal pneumonia, and cholera, to name but a few. Risk-taking behaviour continues to be an increasing global problem: HIV and tobacco causes of death are a large contribution to increasing mortality worldwide. From a health status point of view, it is crucial to prioritize large threats that are growing but amenable to intervention, versus smaller threats (e.g., poliomyelitis/leprosy) that are already on the decline. Women and children continue to be severely disadvantaged in many parts of the world.

38. But it is the discrepancy between the best and the worst that is so striking. More than one-fifth of the world's population or over 1.1 billion live in extreme poverty. In one of the most developed countries, life expectancy is 78, and in one of the least developed, 43 years. Per capita health expenditure ranged from US$ 2765 to US$ 3.[23]

39. The problems that stubbornly resist improvement relate to poverty, malnutrition, poor prioritization of health and development policies, allocative and technical inefficiencies and other aspects of socioeconomic deprivation.

40. The Director-General of WHO refers to the gravity of «the scale of the global human tragedy», and concedes that, in this context, «I am the bearer of bad news».[24]

2.2 WHO's advocacy role

41. Taylor[25] notes that «despite WHO's oft-noted bureaucratic inefficiencies in administering the (HFA) programme, (WHO's) influence has resulted in the wider extension of primary health care services», and has «fostered a rethinking of the role of public health internationally, and, at least at some level, nationally.»

42. Taylor compliments WHO for stimulating a growing awareness of the interrelationship between health and development. WHO has cultivated widespread consensus from Sweden to Swaziland and Australia to Algeria behind the primary health care paradigm, and UNICEF officials, for instance, acknowledge that UNICEF's impressive accomplishments were HFA-inspired. The failure of monitoring is the failure to link health monitoring with the activities of the many development sectors that contribute to it, in other words, to demonstrate the linkages between health and development. Solid information about the health burden is a pre-requisite for investment in actions by relevant development sectors in order to address health and environment issues. In most countries, responsibility for health statistics and epidemiological work belongs wholly or partially to the ministry of health, with important contributions often coming from universities. Such work includes:

    - monitoring health status in relation to environmental conditions and indicators;
    - making an analysis of the impact of development activities of all relevant sectors on health status.

Unfortunately, sufficient capability to fulfil these functions is all too often absent. Also, the conventional ways of monitoring health do not suffice, as they involve data collection and analysis for the apparent purpose of production of national (or generally aggregated) statistics that bear little or no relationship to any causal factors. (For example, a health statistics report may provide information such as the infant mortality of country X is 50 per 1000 live births.) It can be argued that one reason for the failure of intersectoral action for health is that the health authorities have little or no say in development sectors such as housing, agriculture and industry. Thus the

statistics they bring to the table – as, for example, at an intersectoral meeting on environment and development issues – have no analysis of how these sectors impact on health, or what the impact of addressing preventable environmental factors might be. However, studies are increasingly being undertaken that demonstrate links between health and environmental conditions that are modified and (are modifiable) by the work of various development sectors. The HEDLAMP project within WHO is developing guidelines for undertaking various types of linkage studies. One type of study is «intra-urban» differences, whereby huge disparities are demonstrated between different areas within a city, and a link to environmental factors becomes apparent even to urban managers without epidemiological training. Undertaking such a study can provide a powerful impetus to improvement in urban services and conditions in deprived areas. For example, a city with an infant mortality rate of 30 will often be found to consist of many households where the rate is 60, and somewhere it is 10 to 20. Another type of study that can provide useful linkages is a household survey that studies both the environmental conditions in a sample of houses and a range of health and social factors of the inhabitants. Finally, a small number of countries such as the USA and Australia have undertaken national studies on the health burden of disease, with analysis of all the preventable causes. Such analysis is helpful in making clear the responsibilities of various development sectors in improving health, and to provide a basis for actions.

43. Taylor[26] argues that WHO should use potential leverage «through its organizational legitimacy» to influence Member States' policies. WHO should apply all the methods acceptable to it, to promote the right to health as enunciated in the Universal Declaration of Human Rights: «... act as a catalyst for change by propelling practical implementation of HFA through appropriate international and national public health law and effective supervisory institutions». In other words, WHO should lobby for HFA/2000, lobby for the enactment of laws and adoption of conventions that **champion, protect and enforce the right to health** as a human right, and then use every available means to put non-compliant Member States under moral pressure to comply.

44. Taylor continues: «It is apparent that the international declarations and conventions that address the right to health have thus far proven inadequate to ensure effective execution» of such declarations. Part of the reason for this has been the indeterminate norms or vague-

ness with which the right to health is described. Says Taylor: «WHO has frustrated the full potential of the HFA campaign by not using its constitutional powers to encourage states to develop international law that details national obligations pursuant to the right to health.» Like other agencies such as the United Nations Environment Programme (UNEP), the International Maritime Organization (IMO) and the International Labour Organisation (ILO), WHO should strive for the adoption of specific internationally developed standards with regard to HFA/2000 and the right to health, and of mechanisms to monitor compliance, such as auditing procedures.

45. In summary, the results of the HFA/2000 campaign so far have been mixed: indicators have not been defined and effective systems for monitoring the indicators not been developed with the result that efforts to pursue HFA/2000 have not been sufficiently vigorous.

46. However, mechanisms already exist in WHO for joint action by all Member States through resolutions of the World Health Assembly. Concerns over compliance by Member States of these collected decisions have been raised.

47. *Does it imply a failure on the part of the Organization to demonstrate that these monitoring exercises are not mere bureaucratic exercises but are relevant in measuring the success of a country's own efforts and investments?*
How could data and information gathering be improved?
How should WHO strengthen the commitment of its Member States to act in compliance of resolutions that have been collectively adopted?

3. New Public Health – Opportunities and Treats

3.1 Global political considerations

48. In recent years the world has witnessed profound political changes including the end of the Cold War; the assertion of new national identities and sovereignties; civil wars; the yielding of power by, or wresting of power from military and other dictatorial regimes; and an almost universal quest by people of the world for a greater say in

the conduct of their own affairs – in short, democratization. There have been significant changes in the economic capacities of the various countries of the world, with some poor countries getting poorer, others rising out of their economic ashes like the phoenix, and the rich richer.

49. These changes have brought with them extraordinary opportunities – but also potential problems and threats – for development and progress. Here, we look at five of Macedo's concerns.[27]

    (a) **The «New World Order»:** The first threat has to do with the emergence of the so-called New World Order which refers in essence to the reorganized international political and economic relationships. This realignment of political and economic forces, and the resulting competition for world markets, presents great opportunities for the economies of the Third World. At the same time, this New World Order poses «a tremendous risk: that the less developed countries of the world may fall even farther and more irretrievably behind in their ability to compete with the world economic power centers». The Report of the WHO Commission on Health and the Environment presents six environmental issues that have transboundary and international implications: long-range transport of air pollutants, transboundary movement of hazardous products and wastes, stratospheric ozone depletion, climate change and ocean pollution. These issues have the potential to affect large populations. Actions taken with regard to them in one political jurisdiction will almost certainly affect other jurisdictions. They are all issues which require international cooperation and an understanding of the international health impacts. Growing interdependencies and increasing globalization in terms of the transfer of industrial and communications technologies, new trade agreements that facilitate the movement of goods and services and a greater refugee population demand additional emphasis on international health issues. Skills, including the ability to analyse the relationship between health and trade agreements, multinational negotiations, population shifts and increased global communication and technology transfer must be combined to address these complex issues. *Is it necessary to develop a new category of public health internationalist? Are these the core skills for such a specialty?*

    (b) **Science and technology:** Because of the tremendous growth and development in technology and its central role in the mod-

ern fabric of developed society, poorer nations may not be able to position themselves effectively within this set-up, and Macedo sees the danger that «in addition to ... the more advanced countries' economic predominance through the domination of markets and forms of production (there is the potential for) technological and scientific predominance, so pervasive and extensive that **past forms of predominance and domination may pale in comparison**»

(c) **Nationalistic/ethnic/religious conflict**: Notwithstanding the world trend towards globalization and the formation of great economic and political conglomerates, there is definite resurgence of militant national consciousness based on ethnicity, religion or both. These localized fragmentations and resulting civil strife are in danger of depleting the resources that might otherwise be used for health-related activity, and of causing socioeconomic disruption inimical to the New Public Health movement. Certainly, there is not a shortage of examples of this kind of problem in today's world.

(d) **Growing disparity between rich and poor**: specifically targeted in the Declaration of Alma-Ata is a problem not only between countries, but also within countries. «This inequity constitutes perhaps the greatest existing threat to the human race and to civilization as we know it, because it is **impossible** (Macedo's emphasis) to conceive of a world living in peace and in continuous development when three-fourths of humanity have no access to the benefits of that development».

(e) **The environment and sustainable development**: Macedo sees environmental awareness as posing «a series of dangers for those countries that have not yet arrived at the banquet table of progress». Poorer countries need to use their natural resources in order to support their development, which may be in conflict with the global trend of nature conservation, spearheaded by the more developed countries. Macedo says it is going to be virtually untenable to forbid poorer countries from developing their natural resources for their own progress and needs, just so «that the populations of the North might be able to breathe pure air»!

50. This is a particularly significant issue in the light of the perception by some that the New Public Health has not resolved the potential conflict between sustainable development on the one hand, and a

sustainable environment on the other. People in the developed world consume natural resources at a rate 10-20 times that in the developing world.[28]

3.2 Development, health and the environment

51. The environment is another area of opportunities and threats which is repeatedly mentioned *vis-à-vis* the new public health movement. Chapter 6 of Agenda 21 of the Rio Summit states that «Health and development are intimately interconnected. Both insufficient development leading to poverty, and inappropriate development leading to overconsumption coupled with an expanding population, can result in severe environmental health problems in both developing and developed nations».

52. Again on this subject, the **Lancet** editorial[16] had this to say: «Public health thinking is moving into a third phase by seeking to recognize the environmental impact of public health interventions, and to propose public health solutions that sustain local and global ecosystems. Environmental health acknowledges the interdependence of ecosystems and health systems, and fosters concepts of «reciprocal maintenance» (i.e., we should look after the things that look after us) and sustainable development (i.e., improvements in health standards are genuine only when resources used in their achievement can be renewed)».

53. WHO has also acknowledged that the environment is an area of major public health endeavor. For example, of the 38 «focus targets» of the WHO European Regional Office, or things to be done in relation to health for all by the year 2000, eight are directly concerned with the maintenance of healthy environments.

54. Under the Seventh General Programme of Work,[29] WHO targeted rural and urban development and housing. Subsequently, WHO intensified its advocacy role regarding the environmental aspects of housing and urbanization by publishing important guidelines and sponsoring seminars on housing, urbanization and health in cooperation with other agencies such as UNEP, Habitat and the World Bank. All in all, there is hardly an area of environmental health or hazard in which WHO has not been constructively engaged, and continues to be active.

55. Changes in the ecosystems and the resultant relationships with human beings have been an important link in the emergence of new infectious diseases, as well as the geographical colonization of pathogens in parts of the world where they have not been previously reported. Today, environmental considerations are no longer constrained to the protection of physical health. Aesthetic, psychological, and social considerations are now considered part of the ecological dimension that must be factored into any decision regarding the environment versus health equation.

3.3 Population and gender issues

56. The 1994 International Conference on Population and Development highlighted the disturbing questions regarding the impact of continuing demographic growth on poverty, food supplies and the capacity of the earth to withstand the impact of human consumption as numbers multiply. Even more worrying was the fact that the fastest growth occurs in those parts of the world which are the poorest and economically the most fragile.

57. As stated in the World Health Report, unbridled population growth will «strain to the limit the ability of the social, political, environmental and health infrastructures to cope»,[30] the same view has been expressed in numerous WHO documents and in the Saitama Declaration.

58. At least these are the conventional views. There are equally legitimate voices to the contrary, which say that we are dealing here with the chicken-and-egg situation, and that those who blame poverty on population growth confuse aetiology with symptomatology. They argue that demographic shifts are a consequence, not the determinants of the state of wealth of a nation. Certainly, the Malthusian prediction that population growth, if unchecked, would outstrip food production has proved to be false. Today, the food shortages are due more to the problem of distribution than the actual lack. Paul Ehrlich's dire predictions of world shortages in his 1960s book «The Population Bomb»[31] have singularly failed to materialize. However global warming and climatic change, with implications for food production, is becoming increasingly apparent.

59. At this point in history, no country's prosperity can be demonstrably attributed to successful population policies. However, sharp moderation in population growth can be demonstrably attributed to pros-

perity (so the argument goes) in such Roman Catholic countries as Italy, France and Ireland. Finally, just about every one of humanity's «great leaps forward» (such as the Industrial Revolution) occurred precisely during times of population expansion, though one must note that the control of mortality was not similar to what it is now. It is important to note that we are talking here about population control, not about family planning *per se* whose benefits for the individual woman and/or family are beyond doubt.

60. Wherever the philosophical veracity of this debate may lie, there is no doubting the fact that once there are too many people in relation to the available resources, the infrastructure is going to be overwhelmed. Sustainability of services must in the long run and to a large extent depend on a balance between supply and demand.

61. The world's most ruthless killer is extreme poverty. (Ref: World Health Report, 1995.) And it has over one-fifth of humanity in its grasp. Poverty is highlighted in the *World health report* as a mean and pernicious condition, which gets meaner and more pernicious where women are concerned. Women constitute the poorest fraction of the population, risk reproductive disease and death, do the most menial of tasks, receive the lowest wages, constitute the most illiterate segment, and occupy the lowest status in many societies. Both WHO and the United Nations have targeted the area of issues of gender in health. WHO established the Global Commission on Women's Health which drew up a comprehensive agenda for action on women's health. Women's issues received attention at the Saitama Summit on Public Health, the International Conference on Population Development, and at the World Summit for Social Development and, most recently, at the Fourth World Conference on Women.

62. According to a World Bank publication,[15] «the education of females is so important to health improvement that it merits special attention in any reformulation of health policies that aim to improve health outcomes rather than solely improving the delivery of health care services». Educated women reproduce later, survive childbirth better, take better and more informed care of their children, and have lower child mortality rates.

63. Clearly, then, the New Public Health must concern itself with the issues of education as well as many others, which fall outside the traditional concerns of the health sector. *The question is how – beyond advocacy, what can the health sector do?*

64. Today, the overwhelming concern is the cost of health care and the availability of resources. In developed countries there is an urgent call for cost containment, if not reduction. In developing countries, there is pressure to raise or even sustain the modest sums needed to provide minimum health care. In all countries, there is tacit understanding that it is unlikely there will be substantial new funds coming into the health sector.

65. As a result, there is a ferment of change and reform in the health sector in the search for better value. Improvement of management within the health system is often recommended and there is great interest in expanding the private sector and payment by the consumer. In the United States, the rise of health maintenance organizations (HMOs) has coincided with the use of family practitioners, and nurse practitioners and radical changes in the way care is provided. Priorities are being redefined in this relentless rationing of resources. Quality of care and equity may become the casualties unless vigilantly protected. A clear set of ethical principles supported by proper policies would help decision-making and prevent the setting of priorities from becoming a purely budgetary exercise.

66. For developing countries, the World Bank is advocating the use of clinical packages of services which would be efficiently provided by nurses in addressing priority health problems.[32] Priorities can only be as good as the data from which they are identified and there is a great need to improve the process of setting of priorities in developing countries.

67. What are some of the priorities for attaining health for all?
What are the basic ethical tenets that might help us to make better decisions?
Are there universal ethical principles that transcend national boundaries and culture?

4. New Public Health and the Ninth General Programme of Work

4.1 Introduction

68. The Ninth General Programme of Work[33] (9GPW) is the third in a series of General Programmes of Work since the adoption of the health for all by the year 2000 (HFA/2000) resolution.[34] Its functions are to define the policy framework for world action in respect of HFA/2000 during the period 1996 to the year 2001, and to set the framework for programme development and management for WHO itself during this period.

69. The 9GPW establishes the global policy framework for action by the world health community, as well as the framework for WHO's own work in supporting countries to improve their health systems and their people's health, with particular emphasis on the countries in greatest need.

70. Four interrelated **policy orientations** have been identified for focusing action by the world health community and WHO in order to reach specified goals and targets (summarized later on in this section), and to address priority health development problems in the context of specific conditions in each country. The four policy orientations, which form the framework for the rest of this chapter, are:

    (a) integrating health and human development in public policies;
    (b) ensuring equitable access to health services;
    (c) promoting and protecting health;
    (d) preventing and controlling specific problems.

71. These policy orientations fit in well within the contexts of both the HFA/2000 strategy, and the new public health.

4.2 Public policy, equity, and social development

72. The purpose of development is to improve the quality of life (and therefore health) of the people. On the other hand, optimal development itself requires healthy people and a healthy community.

Therefore it is essential that national policy on development takes into account this intermutuality. Health, in this context, is defined in terms of the definition in the WHO Constitution as previously cited. «Development» is defined according to the World Federation of Public Health Associations' 7th International Congress as «the process of improving the quality of life through changes that result in: (1) higher standards of living; (2) increased purchasing power; (3) greater political participation; and (4) access to basic goods and services».

73. The concept of integrating health and development in public policy also encompasses the idea of **social justice** in the setting of national priorities and allocation of resources; and social justice is closely linked with the concept of social and economic equity. The 9GPW acknowledges that greater national wealth alone will not guarantee an improved health status for the people. Such national wealth also will not guarantee that poverty, one of the major determinants of ill health, will be ameliorated. Indeed, major studies from two indisputably wealthy countries, the United Kingdom (Scotland)[35] and the Netherlands,[36] show that socioeconomic disparities exist even within these countries which translate into poorer health and increased mortality among the disadvantaged classes. There is disagreement as to whether the increasing differences in mortality between the rich and the poor are due to growing inequalities in income, or to increased behavioural risk factors among the poor. However, evidence gathered in the United Kingdom would seem to point to income differences as the culprit (although one rather suspects that it is considerably easier to embrace a lifestyle of reduced behavioural risks, to eat sensibly and not become a prostitute, if you are sufficiently well-off to be able to make those choices).

74. In Latin America, Macedo[37] points out that whereas the Latin American region experienced accelerated economic growth during the sixties and seventies, «this old style of development – however miraculous – was not sufficient to solve the problems of poverty, inequality and poor living conditions. If we define poverty as the lack of income, then from the early 1970s to the early 1980s, the number of people living in total poverty in Latin America and the Caribbean (despite the rapid economic growth rates) increased by more than 40 million». Macedo then proposes a new development model, and enumerates a number of elements that such a model must include in order to approach the achievement of some semblance of equity, such as the following:

(a) The great macroeconomic imbalances in national economies need to be corrected, both the external imbalances such as foreign debt, and internal imbalances flowing from fiscal indiscipline, unbridled inflation, and the lack of capacity for savings and investment.

(b) In the context of national development programmes, the pursuit of general well-being and greater equity must be built into the programme. There must be no presumption that these benefits will flow from development. As already indicated, the pursuit alone of increased production, economic growth and subsequent wealth is inadequate to ensure better health for all the people.

(c) New development programmes must take place within the framework of democratic regimes with **real and meaningful** community involvement. It is no longer sufficient to simply establish «representative democracy» and to hold periodic elections. It is a question of firmly implanting democracy as a way of life, as a way to redistribute existing power or to create other sources to empower the people. Governments must be made to be accountable and transparent and these changes will be driven by increasingly well-articulated and organized demands from those who suffer most from the lack of water supply, sanitation and health care.

(d) The new development model must be sustainable and become permanent. Past cycles of growth and recession have done developing countries little good. To achieve sustainability will require: the creation of the necessary political institutions to ensure equality and democracy; a determined effort to keep up with technological advances; finding the balance between exploiting and preserving our environment; developing human resources consistent with the new model; and promoting values that will define social behaviours that in turn will foster the new development process.

(e) It is worth stating that although health should be at the centre of development, this is different to saying that the health sector should be in charge of development. A modest (but specific and effective) role for the health sector should sketched, whereby the responsibility for the health sector's role in a given sector (housing, agriculture) is defined in a way that can be welcomed and not feared by the other sectors.

75. To return to the 9GPW: it will, during the period of its charter, urge and assist countries of the world to: identify and confront the socio-economic determinants of health in a coordinated intersectoral manner; strengthen the capacity of government and policy-makers to address matters of inequity with regard to economic opportunity, gender and age; undertake development programmes designed for the betterment of all the people; and establish sustained global co-operation between, and financial support for, poorer countries by the wealthier ones.

76. WHO will cooperate with countries and provide the necessary support in policy formulation and research in respect of the initiatives in the preceding paragraph. WHO will also play a promoting and coordinating function in this regard.

4.3 Health promotion

77. The 9GPW recognizes the role of industry (marketing and pricing), and institutions such as the family and the media in influencing individual choices with respect to lifestyle and conduct as, for example, smoking and drug use. The 9GPW advocates the adoption by governments and health-related agencies of health promotion policies and campaigns directed at combating these and other threats to general well-being, such as occupational hazards of workers; questions of population growth and the role of woman in society; problems of nutrition, and of water and air pollution.

78. The role of health promotion as a strategy for new public health action was formalized in the «Ottawa Charter for Health Promotion»[38] adopted at the 1986 Ottawa Conference, which stresses the need to:

    (a) **build healthy public policy**: Health promotion goes beyond health care. It puts on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health. Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change;

    (b) **create supportive environments**: Our societies are complex and interrelated. Health cannot be separated from other goals. The

inextricable links between people and their environment constitutes the basis for a socio-ecological approach to health. Changing patterns of life, work and leisure have a significant impact on health. Systematic assessment of the health impact of a rapidly changing environment – particularly in areas of technology, work, energy production and urbanization – is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy;

(c) **strengthen community action**: Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities – their ownership and control of their own endeavours and destinies;

(d) **develop personal skills**: Health promotion supports personal and social development through providing information, education for health, and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health;

(e) **reorient health services**: The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health. The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Reorienting health services also requires stronger attention to health research as well as changes in professional education and training.

4.4 Intersectoral collaboration

79. As has become obvious in this discussion, intersectorality is an indispensable component of the New Public Health. As the WHO Regional Office for Europe has put it: «Intersectorality for health policy development is essential. Public health must be capable of engaging in a dialogue with actors beyond the health sector».[39]

80. A striking illustration of the consequences of the absence of intersectoral coordination is provided by Milio[40]. After reviewing the USA's agricultural policies, including those affecting subsidies to farmers, production quotas, and the pricing of agricultural products, she gives the following account of the effects of policy ramifications on health promotion in a specific situation.

81. Between 1948 and 1968, fat consumption from animal sources in the USA declined by 25%, while vegetable-sourced fat consumption increased by more than 40%. Clearly, this represented a tremendous health-promoting shift towards less saturated fat in line with the recommendations of USA health authorities. Also, the purchase of pork and eggs dropped by 25%, again reflecting a health-conscious trend – but was this health-conscious consumption in response to some successful «eat healthy» campaign? If so, the Department of Agriculture had not heard of it, because the consumption of beef skyrocketed by 58%, and cheese by more than three times, all in response to prescribed pricing policies governed by the rules of that Department. The result was that, despite these shifts, individual dietary cholesterol intake in fact remained at 500 mg according to Milio, the same as 75 years previously! There were other reasons why animal fat consumption appeared to have dropped lower than it did, including the change from animal fat to vegetable oil by fast-food outlets and other commercial concerns.

82. Milio concludes: «Farm policy has a more profound effect on the health of Americans than food policy ... farm and related policies affect nutrient composition and safety of foods, as well as their prices, making some more costly than others. One result is a predictable set of food, tobacco, and alcohol purchase patterns by Americans. Taken together, current policies favor agricultural commodities and products that have health-limiting, and sometimes health-damaging effects on the national profile of health and illness. Policies do not now induce farmers to produce a more health-promoting food supply, one that could protect Americans from currently high risks of illness».

83. The lack of attention to health in various development sectors (agriculture, industry, housing, etc.) is sometimes attributed to a lack of interest in health by the other sectors; however, what is often overlooked is that the health authorities have various responsibilities and tasks that are prerequisites for intersectoral health work.[41] Intersectorality requires:

(a) that the health authority (health ministry, municipal health department or other) possess the necessary **information** on the health impacts of various development activities. Such information must be sufficiently disaggregated to be usable in linking potential health problems with specific environmental and social conditions;

(b) an **analysis** of not only the adverse impact on health of various development projects, but also of the potential opportunities to enhance health that almost every development activity presents;

(c) a strong **advocacy** role by the appropriate authority in promoting the implementation of health-related policies; therefore, it may be part of the legitimate function of the health authority to cultivate maximum political support within «the political machine»;

(d) The charter recognized the need for strong health advocacy, the challenge to mediate between conflicting health interests and the central role of strategies that enable rather than control. It framed health promotion as a social change and social development process towards health, which needs the interaction of the five action areas outlined above, in order to have full impact. Successful tobacco policies the world over have documented this. From the need to integrate personal and organizational change came the proposal for a range of health promotion projects which took their starting point from «settings of everyday life» and the salutogenic question «where is health created». In practice this has led to projects such as Health Cities, healthy villages, healthy neighbourhoods, healthy workplaces and health promoting schools as well as health promoting hospitals. These projects now have worldwide networks, often coordinated by the World Health Organization. They aim to ensure action in the five action areas of the Ottawa Charter through an alliance-building approach, which is seen as a key new public health strategy. The experience which these projects underline is that the new public health does not only define itself through new content, but also through new styles of public health action.[42]

4.5 Prevention of preventable conditions

84. The 9GPW recognizes the gains that have been achieved in this area worldwide: 80% immunization coverage of children against the six

diseases covered by the Expanded Programme on Immunization; the near-eradication of dracunculiasis (guinea-worm disease); 80% reduction in dental caries through fluoridization. However, unnecessary mortality still obtains due to lack of access to appropriate preventive, diagnostic, therapeutic or rehabilitative technology, and WHO pledges itself to assist countries in this regard.

85. A number of countries have shown that it is possible for health authorities to estimate the total disease and accident burden in a country, and also the preventable component of that burden, and then to translate this information into programmes of prevention that aim progressively to increase the proportion of potentially preventable diseases that are actually prevented (for example, the US Healthy People 2000 Initiative).

86. The Healthy Cities Project initiated by the European Office of the WHO in 1986, and which is now a worldwide activity, is one example of a coordinated approach to integrate health promotion and environment health action in order to create supportive and healthy environments. It takes into account the increasing decentralization of health responsibilities to the local level and aims to support local authorities in tackling the new public health challenges – within their remit of responsibility. The project lays down guidelines for participating cities and proposed a networking mechanism for interaction between a constellation of cities in respect of ideas, innovations and research.[43]

87. Ashton and Seymour[44] see prevention at three levels: «primary prevention» which is concerned with removing risk factors from the population or the environment; «secondary prevention» consisting of the screening of high-risk groups for a given condition and offering counselling and treatment where appropriate; and finally «tertiary prevention» which has to do with rehabilitation and treatment of individuals with established disease.

4.6 Equitable access to health services

88. The concept of «access» is well described by Sax,[45] who says that it means «not only availability within a reasonable distance, but also the absence of barriers, such as prices beyond the ability to pay, lack of amenity and courtesy, prolonged waiting for service, inconsistency and poor communications ... Fair access is consistent with a

widely held humanitarian view that individuals should not be denied health care because of their lack of income or wealth».

89. Equitable access is enshrined in Article 25 of the Universal Declaration of Human Rights where it says that «everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including ... medical care ...», a position reinforced in the Constitution of WHO as well as in the Alma-Ata Declaration and the HFA/2000 Strategy.

90. Undoubtedly the availability of financial resources plays a crucial role in determining access. Wealthier nations should logically provide better and more accessible services than poorer ones, but this is not always the case. The questions of fiscal management and political governance also come into play. In Africa, impedance from access has not come, in most countries, from civil conflict, drought or falling commodity markets. The single most important obstacle has been «the weakness of political commitment to better health. Although African countries made numerous promises to adopt ... primary and preventive health care – they have seldom made the institutional and financial changes necessary to bring it about».[46]

91. The 9GPW sees quality assurance of health care and services as an essential part of equitable access. Access must apply equally to populations most in need, such as refugees and other displaced persons. The 9GPW also addresses the problem of disproportionate investment in high technology which is accessible to only a few in the community.

92. WHO undertakes, through the 9GPW, to give support as appropriate to strengthen the infrastructure and the capacity of countries to plan sustainable health services, with emphasis on epidemiological surveillance, monitoring and evaluation, and analysis of service coverage.

93. If public health measures are successful, unnecessary premature deaths will be reduced, and there will be a gradual «greying» of society as is already happening in industrialized countries, which will bring with it the challenges of geriatric care and social security systems with the related costs. In developed countries such as the USA, one of the current challenges is coping with the social security (pension) requirements of a rapidly growing senior citizen population component, underwritten by the contributions of a relatively shrink-

ing gainfully employed younger population component. «The $50 billion spent on health care for the old when President Reagan came into office is expected to reach $200 billion by the year 2000.»[28]

94. Some worry about the fact that, historically, American senior citizens have made more visits to the doctor, consumed more medicine than the average citizen, and used an increasing number of nursing home beds and days. There are others, however, who feel that today's parameters should not be used to predict the situation beyond 2000. WHO's strategy is that by encouraging healthy behaviour from childhood, we can at least hope to ensure healthy ageing. The present offers almost limitless opportunities to enrich the quality of life for the aged, and to enable them to continue to play a meaningful and productive role in society.

4.7 Renewing and recommitting to the health-for-all strategy

95. Health for all by the year 2000 is an aspirational goal. As the target date approaches, it is clear that not all the indicators will be attained. Yet the value of HFA is universally acknowledged.

96. Learning from the experiences since 1978 and incorporating the developments in economics, in politics, in science and in our societies, and in order to inject a new impetus for Member States to maintain the effort of achieving the highest level of health for their entire population and to close the gaps between countries, the Forty-eighth World Health Assembly adopted Resolution WHA48.R16 entitled «WHO response to global change: Renewing the health for all strategy».[47] This calls for a wide range of changes – from the HFA targets to the development of a new global policy and strategy. There will be a new holistic global health policy based on the concepts of equity and solidarity, emphasizing the individual's, the family's and the community's responsibility for health and placing health within the overall development framework.

97. In order to ensure convergence of all relevant efforts and to obtain the strongest government commitment, a lengthy but necessary process of consultation at different levels with all interested parties is envisaged, culminating in adoption of a health-for-all Charter in 1998.

98. The 9GPW remains the basic reference but with emphasis on five strategic priorities:

(a) to reduce poverty and its health consequences;

(b) to ensure equity of access to, utilization of, and outcome of the health system with special measures for those most affected by inequities, such as women;

(c) to squarely place health within the overall development framework, including securing adequate, equitable and sustained financing for health systems based on primary health care;

(d) to ensure the availability of newly-acquired knowledge whenever necessary and the rational application of existing knowledge and technology to the health development process;

(e) to mobilize the various actions in international health work according to their mandates and capacities within the framework of a coordinated country plan managed by the country and supported by WHO.

99. In order to equip itself better for this new challenge, WHO is undergoing radical reforms under the rubric of «WHO response to global change» which started in 1992.[48] The goal is to find a better fit between WHO structures and its functions and to enhance its ability to respond to international health needs in a timely and cohesive manner.

100. The new challenges take the Organization into new and unfamiliar territory. But WHO with its partners will take up the challenge as it did with HFA. Its Member States expect no less.

101. What are the public health causes and consequences of poverty?

For example, poor health impairs urban productivity: there has been research into poverty-illness linkage documenting how poor health impairs productive work.

102. How should WHO address the issue of health and poverty?

Strategies might include: (a) correct identification of the role of poverty in poor health, with greater emphasis on demonstration of different differentials according to socioeconomic conditions, giving more attention to disaggregated data in health monitoring; and (b) greater support to social policies that aim to reduce social inequity, marginalization and exclusion of poor or minority groups.

103. *What implications does renewal of HFA strategy initiative have for public health?*
What lessons have we learnt from the original HFA?
What is the relevance of the 9GPW as described? In future, should public health take a developmental approach to health, whereby health is viewed as the goal and result of development of all national sectors and particularly the housing, education, industry, agriculture, and transport sectors. How can we obtain a better understanding of equity and health relationships? What is the part played by policy to reduce inequity?

5. Public Health Training and Research

5.1 Public health and primary health care

104. Roughly a decade ago, two enquiries – one in the USA and the other in Britain – were established to investigate the role of public health in the light of the then prevailing criticisms. The resultant assessments «pointed to a general disarray in the field, to ambiguity and uncertainty about the mission of public health and about (its) leadership capacity».[49] As one American source puts it: «In recent years, there has been a growing sense that public health, as a profession, as a governmental activity, and as a commitment of society is neither clearly defined, adequately supported, nor fully understood».

105. The uncertainty about the role and mission of public health had a direct bearing on the Alma-Ata Declaration. On the one hand, the Declaration conceives and promotes primary health care (PHC), defined as «the first level of contact of individuals, the family and community with the national health system», a presumably clinical activity. On the other hand, it enumerates as part of PHC «promotive (and) preventive ... services», and «education concerning prevailing health problems and the methods of preventing and controlling them» – presumably a public health activity. The Declaration, in effect, says that these two types of activity are inseparable, and must be performed together. But this was already the case as we have seen going back to the second Expert Committee on Public Health Administration which looked at comprehensive service needs rather than the domain under which they may individually belong.

106. The problem, however, is that those who provide «the first level of contact ... within the national health system» are not the same as those whose task it is to research, plan and provide preventive and promotive services and, historically, the two sides «don't speak».

107. Why not? There are more than one reason for the schism (and, sometimes, hostility) between providers of individual care and practitioners of population-based medicine. Among them is the segregated training at schools of medicine (emphasizing the individual-based curative approach), and schools of public health. In this separation, the medical schools have amassed «overwhelming power» (to use a latter-day American military expression) to project individual curative medicine as the centre of the health universe. «It is true», writes Tudor-Hart «that the public health tradition, here as in most countries, has been impoverished by its divorce from clinical medicine ... Under any circumstances community medicine will take time to recover from a century of banishment to the periphery of medical practice, but clinicians will also take time to recover from their ignorance of the tasks of organization, management, local planning and research-based clinical strategy».[50] The way services are paid for and the income differentials between the two services also contribute to the rift.

108. Clearly, there is a need to define more succinctly the role of public health in PHC, a role that will require significant and meaningful rapprochement between clinicians and public health specialists. That rapprochement may never be achieved, unless the education of both the clinician and the public health practitioner is radically reformed.

109. Clear proposals to reform medical education have emerged from WHO-sponsored conferences (and other sources) around which there appears to be a growing of consensus. There now appears to be agreement in principle that we need to train doctors so that they are as well equipped to prevent disease as they are to treat it. By comparison, public health training reform proposals would seem to be considerably less clear, no less in respect of the role of public health in the undergraduate medical curriculum. And what about other relevant curricula, such as engineering and other disciplines concerned with the human environment?

5.2 Public health training reform

110. One of the major barriers to implementing the new public health and HFA strategies has been the time lag between countries adopting the principles and the changes in the curriculum of medical and other health-related institutions. In an intercountry workshop sponsored by the WHO Regional Office for the Western Pacific, 17-23 July 1993, entitled «New approaches to Public Health Training in the Western Pacific»,[51] the Regional Director, Dr S.T. Han, recognized that the challenges included «changing demographic and epidemiological patterns; the teaching of new technology and the management of technological innovation; providing for the needs of increasingly varied student populations; and utilizing new approaches to teaching and learning».

111. The workshop identified seven major categories of public health training:

(a) **postbasic and postgraduate training for public health** professionals – the graduates «will become either techno-bureaucrats (i.e., high level decision-makers, advisers and senior managers within a health service) or relatively high-level specialists in some field of public health, rather than field practitioners or lower-level managers;

(b) **preservice training for public health workers** intended to produce health workers with a particular set of skills and knowledge required for functioning at a particular level within some component of a public health service;

(c) **public health content in preservice training of other health workers**, i.e., public health content in medical, nursing and allied health curricula;

(d) **in-service training of health personnel**, formal programmes provided by employers for updating and extending knowledge and skills;

(e) **continuing education of public health workers**;

(f) **public health content in the training of workers in related sectors**, especially such professions as teachers, social workers;

(g) **public health training of the community**, this is essentially health promotion.

112. The workshop also advocated that training should be student-oriented, use a problem-solving approach and be interactive, with involvement not only between students and teachers, but between students themselves.

113. In Europe, the quest for reform in public health training and research has been spearheaded by the WHO Regional Office for Europe, in partnership with the Association of Schools of Public Health in the European Region, on the basis that «a new knowledge base is needed for the HFA policy and this knowledge can only emerge out of creating and legimitating new public health sciences».[52] In the Americas, it has been the Pan American Health Organization (PAHO) that has done the spadework, and both WHO/EURO and PAHO have generated considerable literature on this subject.

114. What else is wrong with contemporary public health that should necessitate a reorientation of its training and research?

(a) One criticism is that public health has swung too far from its original sanitary orientation and become too disease oriented or, as has been put more technically, has come to be characterized by «the dominance of the risk factor model of disease».[53]

(b) As a result, public health has become obsessed with epidemiology and other «science» for its own sake (in the way that some individuals are taken up with astronomy or mountain climbing), at the cost of loss of contact with the realities of the people on the ground. The reason for this shift can perhaps be traced to the dawn of bacteriology, when «hygiene» was relegated to the periphery of «soft» science. Henceforth, «hard» bacteriological science would provide all the public health answers. All that was needed now was a science-based «intelligence service» or epidemiology to operate alongside bacteriology. Says Vandenbroucke:[54] «Nobody had proved hygienists wrong, it was just that nobody was interested in their kind of argument anymore. Chairs and institutes of hygiene were turned into chairs and laboratories of bacteriology».

(c) Public health often remained in the periphery of academic medicine and in desperate need of recognition. According to Frenk:[55] «Public health has become increasingly isolated both from scientific advances and from efforts to organize better health systems. This tendency has relegated it to a secondary role both in

academia and in areas of its application, generating a vicious circle between isolation and irrelevance».

(d) Public health research is not making the necessary contribution to public policy. The emphasis at many schools of public health is «on hyper-specialization and publications in international scientific journals. Credit is not awarded by academic peers for health policy development at national, regional or local levels».[10] In fact, schools of public health have tended to want to be seen as «Centres of Excellence» more than as «Centres of Relevance».

115. Probably this is the reason that «only 5% of global expenditure on health research is concerned with the needs of developing countries, which suffer 93% of the world's premature mortality.[56] Clearly, there needs to be a better balance on spending between the developed and developing countries as well as between health service and policy research, and research into specific public health disciplines.

116. The WHO Study Group on Problem-Solving Education for the Health Profession[57] recognized that «most health professionals have little training in the wider aspects of health, the sophistication of their biomedical and clinical training is not matched by comparable training in relevant social sciences, and they have had little opportunity to learn from role models how to address the social, economic and political forces affecting health».

117. On the other hand, Frenk[58] warns that «the biological reductionism of the past should not be replaced by a sociological reductionism. Rather, what is needed is an effort at integration among scientific disciplines». He goes on to say that public health schools must develop the ability to look outside at the growing complexity of their surroundings, and to introspect in order to renew themselves from within. To succeed in this, they should harmonize two values: the relevance of the schools to policy-making in the health sector, and the preservation of the programme's own academic excellence.

118. He proposes two types of public health «schools» according to the product they will produce: those that will train for work, and those that will train for higher education. He sees training for work as a short-term activity not concerned with degrees or, for that matter, with academic institutions. On the other hand, higher education institutions will prepare «professional» specialists for practice as academics, for teaching and research.

119. Like Frenk, the WHO Regional Office for Europe advocates the «town-gown» linkage, because at the present time, «on the one hand, policy-makers and health professionals do not systematically review and use either existing or new knowledge generated by research to support their decisions. On the other, many researchers are ignorant of key issues and developments in health policies».[59]

120. WHO/EURO advocates more radical change in respect of the curricula of schools of public health than Frenk. «What is needed» they assert unequivocally «is a common curriculum or track for all public health students, which should provide a common understanding of the new public health, a focus on the health of populations, on a global and social model of health and of health gain.» WHO/EURO then goes on to underline the crucial need for «a common language, methodologies and tools for all students, including those coming from the social sciences».[60]

5.3 Health management training

121. Health management training is seen by several sources as sorely lacking in the European context (as it is, indeed, in all other contexts). According to Hunter, «there is now a need for synthesis between public health training and health management training. The challenge is posed by the new public health demanding an approach to public health education in which public health managers require a combination of specialist clinical skills and general management skills. Combining these skills in a group of individuals will be vital in the future in meeting the challenges posed by health care systems and by policy-makers».[61] Other needed skills include political science, communication, economics, and policy analysis and development.

122. Chapter 6 of Agenda 21 also calls for intersectoral approaches to the «reform of health personnel development», and emphasizes the need to enhance managerial skills, particularly for district health managers.

123. Ashton[62] warns against PHC physicians (i.e., clinicians) being given the responsibility for public health functions, on three grounds:

    (i) the PHC concept of health promotion would be too narrowly interpreted;

(ii) there will always be public health tasks which cannot be done at PHC level;

(iii) there will always be potential conflict of interest between individual health and collective health; it therefore makes sense to separate the roles of advocate, mediator and enabler.

124. The range of different positions merely reflects the difficulty in defining public health. In a recent study in Australia on the education and training of the public health workforce,[63] this difficulty in defining public health made the researchers resort to looking at people who perceive themselves as working in «public health» and have a need for training in areas relating to public health. This study defines public health workers as «people who are involved in protecting, promoting and/or restoring the collective health of whole or specific populations (as distinct from activities directed to the care of individuals)».

125. The survey found that 53.8% of this workforce did not fall within health and health-related occupations compared to 65.3% of the health industry workforce who are so classified. Those working on environmental health stated their main occupations as either policy/planning or natural sciences. Those working in administrative support roles came either from management and policy/planning or from medical testing occupations (including epidemiology, medical laboratory sciences).

126. In Australia, the four core areas of public health and related courses are: epidemiology, including identification of factors contributing to health status; statistics and information systems; health services management, policy and planning; and behavioural sciences, including health promotion and health education. The study of subpopulation groups and the environmental sciences are areas of emerging importance, as are health economics, ethics, services/programme evaluation and communications.

127. Over 50% of graduate respondents in the study identified a further six areas as being needed in the future: computer studies, advocacy with government, design and conduct of economic analyses, communication on health matters, and qualitative and quantitative analyses.

128. The practice of public health is clearly related to the health system within which it takes place. The content of public health education

must be related to this. Yet, training opportunities are to be found more in the developed countries than in the developing. As an applied science, the specific competencies of public health practice must reflect the actual needs of the practice environment. The quality of public health education must be judged by the extent to which this principle is followed.

129. It may be useful to recall the present reality: social programmes are operating under ever tighter resource constraints. Political, economic, environmental, social and cultural factors influence the operations of the health system and health itself. The contribution of good health to socioeconomic development must be convincingly demonstrated if adequate and sustainable resources are to flow to the health sector. Part of this demonstration requires that management be enhanced at all levels, supported by clear policies and priorities.

130. *What then should be the core competencies of public health that will allow them to operate in their own reality? How best can indigenous capacity be increased and what will be the role of schools of public health in developed countries vis-à-vis those in developing countries?*

131. Does this suggest a hierarchy of skills for the public health workforce? For example, there could be a small number who are involved at the central level dealing with policy analysis and formulation and those dealing with government at central level, followed by the specialists in a wide range of public health subjects who are in turn supported by an even larger body at technical level. The 1993 International Workshop on New Approaches to Public Health Training in the Western Pacific, organized by the WHO Regional office for the Western Pacific, had recognized the diversity of occupational groups within the public health workforce. Public health personnel were classed into the following main categories:

public health techno-bureaucrats
high level decision-makers and their senior staff
public health practitioners
«personal care givers»:
- public health (and community health nurse/midwives
- «community health workers»
- MCH, school health services personnel
- community mental health personnel

- community dental service personnel
- medical assistants/medical officers

environmental health personnel:

- health inspectors/sanitarians
- environmental control scientists/technicians
- analytical chemists/toxicologists
- microbiologists/parasitologists
- public health engineers
- occupational health personnel

health information providers

- epidemiologists
- information scientists

community educators

- health promoters/health educators

management and advisory personnel

- managers, clerical staff, etc.
- health economists
- legal personnel
- policy analysts
- bioethicists.

132. *How should the public health workforce be trained?*
What should be the core content?
How should we achieve a balance between theory and practice?
How do we expand training opportunities and resources in developing countries?
What are the research priorities for HFA?
How should the research outcomes be publicized and application enhanced?

6. The New Public Health – An Afterword

6.1 Globalization

133. The historical achievements of public health, viewed from a historical and global perspective, are a matter of record: the virtual eradication of deadly epidemics, impressive declines in maternal and infant mortality rates, and the progressive increase in overall longevity. However, we live in a rapidly changing world, and public health has had to evolve, change and adapt along with the advances in scientific knowledge, and the emergence of new disease patterns and new forms of risk-taking human behaviour.

134. Developments in the world political scene, advances in electronic communication and in transportation, intertwined trade relations, mobile labour markets and voluntary and involuntary mass migrations have all added up to make the world become like one global village. «But several other, less benign activities, including drug trade, terrorism, and traffic in nuclear materials have also become globalized», says the Commission on Global Governance. «... global cooperation has eradicated smallpox. And it has eliminated tuberculosis and cholera from most places, but the world is now struggling to prevent the resurgence of these traditional diseases and to control the global spread of AIDS».[64]

135. In this massive process of globalization, WHO's traditional role has become even more important: to promote the development of comprehensive services, the prevention and control of diseases, the improvement of environmental conditions, the development of human resources for health, the development and coordination of health research, and the planning and implementation of world health programmes.

6.2 The New Public Health and Renewing the Health-for-all Strategy

136. The Ninth General Programme of Work (9GPW)[65] together with the renewal of the Health-for-all Strategy represent WHO's commitment and revised agenda to continue the health-for-all mandate, and the New Public Health is a reconfiguration of the concept of public health in order to best operationalize the 9GPW.

137. The New Public Health takes into account the health-related fallout from globalization, and endeavours to address the challenges of our changing world: diseases of affluence and of abject poverty between and within countries and regions; the need for sustainable development and the need to conserve our environment; population growth; deprivation and exploitation of women and children; political corruption or mismanagement impacting on health; and the abuse or neglect of the growing population of the aged, and so on.

138. The New Public Health seeks to address the problem of current public health training that has become outdated and irrelevant. It seeks to determine the profile of the public health professional or worker that is needed for today's challenges, and to determine what skills and competencies he or she should acquire to be effective. The role

of such a person calls for more than the mastery of epidemiology. It calls for competence in a wide spectrum of areas such as: policy formulation and policy analysis, management and negotiating skills, economics and communication skills. Then there is the question of how to make public research more relevant, so that researchers are not preoccupied with answering questions no one asked, while policymakers are asking questions for which there are no answers. Furthermore, the New Public Health is concerned with restoring cooperation between the public health specialty, the clinical specialties and other health professions in the common pursuit of HFA/2000.

139. The New Public Health is concerned with issues of equitable access to health services, the provision of such services to the fullest extent of affordability and sustainability, and about the ethical foundations of resource allocation and care. It seeks to put health into the development framework and to ensure that health is protected in public policy.

140. Health should not be a sectoral development issue but must be an integral part of many development sectors, particularly the housing, education, industry, agriculture and transport sectors. The New Public Health requires the health sector to learn to interact with these sectors, building on successful examples, e.g., school health education, health in the workplace, health in local government and municipal health plans.

141. In health monitoring, health statistics will not stand alone, as something the health sector uses for health planning, but rather will link health status to living conditions. Thus specific health problems such as road accidents, malaria or diarrhoea will be analysed in terms of the preventible component of such conditions and the activities and programmes of sectors such as local government, the transport department, and the education department.

142. This assessment requires attributing a proportion of the health burden, and a number of preventable deaths and injuries, to activities of other sectors (e.g., the housing sector, the agriculture sector, etc.). A «causal» attribution is needed to justify the health policy that the ministry of health prepares for each sector. The health authorities will monitor health status but will collect data in a modified way so that incidence rates and causal inferences can be drawn (e.g., more disaggregated data, or including information about whether a workplace accident or otherwise, or whether a hospital admission is a first admission or not, with a specific diagnosis). In most countries, the water authorities will monitor water quality; the air pollu-

tion experts in the Environment Department will monitor air quality. However, data linkage – establishing the linkage between the environmental condition and health – is a health authority function, and health analysts will use all available information (and collaborate with all agencies holding relevant data) to link health status and living conditions.

143. The New Public Health requires the development of a health policy for the competent development sector responsible for key environment and health issues (e.g., local government, housing, the environment, agriculture, industry, transportation, and education sectors). The reason the health sector must develop these sectoral health policies is that it may not be realistic to expect, for example, that the housing sector should develop a health in housing policy. (In practice, many housing experts argue why the housing sector should do it, and can they?) It is therefore recommended that the health sector should develop such a policy, based on an analysis of the types and magnitude of the health problems caused by inadequate housing. A health in housing policy (like policies for other sectors) will seek to exploit many health opportunities that improved housing can bring, including raised health awareness, improved primary care services, neighbourhood safety and injury-prevention programmes.

144. New Public Health involves communication and advocacy of the health policies to the various sectors. For example, the health in housing policy must be advocated and promoted to housing authorities, local government, to NGOs and the private sector. It should emphasize health opportunities, as well as avoidance of hazards. The prevention-oriented public health officer will find health opportunities in the development activities of many different sectors to mobilize people in specific settings. For example, industrial development with workplace health programmes provides the opportunity to address a great many health issues of importance to workers, from accidents to poisonings to AIDS; or reforms of local government may be associated with implementation of healthy neighbourhood (or healthy district or healthy villages) programmes, whereby greater participation of the community in addressing health issues is facilitated.

145. New Public Health will involve greater communication between staff of clinical health care facilities and public health/preventive workers. The close contact of clinical staff with the situation of morbidity and premature mortality in the country -and their insights into the reasons why sick and injured people are carried each day into the

health facilities – are or should be a major foundation for efforts to improve environmental and living conditions that impact on health. (It is not surprising that, for example, the major advances in road safety and accident prevention in some countries have been initiated by surgeons.)

146. The New Public Health has a vested interest in the financing of health care, the possible cooperation between the public and private sector, and ensuring good value for money. At the same time, it is concerned with the needs of the vulnerable and marginalized.

147. Current trends in global economic policy, emphasizing a smaller role for governments and a larger role for market forces, are in potential conflict with some central concerns of the New Public Health. The health needs of the vulnerable and marginalized have been shown to be jeopardized when privatization in health financing and provision is inadequately regulated. Not only does access to curative care of reasonable quality become reduced for these groups, but public health threats increase for the great majority with recrudescent diseases such as cholera, diphtheria and tuberculosis. Furthermore, the present political and economic push towards structural adjustment and privatization, in developing countries, is a further move toward curative and profit-making services, and would hamper promotive and protective activities in public health. *How can public authority reinforce a clear overall strategy to ensure adequate financial and human resource support in the New Public Health?*

148. In short, the New Public Health is not so much a concept as it is a philosophy; a new approach which cannot be defined in a word, but which broadens the older understanding of public health (the health of populations to include the health of the individual) in order to better address contemporary issues (such as environmental, political and social developmental issues) which have not previously been regarded as health issues. As such, no one definition will be sufficiently comprehensive – and that is a strength, because it lends a certain elasticity to the concept which will enable it to accommodate future challenges yet to emerge.

149. Above all, the New Public Health is concerned with **action**. It is concerned not only with finding a framework to address many of these burning issues of the modern times, but also to identify strategies and then to implement those strategies.

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[60] Training and Research in public health (Dialogue series no 1) – *Policy perspectives for a «new public health».* Karlstad (Sweden): WHO, 1994, p.15

[61] *Idem*, p.15.

[62] *Op. cit.*

[63] *The public health workforce education and training study: Overview of findings* (Author: Centre for Public Health, The University of New South Wales, Australian Government Publishing Service, Canberrra) March 1995.

[64] *Our global neighbourhood.* Report of the Commission on Global Governance. Oxford, Oxford University Press, 1995.

[65] *Op. cit.*