Learning from experiences in the European Region

ACCELERATING THE TRANSFORMATION OF PUBLIC HEALTH SERVICES TO TACKLE NCDs

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Summary: Noncommunicable Diseases (NCDs) are a major public health issue globally. This article identifies two priorities to support public health services in tackling NCDs. The first priority is to invest in strengthened health promotion and disease prevention systems through financing, improved professional education and clearer governance. The second priority is to promote proportionate universalism across public services, especially within universal health coverage. The implications of proportionate universalism for NCDs are significant, providing leapfrogging opportunities for Member States to accelerate population health and avoid a potential widening in inequity.

Keywords: Health Promotion, Disease Prevention, Proportionate Universalism, Health Equity, Universal Health Coverage.

Introduction

Noncommunicable Diseases (NCDs) are the public health issue of our time. While progress is being made in terms of premature mortality related to NCDs, progress is heterogeneous across the WHO European Region and in particular, multimorbidity (defined as an individual having two or more chronic diseases) and health equity are major challenges. More must be done to strengthen essential public health services across government and within the health sector, and to facilitate work across sectors for the promotion of health, the primary prevention of disease, and the prevention of further complications for those with established NCDs. This article explores ways in which Member States can accelerate the public health services response to NCDs by learning about what works across the Region.

Health promotion and disease prevention are key

Across the European Region, there are differences in interpretation of the scope and definition of public health services. The European health policy framework and strategy, Health 2020 and the European Action Plan for Strengthening Public Health Services define ‘public health’ as “the science and art of preventing disease, prolonging life, and
promoting health through the organised efforts of society”. The “organised efforts” referred to in the definition are carried out by actors in government and society at large. Within government, numerous sectors are involved, including education, social services, agriculture, transportation and trade. Typically, a number of public health services are delivered from within the health sector, and one key challenge is to achieve horizontal alignment and integration of clinical, and public health services.

The European Action Plan sets out 10 essential public health operations (EPHOs), which illustrate the essential functions that are required to deliver an effective public health service at country level. These include specific public health and more general enabling functions such as governance, finance and workforce. Of particular interest to the issue of NCDs are the public health intelligence services that monitor NCDs, risk factors and determinants (EPHOs 1 and 2); services for health promotion (EPHO 4); and disease prevention (EPHO 5).

Health promotion and disease prevention services are central to the effort to tackle NCDs and mitigate risk factors such as tobacco and alcohol consumption, unhealthy diets and lack of physical activity. Health promotion services include interventions targeting the behaviour of individuals (lifestyle counselling or social marketing, for instance), as well as those aimed at the broader determinants of health (such as measures against tobacco, fat and sugar taxes or food labelling). Disease prevention services include activities that enable the early detection of disease, such as screening programmes for different cancers, as well as maternal and child health programmes, and those services which support behaviour change for those at risk of illness, or for those with established NCDs. We believe that there is an opportunity for Member States to leapfrog their approaches to public health services by adopting successful approaches to public health practitioner education and training and by adopting effective approaches to intersectoral delivery on public health outcomes.

**Switching to public-health enhancing skill-sets by transforming education**

At individual and population levels, delivering promotion and prevention services requires knowledge and competencies that are distinct from those typically required to address communicable diseases. Expertise in areas such as child and maternal health, healthy ageing, occupational health, nutrition, addiction, and violence and injury prevention becomes crucial, as do so-called soft skills such as intercultural competencies, counselling, collaboration and brokering partnerships. In this respect, one important regional feature is that much of the public health workforce currently in place in the countries that are members of the Commonwealth of Independent States (CIS) has been educated and employed to deliver hygienic and sanitary control services targeting communicable diseases. As such, a new cadre of human resources must now be put in place, in many countries of the Region, to augment the current public health workforce.

In order to secure the new human resources required to address the challenge of NCDs, governments will need to invest substantially more into health promotion and disease prevention. In the years following the 2008 financial crisis, governments chose to cut health promotion and disease prevention services, while expenditure on other health services continued to grow, albeit at a slowed pace. In comparison to other areas of health expenditure, funding for public health has also been on the decline in EU Member States since 2009. Beyond financing, the regional trend to give lower priority to disease promotion and the prevention of NCDs is also apparent in the availability of educational programmes and the extent to which governments legislate for public health services.

Since 1990, organisations such as the Association of Schools of Public Health in the European Region (ASPHER), the Open Society Institute and many other bilateral and international funding agencies have invested considerable efforts in modernising public health education in CIS countries. In a review conducted in 2011, Adany et al. noted that much progress has been made in introducing the concept of ‘new public health’ and establishing new schools and departments of public health in countries of Eastern Europe and the Baltic states, but that progress has been much slower in the CIS countries. The Kazakhstan School of Public Health (KSPH), established in 1997, provides an example of the educational transformation required. The KSPH provides educational programmes informed by the work of ASPHER. Students include those wishing to be public health specialists as well as administrators and government employees. In addition, the school provides shorter courses for other specialists working in related disciplines within the health sector. ASPHER has produced clear recommendations for the content of masters-level education for public health professionals.

**A toolkit is available for enhancing concrete intersectoral action**

Intersectoral action on health is not a new concept. It builds on the Declaration of Alma-Ata and is developed in the Ottawa Charter for Health Promotion and the 2008–2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases. The 2010 Adelaide Statement on Health in All Policies sets out the prerequisites for intersectoral action. These include clear leadership and mediation across
Intrinsic to both health promotion and disease prevention services are efforts to address social determinants and health inequity, whether by increasing access (cultural mediation and interpretation services for minorities, or outreach services and mobile clinics for homeless people or sex workers), or through intersectoral action such as policies and plans on employment, housing, the environment, education and development. These services, therefore, play a key role in efforts to ensure that healthy lifestyles are accessible to all people, irrespective of their age, disability, marital status, gender, sexual orientation, religion, ethnicity and socioeconomic status.

In addition to prevention and promotion activities, efforts must be made to tackle not only the immediate risk factors and behaviours but also the ‘causes of the causes’, such as poverty and gender. Health equity, the desire for equality of health across all subgroups of society, through matching the level of health need with an appropriate resource, is a central goal of Health 2020. Socioeconomic deprivation in particular is strongly linked to increased levels of NCDs. There is also clear evidence of earlier onset of NCDs and of multiple NCDs, or multimorbidity, in groups affected by socioeconomic deprivation. The barriers to NCD control vary by socioeconomic deprivation, gender and age. This results in marked differences in life expectancy and healthy life expectancy across societies. Any approach that tackles NCDs must be tailored to account for inequity, as generalised approaches to health and social care can widen existing inequities.

Health inequity has proven remarkably resistant to public health action, despite attempts to focus on preventive care and upstream intersectoral action to address the “causes of the causes”. One of the reasons for this resistance is an over-reliance on targeting vulnerable populations as a strategy for reducing inequity. The Marmot review of health inequalities in England has suggested that targeting fails to reduce inequity and proposes that proportionate universalism provides a more secure approach to tackling health inequity. The report states that:

focuses solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. This is called proportionate universalism. (p.15)

This approach fits well with Sustainable Development Goal 3.8 on universal health coverage (UHC). What is needed is a broader approach for Member States that uses the lever of UHC to tackle health equity from the outset, moving away from narrow, vertically targeted programmes focusing on individual diseases or population groups and instead considers health in a more holistic, multisectoral manner. Such approaches would allow health needs to be addressed in an increasingly proportionate manner: matching the scale and intensity to the levels of need.

The implications of proportionate universalism for NCDs are significant, providing opportunities for Member States to accelerate or ‘leapfrog’ progress on population health and avoid a potential widening in inequity. The approach requires enhanced skills and refined programmes of intervention that take account of groups within the population, focusing on each group to identify and explicitly addressing the barriers and levers for lifestyle change such as culture, gender, poverty, literacy and education. This approach requires clinical and public
health professionals to be equipped with more sophisticated knowledge, skills and competencies. Prevention programmes would also need to match this level of sophistication by analysing prevention needs in a much more granular manner, taking account of intelligence and data on inequity, as well as evidence concerning the barriers and levers for change, and explicitly linking this information to local prevention approaches for each group through the actions of different sectors and actors.

Public health services have a key role to play in the surveillance of health needs and in the creation of multisectoral approaches that can address health inequity in an effective way. This is especially important in the field of NCDs, where risk factor clustering, multimorbidity, poor access to services and limited engagement with health improvement programmes are strongly associated with socioeconomic disadvantage. Spain has implemented a chronic disease stratification programme that combines strong surveillance and intelligence methods, using population-level data on risk factors and diseases obtained from records of health care delivery and utilisation, with local approaches to enhance health care activity in support of prevention and promotion for groups at higher risk. This is an example of using intelligence resources to align the delivery of preventive services with the health needs of the population in a proportionate manner, in order to support health equity. This approach at the population level should be blended with our first message which strengthens the surveillance of health equity, the use of systematic approaches such as health equity impact assessment, stronger multisectoral links and joint working, particularly with primary care services.

Our second message focuses on promoting proportionate universalism through public services, particularly with reference to UHC. The expansion of UHC provides Member States with a unique opportunity to improve population health while avoiding a rise in health inequity within different groups. To achieve this aim public health services will require robust surveillance of health equity, the use of robust surveillance of health equity, the use of systematic approaches such as health equity impact assessment, stronger multisectoral links and joint working, particularly with primary care services.

Priority actions

Our first message is to invest in stronger health promotion and disease prevention. In order to deliver this priority, Member States need to increase resources to health promotion and disease prevention services and simultaneously strengthen professional education and continuous professional development programmes to ensure that public health and clinical staff have the necessary competencies to deliver effective prevention and promotion services. In addition, the public health workforce must be equipped with skills and effective governance to broker NCD promotion and prevention within the health system and across sectors.

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