原　　著

The Schools and Current Situation of Public Health in Europe

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Abstract

The situation of public health in Europe is slightly different from a Winslow's deffinition in the United States. The purpose of this paper is introduced that we are going to design a system for 4-year university for the the education of co-medical workers and in terms of public health because it is an important aspect for the education of them. ASPHER (The Association of Schools of Public Health in the European Region) is now in a transitional phase of reorientation, and of upward acceleration. It was suggested the formation of three task forces on the teaching, research and practice of public health in Europe together with the Commission of the European Union and WHO and in close cooperation with and perhaps divided responsibilities between the European Healthcare Management Association (EHMA), the European Public Health Alliance (EPHA) and the European Public Health Association (EUPHA). The terms of reference should be as pragmatic and down to earth as possible. Our conclusion requires core training scheme which is agreed by almost all workers in activity of public health, an integrated and sufficiently financed research, development program based on public health in Europe and a well managed and enough prepared exchange program and scholarship organization.

Key Words: Public Health, ASPHER, WHO

I. Introduction

Now we are going to design of a system for 4-years university for the education of co-medical workers. Public health is an important aspect as education subject of medical workers, for this purpose, it is a significant matter to know the actual situation of education in european Public Health and the present condition of public health. One of the most forceful advocates of this broader point of view was Winslow[1], who crystallized his thought into what became the best known and most widely accepted definition of public health and of its relationship to other fields. On the other hand, in Europe with regard to public health the final ratification of the Treaty of Maastricht late in 1993 was an event of great importance. As many different views however as there might be around this document, for public health the rules of the game are going to change. For the first time there is an agreed mandate for the

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development of Public Health Policy in Europe, even if admittedly in the first instance it regards only the present Member States of the European Union.

To speak about European status, in spite of the generally high life expectancy in Europe, the health status of many of its subpopulations is unsatisfactory, and such a statement certainly is not restricted to the East. People still suffer from avoidable diseases, impaired somatic and mental functions of daily living and insufficient participation in medical decision making. Social gradients can be demonstrated for the quality of and the access to medical care. On the other hand, more resources are necessary to further improve the population's health. As the marginal benefits decrease for additional resource-allocations in the classical medical sector of clinical care it becomes more apparent that the dominating diseases of today are mainly determined by lifestyle, environment and occupational setting. Here ASPHER's new slogan that "public health investment harvests rich rewards", delineated from Andrija Stampar's writings[2], is immediately applicable. Although by no means a new insight it still constitutes a great challenge to the health systems in the industrized countries. The limitations of conventionally organized health care are obvious.

In the following european researcher shall deal with (A) a common potentially European understanding of public health, (B) the ideal qualities of a European School of Public Health and (C) the specific contributions of the European Schools of Public Health to a Public Health Policy in Europe.

II. Common understanding

In order to define the potential contribution of the "European Schools of Public Health to Public Health in Europe" it is necessary to describe what public health in Europe ought to be. Certainly at the present time there is no consensus on that issue. However, a few cornerstones of what constitutes public health in Europe can be identified. For that purpose researchers take two core definitions or perhaps better still task descriptions of public health in current use throughout Europe. The first it was obtained from discussions under the aegis of the regional office of WHO. It is widely adopted now to our belief by WHO and around the world. To the best of my knowledge it was published originally in the Report on Public Health in England in 1988[3].

1) Public Health is the science and art of preventing disease, prolonging life and promoting health through the organized efforts of society[1]." The second description of public health stems from a political compromise of the Member States of the European Community and is a citation from Public Health in the Treaty of Maastricht (1993)[4].

2) "The Community shall contribute towards ensuring a high level of human health protection by encouraging cooperation between Member States and, if necessary, lending support to their action.

Community action shall be directed towards the prevention of diseases, in particular the major health scourges, including drug dependence, by promoting research into their causes and

their transmission, as well as health information and education. These two organizations constitute the most important "amalgamations" in health care at the European level —, with a technical and a political public health mandate respectively.

a) First and most important, both definitions refer to society and its organisation as a state, not to the individual perse. Although health is a personal good, it is not only an individual but also a collective responsibility[5]. Whereas the monitoring and restoration of individual health mainly is a task of the curative sector in medicine, the health of the entire population is subject to the society and to the democratic state.

It goes far beyond the present condition but opens a wide and important field, one can read. "Health protection requirement shall from a constituent part of the Community's other policies". This wording is a potentially very revolutionary meaning.

b) Second, both citations refer to science and research respectively. Public health cannot be built on either an uncritical (first) administratively executed top-down approach or an uncritical (second) action-oriented bottom-up movement. Rather it needs careful evaluative analysis and monitoring. However, to delay action or put-off intervention until perfect proof from perfect studies is available, would be wrong. What is much more important is to work with the results of imperfect studies keeping critically in mind, that they are imperfect and that newly acquired results might change the action. Unscientific appraisal or overinterpretation are the dangers not the detractions from scientific perfection in public health research.

c) Third, the wording of both accentuates health promotion, definitions stress prevention. The first one is the second health protection. There is a narrow interpretation of prevention as preventive medicine, obviously that is not meant here. Rather the explicit references that health is to be promoted or protected, point to a broader interdisciplinary understanding.

Health is not an ideal or perfect state but a relative condition in terms of adequacy and appropriateness. This relates to the three categories of prevention: maintaining good health, avoiding impaired health to worsen, and enable people to live with reduced health. In this sense e.g. to set a motivational and organizational framework for nursing of the elderly is an important issue of public health.

d) Fourth, there is a striking omission common in both definitions: medicine or at least public health medicine is not mentioned. What then is the relationship between public health and medicine and the medically determined health care system ?

To describe this relationship between medicine and public health from the public health point of view the researcher can modify a quote of Thomasio di Aquino on the role of theology: 'Like the architect thinks out a plan and directs the construction according to it, so the public health professional designs a system for the delivery of medical care.'

The fact that the system of delivery of curative care consumes about 90 % of all financial resources invested in the health sector-i.e. between 5 and 10 % of the GNP — makes it a legitimate subject to consider with regard to its impact on the public health, for example in the context of benefit to cost analyses. Although the problem would be misunderstood if an

economic calculus were applied to the patient-physician relationship directly, the society as a whole must not hesitate to set explicit priorities for resource-allocation wherever possible. This is appropriate as long as limited means are to be distributed in a regulated market, and that is the situation which is founded universally, and certainly everywhere in the European region. Thus although the delivery of medical care has not consciously been made part of the Community's mandate for a European Health Policy, its organization and quality will necessarily come into focus through comparative health systems research. Here e.g. the WHO is very explicit, namely in the wording of target on management, where the effectiveness of the health system is judged according to its impact on the health status and the quality of life of the population. The criteria enumerated are the citizens satisfaction with services, their efficiency or cost-effectiveness and measurable contribution to the HFA-targets[6]. Those are the four cornerstones of public health which it can be extracted from these two definitions: the societal dimension, the scientific foundation, the preventive orientation and the independence of clinical care. Is there anything specifically "European" about the architecture of the house which can be built upon these cornerstones? In order to illustrate that aspect, researchers would like to look back to the year 1883 when Bismarck presented his legislation on sickness funds — the "Krankenversicherungsgesetz" — to the Reichstag[7]. He based it on four principles: obligatory membership for everybody, variety of competing funds, partition of cost between employers and workers, and salary compensation during temporary disablement. What researchers consider to be the European quality is the attempt of Bismarck — who by no means can be called a socialist — to balance solidarity and free choice in such a way that the highest possible degree of equity and social security is achieved.

Tables 1

Qualities of public health in Europe	Resulting institutional features of Schools of Public Health
The societal dimension	Linkage to the political and administrative system
The scientific foundation	Linkage to academia in teaching and research
The preventive orientation	Linkage to practice and intervention
The independence (of care)	Autonomous institutional basis

III. The European School

Before researchers come to deal with the essential contributions of the Schools of Public Health in Europe to a Public Health Policy in Europe, researchers would like to examine from the aforementioned fundamentals what kind of training institutions are needed.

1) First the European School of Public Health in our view should have well defined links with the political and the administrative system. It is known that this statement is not popular everywhere in spite of the fact tha ASPHER's members are state-based institutions. Nevertheless it remains true that exerting influence in an open society is a two-way activity. The

school needs a direct and stable connection to the decision-making process if they want to channel their services adequately.

2) Second in order to study their duties properly and according to scientific standards, the ideal European school requires some links with the universities. Most likely this could be in terms of a postgraduate organization of training schemes leading to academic degrees, and in terms of common projects of applied research. Funding policies should support this kind of cooperation. Also there should be legal provision for exchange of staff between schools and related faculties, and perhaps through national and international scholarship schemes. The difficulty very often is the notorious antagonism between the Ministry of Health and the Ministry of Science to both of which a School of Public Health has to be related.

3) Third as much as public health is an applied science of preventive orientation and not "l'art pour l'art", the schools must relate to the practice of public health and to practical intervention. They have to be institutional change agents not only executives. Researchers believe that they have a good example in the way the faculty of health sciences has contracted a network of institutions in the field like the Johanneswerk or Bethelcaring for the physically and mentally handicapped — the latter well known through the recent visit of our Japanese — or like my own institute, the State Institute for Social Medicine and Public Health (IDIS). Staff of the institutes lecture at the university, students of public health work on their theses in the institutional settings and common research projects are pursued like e.g. the development of a health audit for public construction works or similar activities.

4) Fourth because of multiple and potentially conflicting relationships the European School of Public Health must have an independent institutional basis. It should neither be an institute of the Ministry of Health nor exclusively part of another faculty. A School of Public Health should cooperate closely with but needs to be separate from the school or faculty of medicine. Again this is not always popular, not even in the prevailing model in Europe but at least a department of public health should be an autonomous unit even within a medical faculty. Why is this said? Because it is foreseen that the public health group will remain in a structural minority within the clinical disciplines which means a persistant disadvantage when scarce resources are to be distributed.

In summarizing the European School of Public Health should be an independent institution with equally strong links to the administration, to the universities and to the practicing institutions. How this triangle can be organized and what the locally appropriate balance should be is up to those who want to invest in public health to quote Andrija Stampar's words. Those who tackle the work should also be responsible for these decisions and no binding rule can be set except for the requirement that public health must be anchored in all three corners of the triangle of administration, academia and practice.

Ⅳ. The schools' contributions

Contributions to the public health of Europe was expected from such necessary institutes.

The above defined cornerstones and the delineated qualities of a European School of Public Health can also be read as a broad task description but it needed to be a little more specific and relate to the immediate priorities in the region.

Table 2 High ranking contributions of the European Schools of Public Health to public health in Europe

Teaching	Development and review of European standards and internationally exchangeable training modules
Research	Development of essential public health objectives at the operational level and of a European public health information network, based on standardized health indicators
Practice	Agreement on professional guidelines for the practice of public health in Europe and promotion of mutual inner-European site-visits to enhance personal contact and first hand knowledge

1) Teaching: The primary task of ASPHER is to foster qualified public health training in Europe. This is not restricted to an organizational model e.g. graduate or postgraduate. But as to the application in research and practice, it is necessarily an interdisciplinary one and teaching therefore has to be multidisciplinary. The question is whether this can be done without interdisciplinary communication. Researchers have learned during the early years that this is not a good will action alone — sometimes difficult enough — but one of structure. Not only lecturers have different concepts, languages and terminologies. Also students at least the postgraduate ones depend on their original training and profession. You can not simply add, you have to modify. That can only be done in an interdisciplinary group situation, which brings together students and lecturers of different background in a common setting, even in a common room and over longer periods. They need to accept each other as equal personalities and differently formed intellectual minds. As we believe this is the strongest argument for a liberal admission policy and to some degree for a postgraduate model.

Modifying a little bit Moyses Szklo, one of the most distinguished members of our scientific advisory committee, three groups of basic disciplines of public health: (1) epidemiology and biostatistics, (2) health protection and health promotion was defined (3) health policy and management. These are essential for efficient health planning and policy making.

Table 3 The basic public health sciences

Scientific foundation:(Academia)	epidemiology and biostatistics
Preventive orientation:(Practice)	health protection and health promotion
Societal dimension:(Administration)	health policy and management

The board of ASPHER has presented a European Public Health Training Programme[8] and suggests the establishment of a European Review Board in order to set and to help implement standards of public health training in the region. This will be achieved by proposing a system of certification of Europe-wide acknowledged training modules.

2) Research: To Humboldt's ideal of "Lehre und Forschung", teaching and research interlinked. Therefore if ASPHER is charged with the promotion of public health teaching in Europe, it is also charged with research or more precisely training for research.

It was suggest that in this area the researcher cooperate as closely as possible with the European Public Health Association which was founded as recently as 12.1992 and is still in its early stages of development. To illustrate tentatively the extreme importance of the public health research agenda I want to give you a simple account of the hypotheses developed to explain the widening differences in life expectancy since 1970 between the two Germanies[9], accounting for more than 2 years in favour of the West by the year of change 1989.

Table 4 Hypotheses raised to explain differences in life expectancy between Germany East and West:

※ The organization of health care (centralization, institutionalization)
※ Resources allocated
※ The provision of high-tech medicine
※ Degree of public information and participation (e.g. self-help-groups)
※ Quality of nutrition
※ Consumption of tobacco and alcohol
※ Environmental pollution
※ East-West migration

In order to develop a systematic approach to these issues a reliable routine Public Health Information System is needed in Europe.

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