

**Horst Noack
Dorothea Kahr-Gottlieb (eds.)**

PROMOTING THE PUBLIC'S HEALTH

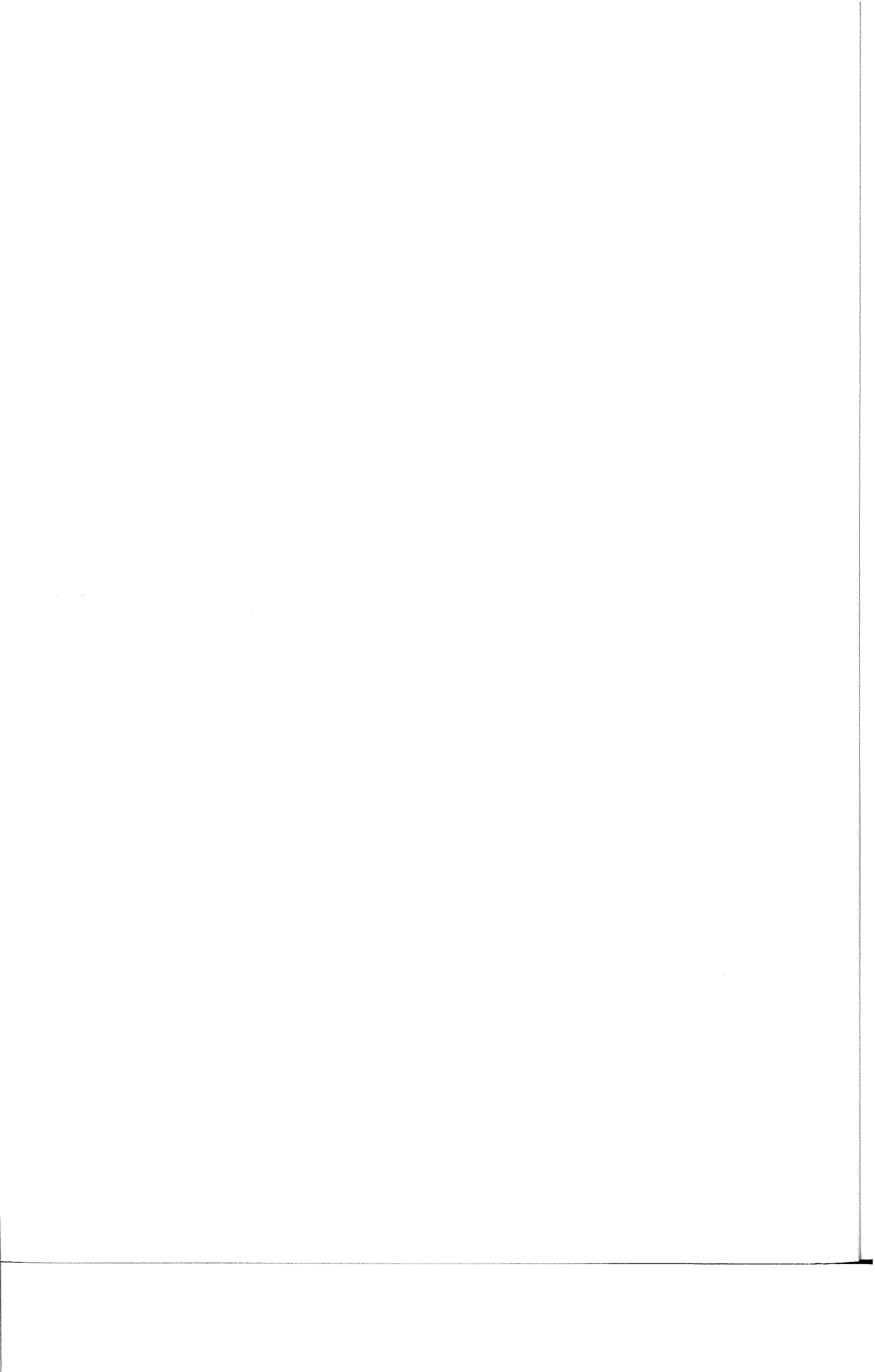
**EUPHA 2005
Conference Book**

**Health Promotion Publications
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Promoting The Public's Health
EUPHA 2005 Conference Book

Editors:

Univ. Prof. Dr. Horst Noack
Dorothea Kahr-Gottlieb
Universitätslehrgang Public Health
Universitätsplatz 4/3
A-8010 Graz
Austria
horst.noack@meduni-graz.at
dorothea.kahrgottlieb@meduni-graz.at

Layout:

Florian Zimmermann
Günter Conrad

Hard Cover Design:

Georg Matal

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The growing burden of chronic disease: New challenges for public health

Iveta Nagyova, Jitse P. van Dijk, Horst Noack^a

Epidemiological trends in the development of chronic diseases

Marked improvement of living conditions as well as advances in the fields of bacteriology, immunology, pharmacology and public health during the last 100 years have resulted in a precipitous decline of morbidity and mortality from communicable and other acute conditions. Rapid increase in longevity is dramatically changing the burden of chronic disease throughout the world.

Today, acute communicable diseases no longer constitute the major threat to health. They account for 9 % of the disease burden in the European region measured in DALYs, while external causes of injury and poisoning account for 14 %, and chronic non-communicable diseases account for 77 % (see chapter by Nedret Emiroglu).

The most frequent chronic conditions are:

- ischemic heart disease,
- depressive disorders,
- cerebrovascular disease,
- alcohol use disorders,
- chronic pulmonary disease and lung cancer, and
- road-traffic injuries.^{1,2}

It is estimated that the population of people with chronic conditions will increase steadily in the next two decades. This rise in chronic illness morbidity is primarily due to increased life expectancy and the aging of society. A study by Anderson & Horvath (2004) shows that 85% of people aged 65 years and older have one or more chronic conditions, compared to 45% of the working-age population and only 23% of children¹. Prevalence of multiple conditions increases with age: Only 5% of children have multiple chronic conditions, 20% of the working-age population, but over 60% of people aged 65 years and older.^a

^a The authors would like to thank Prof. Dr. S.A. Reijneveld from the University Medical Centre Groningen, the Netherlands, for helpful comments on an earlier draft of this chapter.

Given this situation, this chapter examines some of the challenges for public health and the health care sector in coping with the growing burden of chronic disease.

Disability, loss of social participation and quality of life due to chronic diseases

Regardless of their biomedical aetiology, most chronic diseases put similar demands on the health system regarding the organization of healthcare and disease management. Most chronic conditions confront patients and their families with about the same spectrum of problems or tasks: to alter their lifestyle; to cope with the social and emotional impact of symptoms, disability, and approaching death; to cooperate with the medical care system and follow the rules of prescribed or suggested treatment.^{3,4}

A common feature of chronic diseases is their tendency to limit functional abilities. The International Classification of Functioning, Disability and Health (ICF) provides standardized definitions of these limitations as well as a classification system for the consequences of chronic disease.⁵ Disability within the ICF serves as an umbrella term covering the experience of functional limitation at the level of the human body, of the individual person and the social or physical environment. Disability is considered to be the outcome of the dynamic interaction between a person's health-related factors and his or her life context. Important health-related personal factors are age and gender; health status; psychological and physical abilities; social status, education and ethnicity. The life context is made up of numerous factors of the natural and physical environments: assistive technologies; health and social services; social networks and social support; health-related practices and lifestyles; health and social policies; social values and attitudes.

Disability is defined according to three dimensions:

1. body functions or structures – an experience of disability is defined as an impairment (e.g. lack of muscle tone, incontinence, intellectual impairment);
2. personal activities – an experience of disability is defined as an activity limitation (e.g. inability to walk, communicate, self-care);
3. social participation – an experience of disability is defined as a participation restriction (e.g. not working because of an inaccessible workplace).⁵

Since the publication of the ICF, growing attention has been paid to social participation, and particularly to a disabled person's involvement in family and community life. According to Cardol et al. (2002), a thorough assessment of

perceived restriction(s) in social participation is essential to understand the social impact of chronic illness on personal life, and to be able to offer tailored rehabilitation programmes, specific social interventions, or environmental adjustments for meeting the needs of disabled persons.⁶ Given the appropriate environmental adjustment and social facilitation, a severely disabled person, for example a person in a wheelchair, may well be able fully to participate in family and community life.

As the prevalence of chronic diseases grows and the perspective of public health widens, the focus of health care seems to be slowly shifting from *'adding years to life'* to *'adding life to years'*. Chronically ill persons often have multiple pathologies and reduced physiological and psychological capacities, and they may also experience a more restrictive social environment. These trends have led to growing interest in the Quality of Life (QoL) construct and its assessment.⁷ Multi-level assessment across the physical, psychological and social domains of quality of life is becoming important, as it provides the basis for a comprehensive assessment of QoL.

Assessment both of disability and of quality of life may be seen as necessary because the medical diagnosis alone may often not be sufficient to define service needs, to assure quality of care and to facilitate social participation. An adequate information base on disability patterns within the chronically ill population, as well as continuous monitoring of quality of life, are essential prerequisites for identifying health care needs. They set priorities for effective interventions, matching health needs and resources, and measuring the outcomes, effectiveness and efficiency of health care policies. From a public health perspective, there is a growing need for suitable ICF and QoL instruments to assess disability patterns within chronically ill population groups, to monitor changes and to evaluate the outcomes, the effectiveness and efficiency of intervention policies. Instruments should be developed through theory-guided empirical research. They should be compatible with international classification systems and produce internationally comparable information on the development of chronic diseases.^{5,7}

Challenges for public health in the 21st century

Over the last century, the industrialised countries have experienced a major epidemiological transition. They moved from a pattern of predominantly acute communicable diseases early in the century to a pattern of predominantly chronic non-communicable diseases within the second half of the century. As already mentioned, this transition is to be attributed largely to an unprecedented improvement in the population's standard of living, but in some degree also to

major advances in medical science, health technology and the provision of accessible and effective health services.

While the shift of the burden of disease toward chronic diseases already became evident in the 1960s, most European public health systems responded rather late and largely inadequately; they were deadlocked in their traditional functions of public hygiene, sanitary control, vaccination and medical prevention. Whereas infant mortality, unplanned pregnancy, malnutrition and infectious diseases no longer constitute major threats to population health in the European region, they remain serious challenges for many developing countries. The vast majority of these countries are now struggling with a growing '*double burden*' of disease, including both acute and chronic conditions.^{4,8,9}

A large body of sound knowledge, from both empirical scientific research and practical experience, clearly indicates that an efficient strategy to achieve a sustained decline of the chronic disease burden must successfully integrate long-term disease prevention and comprehensive disease care. Primary prevention of chronic diseases should be the primary goal, followed by secondary prevention, medical treatment and tertiary prevention. Primary prevention seeks to systematically reduce exposure to behavioural and environmental risk factors. Secondary prevention aims at the early detection and cure of chronic conditions. Following a comprehensive approach to clinical disease care, tertiary prevention typically sets out to minimise the risk of recurrence of chronic conditions, and to re-integrate treated patients into everyday family and professional life.

Yet the aims of the three approaches to chronic disease prevention are difficult to meet and, indeed, have often not been met. As the North Karelia project and other Finnish programmes have shown, sustained primary prevention of cardiovascular disease and lung cancer is possible if (and only if) population-wide lifestyle changes can be achieved through integrated community programmes focusing on nutrition, physical activity, smoking and health promotion.¹⁰ Secondary prevention of coronary heart disease, type 2 diabetes, breast cancer and other conditions is possible if comprehensive programmes successfully integrate high-quality screening, effective treatment, rehabilitation and long-term health promotion efforts. Although little evidence seems to be available, on theoretical grounds it can be expected that tertiary prevention will also be quite effective if appropriate conditions exist.

From a modern public health perspective it can be shown that available knowledge about the prevention of chronic diseases has scarcely been transferred into health policy and practice. The whole field has largely remained a neglected issue in Europe, as well as in other regions of the world. To tap the great potential of preventing chronic diseases is one of the big challenges for 21st century public health.

The question has been raised, why the medical care system has been so slow to respond to the growing burden of chronic diseases. According to Epping-Jordan (2004) health care systems are still largely using episodic, biomedical practice models. Care is fragmented, based on acute and emergent symptoms, and often provided without a behaviourally informed approach.¹¹ For the most part, health care systems around the world are trying to prevent and manage chronic conditions using systems and methods of care that were designed for a different set of problems. As both public health and medical care continue to pursue their traditional functions, the growing problem of chronic diseases and, even more importantly, the problems of co-morbidities are largely ignored. The chronic disease management model is far more complex than that required for handling acute patient-centred problems. It entails multiple causal factors spread out over the entire life course and implies a broader approach integrating both horizontal and vertical systems' levels, where the patient, the family and the community are involved as active participants.^{8,12,13}

In many countries, there is growing recognition of the need for an evidence-based and patient-centred organisation and practice of health systems.^{4,13} Comprehensive models have been developed to guide policy makers and practitioners. For example, the *Innovative Care for Chronic Conditions (ICCC)* framework (2002), an expanded and internationalized adaptation of the earlier *Chronic Care Model* developed by Wagner and colleagues (1999)^{14,15}, outlines the components necessary to improve patient care at three levels of the health system: the general policy environment, the level of health care organizations or community, and the patient-care level.

In a recent document, WHO (2005) calls for a reform of health care workforce training better to meet the needs of caring for patients with chronic conditions.¹⁶ A new expanded training model defines a set of core competencies of the health care workforce active in chronic disease care, i.e. lay health workers, nurses, physicians, pharmacists, dentists, and allied health professionals:

1. patient-centred care – supporting patients' self-management, a proactive approach;
2. partnering – working closely with patients, but also with other providers and with communities;
3. quality improvement – safety and quality of patient care, translating evidence into practice;
4. information and communication technology – internet-based health information system;

5. public health perspective – population-based care, systems thinking, working across the care continuum.

Concluding remarks

The burden of disease has largely shifted to chronic non-communicable diseases. In Europe, as well as in other regions, chronic conditions represent about four fifths of the disease burden. Yet health care policy and health care governance have not been adequately adapted to the change. An overwhelming body of evidence clearly indicates that a narrow approach to public health, based on the medical model, is largely inadequate to cope with the 'chronic disease epidemic'. A broad model of public health is needed, guiding comprehensive public health action: the assessment of disability patterns and of preventive and health care needs; the development and implementation of integrated strategies of primary prevention, secondary prevention, effective treatment, rehabilitation and tertiary prevention; and new efforts in health education and workforce development.

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List of Authors

List of Authors

Tit ALBREHT

Institute of Public Health of the Republic of Slovenia
tit.albreht@ivz-rs.si

Kristina ALEXANDERSON

Department of Clinical Neuroscience, Karolinska Institute, Stockholm,
Sweden
kristina.alexanderson@cns.ki.se

Toni ASHTON

Centre for Health Services Research and Policy, New Zealand, School of
Population Health, University of Auckland
t.ashton@auckland.ac.nz

Bernhard BADURA

Faculty of Health Sciences, University of Bielefeld, Germany
bernhard.badura@uni-bielefeld.de

Barbara BERNIK

Institute of Public Health of the Republic of Slovenia
barbara.bernik@ivz-rs.si

Christopher BIRT

University of Manchester and Heart of Mersey, United Kingdom
christopher.birt@heartofmersey.org.uk

Angela BRAND

German Center for Public Health Genomics, University of Applied Sciences,
Bielefeld, Germany
angela.brand@fh-bielefeld.de

Helmut BRAND

Institute of Public Health NRW (lögD), Bielefeld, Germany
helmut.brand@loegd.nrw.de

Nedret EMIROGLU

WHO Regional Office for Europe, Copenhagen, Denmark
NEM@euro.who.int

Armin FIDLER

Health Sector Manager for Europe and Central Asia, The World Bank, Wash-
ington DC, USA
afidler@worldbank.org

Dorothea KAHR-GOTTLIEB

Master's Programme for Public Health, Medical University of Graz, Austria
dorothea.kahrgottlieb@meduni-graz.at

Ilona KICKBUSCH

Senior health policy advisor to the Swiss Federal Office of Public Health,
Switzerland
kickbusch@bluewin.ch

Wilhelm KIRCH

Institute for Clinical Pharmacology at the Faculty of Medicine, University of
Technology, Dresden, Germany
wilhelm.kirch@mailbox.tu-dresden.de

Horst KLOPPENBURG

European Commission, Health and Consumer Protection, Directorate General
horst.kloppenbourg@cec.eu.int

Mihály KÖKÉNY

Former Government Commissioner for Public Health, Chairman of the Health
Committee of the Hungarian Parliament, Hungary
mihaly.kokeny@parlament.hu

Alenka KRAIGHIER

Institute of Public Health of the Republic of Slovenia
alenka.kraigher@ivz-rs.si

Andrej MARUŠIČ

Institute of Public Health of the Republic of Slovenia
Andrej.Marusic@ivz-rs.si

Martin McKEE

London School of Hygiene and Tropical Medicine, United Kingdom
martin.mckee@lshtm.ac.uk

Enni MERTANEN

Jyväskylä University of Applied Sciences, School of Tourism and Services
Management, Jyväskylä, Finland
enni.mertanen@jamk.fi

Iveta NAGYOVA

Institute of Social Sciences and Kosice Institute for Society and Health,
Faculty of Science, University of PJ Safarik, Kosice, Slovakia
SAVEZ – Slovak Public Health Association
rajnicova@upjs.sk

Horst NOACK

EUPHA President
Master's Programme for Public Health, Medical University of Graz, Austria
horst.noack@meduni-graz.at

Christoph PAMMER

Master's Programme for Public Health, Medical University of Graz, Austria
christoph.pammer@meduni-graz.at

Jürgen PELIKAN

Institute for Sociology, University of Vienna; Ludwig Boltzmann Institute of Health and Medicine, Vienna, Austria
juergen.pelikan@univie.ac.at

Ursula REICHENPFADER

Institute for Health Promotion / Prevention Josefhof, Graz, Austria
ureichenpfader@hotmail.com

Karin REIS-KLINGSPIEGL

Styria vitalis, Styrian Society for Health Promotion and Prevention, Graz, Austria
karin.reis-klingspiegl@styriavitalis.at

Walter RICCIARDI

Institute of Hygiene at the Università Cattolica del Sacro Cuore, Rome, Italy
wricciardi@rm.unicatt.it

Hans SAAN

Health promotion consultant on policy, strategy, quality and professional development
hans.saan@hccnet.nl

Regina SAUTO ARCE

Centre for European Policy Studies, Brussels, Belgium
reginasauto@yahoo.com

Selma ŠOGORIĆ

Andrija Štampar School of Public Health, Department of Social Medicine and Organisation of Health Care
ssogoric@snz.hr

Martin SPRENGER

Master's Programme for Public Health, Medical University of Graz, Austria
martin.sprenger@meduni-graz.at

Marc SUHRCKE

WHO European Office for Investment for Health and Development in Venice, Italy
msu@ihd.euro.who.int

Gunnar TELLNES

Department of General Practice and Community Medicine, University of Oslo, Norway
Past president of EUPHA
gunnar.tellnes@medisin.uio.no

Jitse P VAN DIJK

Department of Social Medicine, University Medical Center Groningen, University of Groningen, The Netherlands
j.p.van.dijk@med.umcg.nl

Paolo VILLARI

Department of Experimental Medicine and Pathology, Università La Sapienza, Rome, Italy
paolo.villari@uniroma1.it

Božidar VOLJČ

Blood Transfusion Centre of Slovenia
bozidar.voljc@ztn.si

Dineke ZEEGERS PAGET

EUPHA manager, Utrecht, The Netherlands
d.zeegers@nivel.nl

PROMOTING THE PUBLIC'S HEALTH

The conference book highlights the outcomes of the 2005 EUPHA conference held in November 2005 in Graz, which attracted 900 public health researchers, policy experts and practitioners from all continents. It addresses three broad questions:

- Are the determinants of population health a major issue of research, practice and policies in European public health?
- What efforts have been taken to build adequate public health capacities?
- Is population health a reasonable aim of public health policy?

The European public health community seems to share a reasonably strong value and knowledge base related to the determinants of public health which, however, varies markedly between countries.

Yet, in most countries there is a serious need to invest in capacity building in order to develop sustained public health infrastructures and appropriate problem-solving capacities.

The book shows that European countries need to move towards a comprehensive health policy if they aim at a more equitable social distribution of health opportunities, a better balance of health promotion, disease prevention and curative care – and ultimately a healthier population.

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