UCAP UTAMA

PAVING THE WAY FOR A PUBLIC HEALTH RENAISSANCE

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INTRODUCTION

Public Health has been defined as "the provision of health care to groups of populations using public health strategies focusing on preventive aspects of health". Hence, a Public Health Renaissance would mean a revival of sorts in the field of health care provision to the public from the Public Health viewpoint.

In the first place, is there really a need for a Public Health Renaissance? Have the public and/or powers-that-be been so disillusioned with the present state of affairs as to warrant a revival of the whole domain of Public Health? Or is it just a term coined up by a few "visionaries" for something that has been and is already taking place within the domain realm? Are we not already in the midst of this so-called "Renaissance"? And if we are, where are we, how far have we gone and in what form is the "Renaissance" taking place?

Come to think of it, what does the process of undergoing a "Renaissance" really entail? Does it essentially involve paradigm shifts and mindset changes of individuals or is it a total revolutionary migration of visions and missions of whole vast organisations and systems? Is it a slow, evolutionary process, allowed to gradually unfold or is it a drastic all-or- nothing event? And does it refer to the "New Public Health" that we have been talking about in recent times?

THE NEW PUBLIC HEALTH

In recent years, we have been inundated with the concept of "The New Public Health" which essentially consists of a few core issues revolving around the following:

Partnership in health care

Public sector partnership with the private sector is not a new phenomenon. What is being questioned is the proportion and quality of partnership involvement. What has frequently happened in the past points to an unequal balance between the public and private sector, in terms of expertise of health professionals, remuneration for services rendered and health service delivery itself. Previous partnerships have also been fairly unproductive because both the public and private sectors were working in parallel but not in tandem or synergy with one another. The new "smart partnership" concept as mooted by the government calls for a partnership resulting in win-win situations for all parties concerned. The private sector is not only made up of

individual and group general practices but increasingly, these practices are being merged and result in the formation of bigger management practices and with the burgeoning interest of big corporations or multinational groups in the lucrative health care industry, it is beginning to get a bit overcrowded. The choice of public versus individual good in setting priorities for such partnerships will pose a particular challenge. The role of academia as partners with the public and even the private sector has to be exploited and optimised to the full.

Community development

In 1976, the Alma-Ata Declaration of Health For All by the year 2000 was made. We are now on the brink of that year 2000. What have we achieved in light of this declaration so far? Are we there yet? The emphasis of this declaration centred on a Primary healthcare approach and a community approach participation. What is the state of our Primary Care Services? Have we done justice to the traditional WHO concepts or have we evolved our own concept of primary health care? If we have not achieved the Alma Ata objectives yet, does this indicate the need for a Public Health Renaissance?

Community-approach participation

There is only so much that the government or health services provider can do for the individual and community's health. The role that the community plays in improving its health status is monumental and is the key to the success or failure of a particular health programme. To this end, most public health strategies incorporate community participation among its tenets.

Health services delivery development

i)   Private-public

Historically, public health sector contribution to health services delivery was small and mainly related to sanitation aspects and malaria control. In fact, health services delivery was the domain of a mainly private sector, whereby the colonial masters interested in maintaining their employees' health, established employee healthcare facilities such as estate clinics. It was only after Independence that the Rural Health delivery system emerged (in 1958) whereby a proper infrastructure was put in place. The 3-tier system was subsequently replaced by a 2-tier system, which ultimately aimed to serve every citizen of Malaysia within a 5 kilometre radius. At present, the private-public ratio in health care delivery would safely be estimated at 40:60 although in times of economic recession, the figure would more likely be 20:80. It is the long term view of the Ministry of Health to ultimately divest itself of the bulk responsibility of health services delivery; however, how and when privatisation of health services will take place is open to conjencture.

ii)   *Financing*

Prior to Independence, the majority of health care services (of curative nature) were taken up by employers of workers within the colonial set-up. It was only after Independence that the government started financing the health services. However, because of convenience and other factors, in addition to curative care, employers still undertook the onus of responsibility upon themselves for their workers' primary health care. Hence it remains to this day that the Government and the Employers play a major role in the primary healthcare financing of the nation. This is in contrast to many other countries of the world where the government and individuals finance primary healthcare, whereas the Employers concentrate on other aspects of healthcare. That is why that the government of Malaysia may be looking to the Employers to divest itself of the bulk of its primary care responsibilities (via health insurance schemes etc). For the individual, the options for healthcare financing lie in either out-of-pocket expenditure, health insurance schemes or a national health financing scheme (which is still in the offing after a decade or so of considerations).

iii)   *Needs versus Demands*

Needs are perceived as basic living necessities which require fulfillment whilst demands connote ideas of luxury and affordability. Are demands changing into needs then? When do demands change into needs? Who decides? For example, when does the availability of and accessibility to a heart bypass operation become a need as opposed to a demand? These are issues facing contemporary society.

iv)   *New health needs*

With the changing pattern of disease following changes in demographic makeup and modernisation sweeping across developing countries, a whole emerging spectrum of hitherto unanticipated diseases has emerged. These include emerging and reemerging infectious disease, lifestyle-related diseases and diseases resulting from the occupational and environmental impact on health. In addition to that, we also have health impacts related to warfare, civil strife and economic recessions.

v)   *Use of appropriate technology*

Many health care professionals undergo some from of training overseas and inevitably, end up bringing back technology from elsewhere. The question is how appropriate that imported technology in the light of local settings and scenarios. A lot of times, by the time that imported technology has been modified to be used locally, it has already become obsolete in its place of origin, hence this "transfer of technology" is counterproductive. Mechanisms of health technology assessment need to be established and accepted as a culture within the health portals.
      Whether the Public Health Renaissance as envisaged incorporates these elements of the New Public Health remains to be discussed. So where are we in the

grand scheme of things? Probably, in all eventuality, we'll arrive there. But as it stands, we are not there yet. What has prevented us from our imminent arrival? Probably, the existence of some current and foreseeable challenges stand in the way.

CHALLENGES FACED

What are the challenges that face Public Health workers currently and in the years to come? Maybe we can formulate some strategies to overcome or even reduce them. The challenges stated below have been put forward based on predictions of future problems as evidenced by national and global trends (megatrends).

Problems related to the environment and essential resources

This is a global issue. We have inherited the Earth and it is imperative that we take care of it for our future generations. A lot of the problems related to the environment have been a result of industries and transport systems. Pollution arising from these entities warrant the need for alternative transport systems and alternative power sources. In Malaysia, the effectiveness of hazardous waste is questionable. Good clean-up of waste zones is especially doubtful locally. On the issue of dumping across national boundaries, OACD measures of hazardous waste disposal is as odds with recipient countries' apparent acceptance of such wastes. As regards trans-boundary pollution, a good example in hand is the haze problem over South-East Asia. The mainly reactive stand taken by affected countries as opposed to proactive stance, means that the problem will take a long time to be resolved, and one wonders at the effectiveness of efforts being expended.

Epidemics and infectious disease

Much of the situation being experienced worldwide is a result of complacency on the part of the public health sector with regard to communicable disease control. Much has been said and focussed on non-communicable or lifestyle disease that we have lost the momentum and impetus for the drive against communicable and infectious disease. The so-called "epidemiological transition" resulting in a shift from communicable to non-communicable disease might no be the case at all. Is there really a transition? It just may be the case that we'll always have communicable disease with us; that we are newly detecting what has always been there. Hence, the problems of new emerging disease and reemergence of old infectious disease will continue to ai11ict us should we still adhere to this theory.

Development of the "Magic bullets" – Vaccines

The reaffirmation of the importance of infectious disease in global proportions has rejuvenated the need for the development of vaccines, an extremely expensive and technology-intensive endeavour. Added to that is the problem of "the catching-up game" whereby the infectious agent, in its pursuit of survival of its species, is leading

mankind on quite a wild goose-chase. These infectious agents have the ability to mutate, change strains at will and thereby pose a great challenge in developing the appropriate vaccines against them. As a result, there are actually very few successes story where vaccine development is concerned.

New technology including gene technology, genetic engineering etc

The controversy surrounding the theory of "nature versus nurture" in disease susceptibilty and disease risk is still unresolved. In going towards gene technology, one would actually like to have an idea of the contribution of genetic factors (or the nature component) toward disease susceptibility and risk as opposed to environmental and lifestyle influences. If the genetic contribution is minimal or highly specific, then are we justified in spending time, effort and money in developing highly specialized but fairly unapplicable technology? Or are we justified in pursuing the satisfaction of imagined needs (of human perfection and cloning) at the expense of being practical? There are a lot of ethical issues also involved in this. Do we have the right to select or reject genetic material based on its scientific merits (in the pursuit of a supreme human race)?

Food production

In these times, a lot of foods are mass-produced. Genetic engineering of food has come to the forefront in Man's quest for perfection and insatiable thirst for better quality foods. Due to mass production of foods, the opportunity for mass-contamination arises; either as an unintentional act or as an act of sabotage.

Alternative healthcare products

International marketing of healthcare products is a lucrative global industry. Multilevel marketing business entities thrive on pushing their products to an undiscriminating public. Currently, there are no monitoring or regulatory mechanisms to verify effectiveness of such products. No control measures are in place to prevent exploitation of the public and market. On another front, Malaysia being blessed with a rich ecosystem (both flora and fauna), needs to become street-smart in its pursuit of the global herbal medicinal market. Although we have in existence, an industry catering to natural and herbal products, we have to be on guard and jealously avoid Western exploitation of our own natural resources.

Fast-moving technology

Fast-moving technology has necessitated the need to retool and retrain healthcare providers to enable them to utilize changing technology. Fast moving technology also means, at times, the purchase of expired and outdated technology. These two factors has immense most implications and need to be factored in any planning activities.

The social contract

The government has been given the mandate to rule and in line with its manifesto, a social contract of sorts is in existence. The social contract with regard to payment of healthcare is of paramount importance. So far, the government has been responsible for the bulk of healthcare expenditure. However, in line with its quest to reduce its expenditure, the government is obliged to come up with a financial scheme that will benefit all the stakeholders within the health domain in Malaysia.

The social contract

The government has been given the mandate to rule and in line with its manifesto, a social contract of sorts is in existence. The social contract with regard to payment of healthcare is of paramount importance. So far, the government has been responsible for the bulk of healthcare expenditure. It has done very well in keeping costs affordable to the general public. For instance, registration at a hospital facility costs only RM1, whilst specialist service requires a RM30 registration. However, in line with its quest to reduce its expenditure, the government is obliged to come up with a financial scheme that will benefit all the stakeholders within the health domain in Malaysia. For the private healthcare sector, social responsibilities must be upheld. Oft-times, we hear that a patient has been turned away from a private facility due to financial deficiencies, even at times of medical emergency, which warrants urgent attention. Quality control of healthcare needs to be instituted by the different stakeholders of the healthcare domain. We surely cannot expect the government player (i.e. the Ministry of Health) to be its own arbitrator of standards. In this day and age of political milieu, where hidden agendas preside over overt ones, there is a serious need for independent arbitration of standards of care. Consumer protection is also an important issue. Consumers must be empowered to be able to make health decisions of their own accord. Implications of libel suits in medical negligence cases need to be explored too.

Health needs and demands

With empowerment of the public regarding health issues and greater access to health information, needs and demands become interchangeable . Will it become provider-defined needs (since availability of services can induce demand) or will it become client-directed needs (based on evidence, national surveys or scientific studies? Indeed, who decides?

Globalisation and Regionalisation

Globally, at least for the public health sector, WHO is the agency entrusted with monitoring of health-related activities. But can we, in the foreseeable future, envisage world healthcare in the hands of 6 or 7 multinational healthcare corporations? A similar situation that we can see within the petroleum industry, where 6 or 7

multinational corporations dominate the entire globe. But, is Healthcare an industry? Is it subject to globalisation and borderless forces? If yes, then who dictates it? If it is not an industry, then should there be healthcare for profit?

Should Regionalisation be encouraged and anticipated then? Do we want a similar mechanism as evidenced in the European Union? In EU, certain practices of exclusivity of EU membership, uniform standards of practice thereby leading to interchangeability of practice based on qualifications have raised numerous controversial issues. If here in the ASEAN region, we would like to emulate such regionalised EU practices, then we would be able to see concensus on air pollution standards, cross-practice standards, eligibility criteria for healthcare standards etc which woul definitely make the ASEAN region a more livable place. But the problem arises with benchmark standards to be used. If we set it at too high a level (for example following EU specifications), then that would probably limit regional participation. On the other hand, too low a level would make a mockery of the whole concept.

In such a scenario of globalisation and/or regionalisation then, the role of national healthcare providers like the Ministry of Health would be in limbo. Would it take on a regulatory role in terms of quality control and cost-containment or would an international body such as WHO (or even some multinational corporation) take over? If healthcare is seen as an industry, then can healthcare as a commercial product be overseen by international trade organisations such as WTO? As an existing entity, Malaysia Inc can be an active participant in providing healthcare or health-related services internationally or transboundary, for example setting up medical faculties in other countries.

Provision of care to special groups of people

i)   Migrants

In fact, should the concept of regionalisation of healthcare take root, the term "migrant" might not be used anymore. Currently though, the question to ask is "Who actually takes care of the migrant population's health"? They are generally treated as second class citizens where healthcare is concerned. Not only do they have to pay more (double) that of local citizens, but also the quality afforded them may even be less superior than what they receive back where they came from. There should be a social responsibility towards this group of people from all healthcare stakeholders and players.

ii)   Elderly

With increased life expectancy of the Malaysia population and social development of the extended family, more and more of the elderly survive but in dire circumstances. The needs of the elderly revolve around both health and social issues and the responsibility for their welfare should be undertaken by a multidisciplinary and multipronged approach.

iii)   Workers

The emergence of new industries in this country with hitherto unknown hazards added on to identifiable, existing hazards of the current industries, has pushed worker healthcare and safety to the forefront. However, inaccessibility to industry premises and work processes has dampened the initiative to improve worker healthcare and working conditions.

POSSIBLE STEPS TO BE TAKEN TO PAVE THE WAY

Firstly, we have to have some idea of where we are and some idea of where we're headed. The options open to us consist of the following:

Continued use of public health strategies

However, these strategies would have to be modified and made innovative and sensitive enough to meet the changing needs of the client population. To do so, would entail a better understanding of the client's perception of risk to better bring about behavioural changes. The use of empowerment of health strategies and risk assessment methods for the public should be considered. There is also a need for evaluation of Risk Communication strategies and the state of Risk Perception by the public.

Use of innovative methods in information technology

The portal of Telemedicine can be optimised for bringing about empowerment information exchange to the general public, i.e. through the application of the Mass Customised Public Health Information and Education. For the health professionals, the application of Continuing Medical Education via Web-based material is mooted. The application of Lifetime Health Plan will provide a seamless record of patient care irrespective of healthcare provider and premise and covers a person's health record from womb to tomb. The application of Teleconsultation will enable referrals and second opinions be made over distance and time constraints.

Use of evidence-based criteria

The much vaulted and acclaimed use of evidence-based criteria needs to be looked at in perspective. Is it really useful? Oft-times, when recommendations based on evidenced material are made, questions arise as to the parallel need for cost-benefit assessments. Thus the usefulness of such evidence is questionable. In fact, might not this whole "evidence-based" concept be the start of a new religion or trend in public health circles which may be well-propounded but in fact be little more than choice words with little meaning?

Concensus statements in Public Health Practice

There is a need to standardise some public health practices example pertaining to epidemic control activities, hazard evaluation criteria and risk communication strategies.

Criteria-based evaluation to measure effectiveness

Oft-times, the main drawback in programmes formulated for healthcare services is with regard to its lack of evaluation criteria. It is interesting to note that the decade-old Healthy Lifestyle campaign carried out by the Ministry of Health has yet to be evaluated for effectiveness in terms of public behavioural change as well as other measurable outcomes.

Use of the "5-levels of prevention" strategy

Level 1:   Health promotion - The emphasis now is to use Promotion of Wellness or improving quality of life as the main strategy rather than prevention or curing diseases. Wellness is promoted through nutrition education, healthy lifestyle etc.
Level 2:   Specific protection - This involves the development and provision of vaccines to combat specific diseases
Level 3:   Early diagnosis - The development of appropriate screening protocols especially for diseases like cervical cancer "down staging" methods and genetic technology may be examples.
Level 4:   Prompt treatment - This takes into consideration, new therapeutics, aspects of cost, enhancing compliance and monitoring of adverse effects
Level 5:   Disability limitation and rehabilitation - The ultimate objective being provision of an acceptable quality of life for the patient.

As a layman, looking at the issues from the outside, yet like others in my position, immensely interested in the steps ahead, public health presents a bewildering picture, much promise but equally fraught with possibilities of wrong choices, Malaysia stands on the threshold, seized responsibilities and needing to make the right choices for its population and fully mindful of the social implication especially to the lower income and the rural population.