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Prevention and health promotion in the Federal Republic of Germany: paper prepared for the conference on "Community participation and empowerment strategies in health promotion", Zentrum für interdisziplinäre Forschung (ZiF), Universität Bielefeld, June 5.-9, 1989

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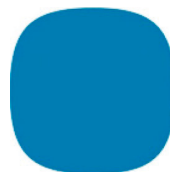
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Wissenschaftszentrum Berlin
für Sozialforschung

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Prevention and Health Promotion in the Federal Republic of Germany

Paper prepared for the Conference on "Community Participation
and Empowerment Strategies in Health Promotion"
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Universität Bielefeld, June 5 - 9, 1989

This paper focuses on three theses about the situation of preventive health policy in the Federal Republic of Germany:

- I. Much necessary and possible prevention is being shunned.
- II. Political and economic factors are responsible for this, at least in large part.
- III. There are specific ways to surmount the obstacles posed by these factors and thereby considerably enhance the effectiveness of prevention.

This rather optimistic note requires a rather bitter preface. In the Federal Republic of Germany, as elsewhere, the scientific and political preoccupation with public health policy threatens to obscure the fact that important political fields are host to relatively unimpeded processes whose impacts are so obvious and inimical to both health and prevention that the only effective ways to ensure prevention lie in a fundamental reorientation of policies in those fields. Counting the hidden labor force, 3.7 million persons will be unemployed in the Federal Republic of Germany in 1989. In 1988 16.5% of the registered unemployed were jobless longer than two years. Unemployment is uprooting, it destroys a person's sense of himself and robs him of

meaning and rhythm. Even the employed, however, are not much better off. In addition to a high basic level of classical unhealthy conditions in working life, new--especially psychological--stresses are growing rapidly. The share of employment contracts that fail to provide adequate social protection and long-term perspective is expanding. Manifest poverty is expanding. The resulting overt and covert hardship cases are being individualized more and more through ideology and social policy. The access to compensatory social and health services is being drastically restricted in some instances. The pathogenetic impacts of such life settings, some of which are epidemiologically dramatic, have been clearly documented many times. Simultaneously, we are confronted every day with fresh news about present and impending environmental catastrophes that will eventually threaten the foundations of our lives. That is frightening and can be discouraging, as are the debates that cruelly play on the fear of the end of the world with every new round in the arms race. Anxiety and discouragement make for an inconceivably poor climate for positive activities. But as a positive activity, prevention in the sense of protection from diseases virtually depends on an appropriate climate.

Instead of breaking off my lecture and resigning at this point, I would rather draw two interim conclusions. First, it is evidently not customary to examine measures of labor-market policy, technology policy, and innovation policy systematically for their impacts on health or to measure their permissibility by the degree to which they promote health. The aim of doing justice to health has no lobby

comparable to the one that made a city's compatibility with the automobile the yardstick of settlement and urban development in the 1960s. A well-conceived, healthy public policy in the Federal Republic of Germany simply does not exist. Second, even these few examples of processes suggest that whoever insists on seeing individual behavior as the most important cause of disease--and thereby as the target of effective prevention policy--must put on blinders to block out the socially produced conditions affecting behavior differently from one individual to another, the very conditions that would have to be socially changed to promote health.

I. This point may become still clearer if I support my first thesis about the possibility and necessity of prevention by saying a few words about the panorama of diseases and causes of death. Morbidity and mortality in the Federal Republic of Germany are dominated by a few, usually chronic diseases, which thus assume the rank of common epidemics. Cardiovascular diseases, carcinomas, noninfectious rheumatism, chronic bronchitis, some afflictions of the stomach and intestinal tract and the liver, diabetes mellitus, and addictions and mental ailments account for more than three quarters of the morbidity and mortality rates in the industrialized countries. Out of every 100 inhabitants of the Federal Republic of Germany on any given day, 15 feel ill, two-thirds of them chronically. Chronic and mostly degenerative diseases are on the increase and are spreading to more and more young age groups.

For all their diversity of causes, courses, and terminations, these diseases have three characteristics in common:

1. None of them can be either prevented or cured by medical means. Even vastly increased medical efforts, including earlier diagnosis, would not change this fact much on the whole. Historically, all major common diseases since at least the industrial revolution have been fought first and most effectively by primary prevention, not by medical science. Improvements in living, working, and educational conditions as well as spontaneous and publicly encouraged or initiated behavioral changes had always already broken the waves of the great, usually infectious epidemics, mainly those of nineteenth-century Europe, by the time modern medicine and its effective weapons of immunization and therapy were able to take effect and ensure success.

The onslaught of AIDS is currently challenging us to repeat that success. In light of experience and modern knowledge of ways to influence behavior, the undertaking does not seem hopeless. But this point is only incidental in the present context, for in the Federal Republic of Germany AIDS is a minor disease in epidemiological terms. It is, and one hopes it will remain, atypical of the country's clinical picture.

2. The beginning of what are usually most long and multifaceted causal chains of chronically degenerative diseases always lies well before their manifest outbreak. It lies wholly or largely outside the individual, in living, work-

ing, or environmental conditions, that is, in spheres that can be shaped through policy.

3. The risk of becoming ill or dying, the possibility of countering unhealthy conditions through individual behavior, and the chances of physically, mentally, and socially overcoming a disease are inequitably distributed in society. A thirty-five-year-old university professor lives an average of ten years longer than a semiskilled worker. Although equal access to health care is largely guaranteed by insurance laws, it is still unable to close the widening gap of social inequity in the face of disease and death.

This realization has given rise to a broad consensus that breakthroughs in health policy must be achieved against all the aforementioned diseases, particularly by intervening before they become manifest.

Prevention it is, then; but where? At which level? By whom and with which instruments? There is no pat answer to these questions. Should prevention focus on changing unwholesome living and working conditions or on reducing unhealthy behavior of the persons affected? The research results and experiences gathered in the Federal Republic of Germany and abroad since the 1970s only permit the conclusion that this question should be answered first and foremost according to the criteria of effectiveness and expediency, with both being bounded, of course, by ethical and legal considerations.

Representatives of behavioral prevention as well as the advocates of preventing conditions that undermine health

can point to successful and unsuccessful examples of the effectiveness of their strategies. The enormous improvements of personal hygiene in the fight against the old contagious diseases, the safety belt in automobile travel, the successes in preventing dental cavities (as in Switzerland), the dramatic changes in behavior of the groups mainly affected by AIDS, and the recent, drastic decline in smoking in the United States show that public policy can nudge behavior toward more prevention. And the greater the number of appropriate strategies that follow the motto of the World Health Organization ("Make the healthier way the easier choice"), the more effective that encouragement is. True, little progress has been made against poor dietary habits, the consumption of common drugs (especially alcohol), and lack of exercise. But then again, a wife and mother of two children who performs poorly paid, monotonous shiftwork, spends an hour a day getting from a satellite town to her job and back, and takes care of her sick mother on the side is not going to be easily convinced that she could cook healthier meals, jog on the weekends, quit smoking, and cut down on drinking. This portrait highlights the limits of strategies that are intended to influence behavior in isolation. People living under such stress do not regularly attend cooking courses or training on how to cope with stress when they are offered by the sickness funds or the adult education centers.

Despite all the problems with the effort to prevent stressful conditions, indisputable successes have been scored in the technological sphere of properly caring for health and improving safety in the world of work and on pub-

lic roads, particularly over the last fifteen years. The same can be said of food hygiene, of some areas of environmental policy, and of other fields of the public health service, which still achieves a great deal despite a variety of structural obstacles.

At the same time, the prevention of unhealthy conditions usually ends where vested economic and political interests are at stake. The warnings of diminished profits and competitiveness on the world market--most of which are empirically questionable and, for decision-makers dealing with health policy, not even intelligible--have repeatedly thwarted effective prevention. They are obstacles that only political measures are likely to overcome. To the extent that that is not possible, actors will tend to turn evasively--or more accurately, tend to retreat--to behavioral approaches: recommending gymnastics instead of improving the ergonomic structures of jobs, and recommending consumption patterns and leisure behavior alien to the reality of people's lives and work. Even well-meant social marketing cannot make such recommendations more livable and feasible.

The politically often fruitful dispute over whether to prevent behavior or prevent unhealthy conditions regularly becomes idle the moment it becomes a feud over principles. By and large, it is a matter of intervening in the multifaceted causal chain of primary, secondary, and tertiary risk factors and risk constellations as early as it is scientifically plausible, politically possible, and ethically permissible to do so. When doubt arises, approaches to preventing unhealthy conditions are more expedient because their effects are automatic, consistent over time, and

socially nondiscriminatory. In order to help reduce unwholesome behavior, appropriate campaigns aimed at specific groups and social strata must be conceived. The social conditions giving rise to unhealthy behavior, if not already eliminated, must at least be openly discussed in such programs. The difference between preventing behavior and preventing unhealthy conditions disappears when the learning program is made to include the conscious effort to overcome the social conditions shaping the undesirable behavior. These are approaches that begin directly with the way of life led by the threatened population groups, providing nonpatronizing information and specific kinds of assistance to start building their individual and collective capacity to improve the way they deal with health hazards.

II. If prevention is thereby not only necessary but also possible, then one is compelled to ask why more is not being done to promote it. In this context, one often hears the objection that the effectiveness of nonspecific prevention in particular must first be proven before it can be invested in. A glance at the history of health teaches something else, however. The most effective strategies for warding off disease were semiexperimentally conceived and implemented, that is, without definite knowledge of their positive impacts. It is precisely nonspecific prevention--to which the multifactorial genesis of common modern diseases leave absolutely no alternative--whose effectiveness usually cannot be proven in advance. Rudolf Virchow and Max von Pettenkofer were incorrect about the genesis of the diseases for which they proposed effective preventive measures. We know far more today. But what is lacking is the broad test-

ing of preventive models through plausibility and common sense. Conversely, definitive knowledge about ways to prevent diseases such as rheumatism in the world of work or respiratory ailments caused by air pollution have not inspired corresponding preventive efforts. Such experimentation was especially intense in the 1970s, when strategies and instruments of social prevention pertaining to occupational safety and health, health-related environmental policy, self-help groups, and the local supply of health goods were developed and in some cases experimented with. With few exceptions, however, they were never implemented in a manner that could have optimized their scientific possibilities. In the wake of economic crisis, mass unemployment, and financial austerity, even promising approaches were deprived of what they needed, one reason frequently being the simultaneous, relatively uncontrolled increase in expenditures on the health-care system. Contrary to many a legend, the 1970s in retrospect emerged not as the decade of failure to make progress toward prevention but as the decade of failure to establish a systematic framework for it. It was a program that became entangled in the thicket of economic interests and institutional vanities.

That fate has to do with three factors, which can be treated only briefly in the present context.

(a) No one has been made responsible for social prevention. Health policy is largely understood in the Federal Republic of Germany to refer to medical services. That is, intervention occurs when it is basically too late. Recent attempts to push this responsibility onto the sickness funds are inadequate, as demonstrated by the Health Reform Act of

1989. True, according to § 20 the sickness funds are supposed "to pursue the causes of health hazards and health damages and work to eliminate them," but the law permits only the kind of measures that can be dispensed by the sickness funds as services to their own members. Since the sickness funds are simultaneously supposed to compete for various insurant groups more and more among themselves with differentiated rates and catalogues of services, prevention is usually reduced to commercialized slogans and PR.

A situation is building in which decision-makers can point both reassured and reassuringly to the fact that prevention is now a responsibility of the sickness funds while at the same time these institutions have little latitude, few resources, and no motivation to be genuinely resolute about pursuing strategies to prevent disease. To the political scientist such practices are well known as "symbolic policy." It remains to be seen how the old and new social movements, the critically inclined medical and nonmedical health professionals, and experimentally minded parts of the government apparatus will deal with this new situation. There seems to be little reason for much optimism.

(b) A second reason that the possibilities of prevention are underutilized lies in the fact that health and disease have been defined and managed for a century by curative medicine centered on the individual patient. That is good and necessary, provided it is focused on healing and affording relief from diseases and on caring for the sick. It goes very little further where individual medical care is taken as the privileged starting point for prevention. For social pre-

vention and preventive individual medicine follow two different guiding principles. Preventive individual medicine asks how we can detect as early as possible that an individual is falling ill and what we can do to arrest or reverse the individual course of the disease. By contrast, the question at the root of social prevention is under which conditions human beings remain healthy, or under which conditions the incidence of major diseases declines, and what we can do to bring about or maintain these conditions for as many people as possible.

Accordingly, the approach taken in individual medicine is that of early diagnosis and early treatment, and medical technological has made impressive advances in the former area in recent decades. The gulf between medicine's diagnostic possibilities and therapeutic capabilities continues to widen, however. Medical findings indicating unknown but dramatic and even fatal consequences if disease breaks out are mounting, but the possibilities for successful medical intervention are nowhere near to keeping pace. Judging by the results of Anglo-American social epidemiology in particular, much of the programs for early diagnosis have scarcely any demonstrable epidemiological benefit today.

Moreover, the people who avail themselves of early diagnosis programs least are the ones for whom the probability of successful intervention would still be relatively high. More and more medical swords of Damocles are being created without effective therapeutic follow-up being available. Think of the controversial discussions about the role of HIV antibody tests for the prevention and treatment of AIDS. With the possibility of detecting genetic disposi-

tions, which gene technology is now making possible, qualitative leaps are in store for us in this respect.

To avoid misunderstandings, it should be stated that early-diagnosis examinations for infants and small children are a good and very effective instrument of prevention. Early diagnosis of cervical cancer, and perhaps also of intestinal cancer and breast cancer may be worthwhile if they actually reach the target groups, especially those in the lower classes. By contrast, the literature has no sufficient epidemiological evidence for the effectiveness of general check-ups as introduced by the Health Reform Act under the misleading heading of "health examinations." In any case, we will not be able to defeat the major common diseases by promoting ever larger early-diagnosis programs. The need is thus to ensure that the strategies of social and medical prevention have the same conditions for development and the same standards by which to measure their effectiveness. For with dissimilar instruments but comparable effectiveness, the two types of strategies seek to protect against dramatic outbreaks of disease.

Allow me to illustrate this point briefly with the example of heart failure. In cases of heart failure, preventive medicine intervenes with *surgical means* (pacemakers, bypass operations, angioplasty, vascular surgery with lasers, for example) and *long-acting medication* (antihypertensives, nitropreparations, beta-blockers, and calcium antagonists, and for example). These interventions compete with strategies of social prevention, which relies on prevention of unwholesome conditions and/or *protection from exposure* such as specific and nonspecific stress reduc-

tion, particularly in the work environment; *various coping techniques* such as attempts to influence techniques of coping with stress; *behavioral changes* based on risk-factor models relating to smoking, exercise, diet, salt intake, and other problems; and approaches of *health promotion* that focus on strengthening social networks and on offering opportunities for the individual to become active.

A glance at the picture of health policy teaches that the modes of medical intervention are always favored in this competition against the strategies of social prevention. This practice may be leading ever further down a blind alley. It would be necessary to compare the two types of intervention dispassionately and seek ways to combine them synergetically. Among other problems, however, there is no overall institutional responsibility to for this (see below).

(c) A third reason that prevention has been neglected has already been mentioned. When it comes to restructuring jobs, physiologically and socially conducive working-time regimes, healthy structures of durable goods and consumer goods, or improved commuter conditions and leisure, important economic and political bastions usually obstruct the path to effective prevention.

These factors are unlikely to change much in the foreseeable future. These are thick walls at which one must doggedly keep boring. For all their diversity in other regards, these factors pull the discussion in the same direction: the underestimation, and thereby underutiliza-

tion, of the possibilities offered by social prevention, without which a health policy appropriate for the future can hardly be conceived.

III. To conclude, I would like to cite at least a few positive ways to begin establishing or disseminating effective strategies of prevention. Identifying such points is often made difficult by two typical misjudgments of the situation regarding preventive policy in the Federal Republic of Germany. In the one position behavior and structures inimical to health are viewed as being largely resistant to policy. The result is a tendency toward resignation that is often combined with an inclination to find fault with the citizens and the people affected for not wanting to be helped. Resignation then frequently comes to include "blaming the victim." Many times the cause of this attitude is rooted in the genuinely meagre successes of approaches based purely on educating for health. The major difficulties of establishing effective prevention are commonly confounded with the minimal effectiveness of such strategies.

The other position consists in the seductiveness of blithe messages about health conveyed in rosy ceremonial addresses on health promotion, by the mere renaming of institutions, and by the smugness behind highly modest offers to change behavior. These things only tend to discredit serious prophylaxis. To be perfectly sober about it, prevention of the major diseases of our times is a field of science and a policy in which we are only just beginning to move. To develop it we must content with many obstacles: lack of knowledge, learning difficulties, and problems of

political feasibility. Surmounting them requires initiative and courage to innovate, including institutional innovation.

Whether it is prevention in the local community, the world of work, or individual ways of life, the most important point is to help those who are affected to strengthen their capacity to perceive and cope with health hazards. Herein lies the great productive power of prevention. From the perspective of health policy dominated by medicine, this is often called the "layman's system." The term is not accurate, however. Where human beings perceive for themselves that their health is, or may be, at risk and then do something about it, they are, first of all, not laymen but rather the top experts.

This capacity should be promoted. In terms of government policy and the influence exerted by associations, this is complicated, for it is primarily a matter of developing the capacities of those affected and creating real possibilities to exert influence. It is not a matter of patronizing, incorporating, subordinating, and pacifying. The aim is to recognize that the more or less organized capacity of those affected represents an independent pillar of the manner in which society deals with health and disease. The aim is also to translate that realization into policy to be pursued by the government and the relevant interest associations. This competence must be given opportunities to develop that are comparable to those in other systems of care and support.

The most dynamic part of the social efforts to forge a new, preventive understanding of health policy consists of the diverse, very heterogeneous health movements that exist.

I am not thinking only of spectacular events like health days attended by tens of thousands of people but also of the approximately thirty "health shops," the five thousand to ten thousand health-related self-help groups, and the innumerable grass-roots initiatives against environmental damages, the nuisances of traffic, and other problems. The more the plant employees themselves can be brought to identify health hazards on the shop floor, especially complex multiple stresses, and the more they can be motivated and trained to work out stress-reducing measures, the keener their awareness of such risk constellations becomes. Combining the world of work for the relatively easily recognized constellations of risk that contribute to noninfectious rheumatism and cardiovascular diseases, for instance, could be initiated best by the employees themselves and would presumably effect a high level of prevention. As for AIDS, note how for the first time effective primary prevention is being managed through about sixty local government-supported self-help AIDS organizations that represent and coordinate the expertise of those affected.

It is probable that prevention policy can be effective only if its thrust is to develop the capacity of those affected and to make the implementation of flanking measures and strategies of the government and modern medicine contingent upon whether they serve this objective or tend to thwart it.

It is evident that such activities initially emerge decentrally and should be promoted decentrally. Public institutionalization of the public interest in health could play an important role in this respect. This would include,

for example, regional health conferences at which the local or regional administration and the social welfare institutions are represented equally at public meetings in which priorities, objectives, measures, and the resources necessary for them are discussed with the entire range of actors. Organizations of the world of work and environmental protection quarters, consumer associations, grass-roots initiatives, self-help groups, and, of course, members of the local medical community could be partners in the discussions that take place in that setting, even in spectacular processes of direct negotiations with the public. Such conferences could further public discussion, encouragement, and public support.

Naturally, there is an even greater lack of a solid data base in the Federal Republic of Germany than elsewhere. Although the academic discipline of social epidemiology originated and flowered in Germany at the beginning of this century, it has never been unable to recover from the blows dealt it in 1933. It took a long time for the idea to prevail in the Federal Republic of Germany that the grounding of effective prevention also requires scientific institutions like those that have been working successfully in other countries for a long time as "schools of public health," for example.

Nevertheless, the approaches we already have are enough to launch and provide foundations for both national and regional monitoring and assessment of health. Regional reporting on health is thus not a new burial ground for data. From territorial, industrial, and social perspectives, its goal is to give an organized overview of the

health problems and risks in a region, their social distribution, and the possibilities for reducing the risk to health and evaluating suitable approaches.

A regional system of monitoring and assessing health of such design can become an instrument of mobilization and leadership for regional prevention policy. In this context, nodes of air pollution, occupational illness, traffic hazards, social focal points, morbidity rates, and the measures of unspecific and specific, medical and nonmedical prevention interrelate. The benefit of developing and implementing effective prevention lies in longer active lives. Nothing suggests that this would be beyond our ability to pay.

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