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Recent developments in disease prevention/health promotion in the Federal Republic of Germany

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**RECENT DEVELOPMENTS IN
DISEASE PREVENTION/HEALTH PROMOTION
IN THE FEDERAL REPUBLIC OF GERMANY**

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RECENT DEVELOPMENTS IN DISEASE PREVENTION / HEALTH
PROMOTION
IN THE FEDERAL REPUBLIC OF GERMANY

by Rolf Rosenbrock

I. To speak about disease prevention/health promotion means to speak about specific fields in the manifold landscape of how society deals with health. Although the problems of access to the health care system and the problems of structuring, shaping, steering and financing it are internationally dominant in the debates on health policy, there is a broad consensus in the professional world of public health, that breakthroughs in health policy must be achieved first and foremost by intervening before diseases become manifest and that, in the areas of preventative health policy, the largest reserves for improvement of its efficacy have yet to be mined.

- This will be seen more clearly, perhaps, 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. As in all industrialized countries, 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, diabetes mellitus, some afflictions of the stomach , intestinal tract and liver, as well as addictions and mental ailments account for more than three-quarters of the morbidity and mortality rates in industrialized countries. On any given day, 15 out of every 100 inhabitants of the Federal Republic of Germany feel ill, two-thirds of them chronically. Chronic and mostly degenerative diseases are on the increase and some of them 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:

ad 1.) First, none of them, in terms of epidemiology, can be either prevented or cured by medical means. Even vastly increased medical efforts, including earlier diagnosis, would not change this fact much. Historically, since at least the industrial revolution, all major common diseases have been fought first and most effectively by primary prevention, not by medical science. The same seems to be true for the impressive decrease in coronary heart disease, especially in the U.S., although no one really knows how to explain this astonishing development. 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 - primarily those of nineteenth-century Europe - by the time modern medicine and its effective weapons of immunization and therapy were able to take effect and insure that 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. ¹

ad 2.) Secondly, the beginning of what are most usually long and multifaceted causal chains of chronically degenerative diseases always lies well before their manifest outbreak. It lies wholly or largely outside the individual biology, in living, working, or environmental conditions, that is, in spheres that can be shaped through policy.

ad 3.) Finally, 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 semi-skilled worker.

Although equal access to health care in Germany is largely guaranteed by insurance laws, it is still, and shall remain, unable to close the widening gap of social inequity in the face of disease and death.

II. Thus far, however, the resources invested and the results obtained in the area of preventive health policy stand in remarkable contrast to its importance and to its verbal acknowledgement.² There is no health-policy criterion at all in the political decision-making process, regarding some of the most important areas of reduceable health risks and, therefore, preventable ill-health, even though every political decision and non-decision in these areas has severe and epidemiologically measurable consequences:

Including the hidden labor force, 3.7 million people were 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 self and robs him, or her, of meaning and rhythm. The share of employment contracts that fail to provide adequate social protection and long-term perspective is expanding. Manifest poverty is also expanding. The resulting overt and covert hardship cases are being individualized more and more through neo-

Darwinist 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. It is evidently not customary to systematically examine measures of labor-market policy, technology policy, and innovation policy for their impact on health, nor to determine 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 1960's. A well-conceived, healthy public policy in the Federal Republic of Germany simply does not exist.

All this together, means that some of the most important areas of health policy intervention are simply not perceived as such. And, even in those areas where some health policy activities can be seen, the quantity and performance of those efforts remain poor. The only striking preventive public health campaigns in West Germany during the past two decades have been for seat-belt use in cars and condom use in preventing HIV transmission. There have been no exercise, nutrition, nor anti-smoking campaigns, as may be found in the U.S. I am not saying that the

U.S. approach of primarily reducing preventive policy to behavior modification is the ideal one. However, compared to West Germany, it must be said that, in this country, there is much more public concern, as well as more public funding and activities.

This is not true for those aspects of preventive policy which concentrate more on problems of reducing health risks by changing unhealthy conditions. The German labor-unions and, also, during the 1970's, the federal government, have made unhealthy working conditions a major point of their agenda. These include: work-schedule, work-load, stress, job security, meaningfulness of work, etc. The results, though, are rather limited and have decreased in recent years, due to power-relations which are mainly a result of labor supply-demand ratios.³

Also, despite the frequent scandalous publicity they receive, environmental health problems are not yet sufficiently recognized by state policy and remain more the concern of the social movements involved.

Thus, underuse and, in part, misleading concepts emerge as the summary finding of preventive health policy in West Germany. I will try to explain and illustrate this view by outlining three recent developments in West German health policy. These three examples should demonstrate:

- a) - that there is a lack of politically organized lobbying in the struggle for effective prevention, which leads at best to suboptimal approaches, if any at all.
- b) - that there is too much influence from the individual-oriented medical complex, in defining health problems and designing intervention strategies, and
- c) - that there is still a large deficit in the scientific founding and institutionalizing of public health in West Germany.

III. ad a) I would like to illustrate the first point by discussing the role and tasks in prevention assigned recently to the German Social Health Insurance System. The German Sickness Funds cover nearly the entire population, providing full medical service at practically no extra charge. Dues are proportional to income, and pay for full-family coverage. These institutions are run by equally represented groups of employers and unions under federal legislation. Aside from the problems encountered by these institutions in attempting to effectively control quality and costs of the privately organized and market-oriented health-goods suppliers, the system has developed for nearly 100 years as a cornerstone of state welfare and, thus, social stability.

In its last attempt, primarily in order to control costs and, to a lesser extent, to reform structures in this field⁴, the federal government passed a law, which came into force at the beginning of 1989. For the first time in history, this law passed a large share of responsibility for preventive policy to these institutions. According to paragraph 20 of this law, the sickness funds are supposed "to pursue the causes of health hazards and health damages and work to eliminate them." That sounds great. But a closer look at the personal, financial and power resources, as well as institutional motivation and decision making latitude, reveals the very severe limitations built into any possibilities for fulfilling this task.

First, according to the law, each of the approximately 1,200 individual sickness funds is entitled to expend money and effort on its own clients only. This means, that there is little motivation to tackle the aforementioned nationwide public-health problems of unemployment and environment, housing and social deprivation, which will no doubt increase substantially in the coming years, during the process of unification in Germany. There is no incentive for the individual sickness fund to try to influence even local traffic-, environment-, recreation-, or education policy, for the reason, that each respective target population is composed

of members of different sickness funds. This remains true, even when and if the sickness funds should hire appropriate professionals to handle such public health problems, which they are not used to managing. Whether they will be able to do this in an appropriate manner depends on two doubtful premises: the total amount for preventive activities (excluding medical secondary prevention, which I shall address later) is not allowed by the Federal Government to exceed \$700 million per year, which is not much, when compared with the \$90 billion per year total expenditures of the sickness funds. The second premise is the availability of well-educated professionals, who might also be scarce, due to the lack of scientific infrastructure, given the absence of Schools of Public Health in West Germany (I shall return to this point later, as well).

An even greater obstacle against effective prevention managed by sickness-funds is the fact that the labor-capital composition of the supervisory boards effectively impedes the thematization and management of health problems, whose roots cling to politically conflictive ground. Thus, the majority of work-, environment-, and consumer-goods-quality problems are marginalized from the agenda, which is structured according to areas of common interest among the involved actors, rather than addressing areas of conflict or controversy.

But, even in the event that a coalition of reason and health-interest, combined with some ability to enter into areas of conflict between these institutions, should manage to surmount these obstacles, their instruments are very weak: they have only limited access to data, they are only entitled to give advice and they have no regulatory power. And there is little hope that the few prevention-oriented interests could pool their energies across the borders between the many sickness-fund institutions. According to the ruling philosophy in West Germany, these institutions are supposed to act in the future, more and more, like competing market entities. This will most probably boost the tendency towards reducing preventive activities to those which are useful for public relations; this often being a more important criterion than epidemiological needs, or the state-of -the-art of intervention.⁵

Thus, we see a good example of symbolic use of politics: The government has done something; it has charged a prestigious institution with the task of disease prevention and health promotion. These institutions will, according to their possibilities and interests, mainly take such actions as will not be in conflict with vested interests. However, they will try to make these activities very visible. Consequently, this means a concentration of prevention policy on PR-

campaigns and the offer of some behavior-modification programs to their own clients. But that is only one - and probably the smaller - part of the problem. Since the question of whether prevention should focus on changing unwholesome living and working conditions, or on reducing unhealthy behavior, is not answered, under these institutional conditions, first and foremost according to criteria of effectiveness and expediency.⁶ Rather, it is biased from the beginning of the decision making process, starting with problem awareness and risk perception.

From the standpoint of public health, I would conclude from this section, that the new german federal legislation on prevention limits the scope of public preventive policy to measures which can be applied to individuals, mostly in the form of education or service-packs; that means: in the form of commodities.⁷ It remains to be seen how the old and new social movements, the critically inclined medical and non-medical health professionals, and experimentally-minded parts of the government apparatus will deal with this new situation.⁸ There seems to be little reason for much optimism.

IV. ad b) I would like to illustrate my second thesis - that there is too much emphasis on individual-oriented medicine in german public-health

affairs - with a further example from the aforementioned federal law. The law entitles every insured person older than 35 to a general check-up diagnosis every two years. This takes place in a country, where the population-wide insurance-paid early-detection programs count among the most elaborate and expensive in the world. This preventive-medical approach counts as prevention, as do social prevention or behavior modification; though under quite different principles: Preventive individual medicine asks: "How can we detect as early as possible, that an individual is falling ill, and what can we 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 do human beings remain healthy, or, under which conditions does the incidence of major diseases decline? What can we do to bring about or maintain these conditions for as many people at risk as possible?"

Accordingly, the approach taken in individual medicine is that of early diagnosis and early treatment. And medical technology has made impressive advances in the former area in recent decades. Medical findings indicating unknown but dramatic or even fatal consequences, if disease breaks out, are mounting. But the possibilities for successful medical intervention are nowhere near to keeping pace. The gulf between

medicine's diagnostic possibilities and its therapeutic capabilities is widening. Judging, in particular, by the results of international social epidemiology, many of the programs for early diagnosis have scarcely any demonstrable epidemiological benefit today. Moreover, the people who avail themselves of early diagnosis programs the least, are the ones for whom the probability of successful intervention would still be relatively high.

To avoid misunderstandings, it should be stated that early-diagnosis examinations established in West Germany for infants and small children are a very good and very effective instrument of prevention. Early diagnosis of cervical cancer and also, perhaps, of 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 abovementioned and so-called "Health Reform Act."

The costs of this program are estimated to amount to an additional \$500 million per year, not including the following treatments, whose effects on health are also somewhat disputable. More important, though, is the following observation: This program was established without any time limitations, nor any proof of its efficacy, and was established

against the evidence of a broad national and international literature. Imagine what would happen, if public health professionals would ask the government or the sickness funds for a comparable amount for reducing the risk of cardiovascular diseases, low-back pain, or whatever, by restructuring working conditions and workplaces according to state-of-the-art knowledge. They would have no chance of funding, even if they were able to show more evidence, or at least reasonable probability, of the health success of such a venture.

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 and, therefore, should be treated and estimated equally.

What is still only a small but increasing minority of west german physicians and, until now, very few medical representative/professional organizations, are presently willing to accept such equality in practice. Thus, a lot of professional political energy in West Germany's preventive policy is wasted by struggling for claim-frontiers of competence between the different professions. This unfruitful constellation, which seems to

be harder in Germany than in other countries, is not motivated solely by economic interests, but also has some of its origins in the history of german public health science. This brings me to my third and final thesis.

v. ad c) Foreign visitors in West Germany are time and again astonished that there are still no schools of public health in this country. All the more, since the concept of social epidemiology as the core of public health, originated and flowered in Germany at the beginning of this century.

In fact, not only was there the work of Rudolf Virchow and Max von Pettenkofer, but, also, a tremendous amount of academic research on social causation of health and sickness was done, especially in the 1920's. There were many, often successful attempts at implementing such knowledge in public policy, as well. But this science was considered to be left-wing, and there were many Germans of Jewish descent among the leading academics. So, the discipline was decapitated and abolished when the Nazis came to power in 1933. Many of the leading academics emigrated, often to the U.S.; many were imprisoned or killed; many had to change their professional field. Some of the remaining epidemiologists submitted themselves to fascism and participated in racist and social-

darwinist programs, bringing the discipline into murderous discredit. Thus, at the end of World War II, there was no one other than traditional physicians left to define - both in terms of policy and politics - first, what is considered to be a health problem and, then, what measures should be taken to counteract it.

Only at the beginning of the 1960's were a very few chairs of epidemiology established in west german universities, nearly all of them within traditional schools of medicine, all without very remarkable effects. At the same time, social sciences became more aware of social causations of health and sickness. They also noted social factors which impede or foster both preventing against, and coping with health problems on individual, institutional and societal levels. From an international perspective, as well, the research in these fields is quite well elaborated, but it is still sometimes missing links with clinical knowledge and medical epidemiology, and lacks possibilities for implementation and learning by doing.

At present, several attempts are being made to overcome this shortcoming.⁹ There are at least six schools of public health in the process of foundation. It is true, that four of these initiatives come from medical schools which insist on restricting access to this post-graduate

education, to physicians.¹⁰ Only two of the new schools, at the Universities of West Berlin and Bielefeld, will be open to graduates from other schools too.

These schools could not only educate the necessarily needed professionals in population-oriented health sciences, but could also serve as principal foci of pilot intervention programs. The U.S. experience shows remarkable success in this field. German universities, with increasingly regionalized approaches, are better prepared now, than only a decade ago. Thus, the schools must fulfill the challenging task of combining advanced epidemiology with the knowledge gained in etiological and intervention research. This must be linked with appropriate concepts for influencing unwholesome living conditions and unhealthy behavior. All this must be based on the background of a sound analysis of the fostering and impeding interests and conditions in the various fields of causation. In this way, the new public health efforts in Germany could contribute to enlightening the public and its different political actors, in order to overcome the aforementioned obstacles, to improve health, and to close the gap of social inequality in the face of disease and death.

ENDNOTES

1. I say this as a member of the Federal Parliament Committee on AIDS, which finished the active portion of its work by publishing the final report on AIDS-Prevention this spring. Deutscher Bundestag. Enquête Kommission *"Gefahren von AIDS und wirksame Wege zu ihrer Eindämmung"* -- Endbericht, BT-DS 11/7200, (Inquiry Committee on AIDS, Final Report) Bonn 1990. Report will be reprinted and published as a book in 1990 in the series: Deutscher Bundestag (ed.): *Zur Sache: Themen parlamentarischer Beratung*, Bonn.
2. In the German Federal Parliament Commission on the Structural Reform of the Health Insurance System, it was even politically debated to open the final report and, thereby, the political recommendations of the Commission, with the chapter on "Social Epidemiology and Prevention." See: R. Rosenbrock: *A Tightrope Walk Between Two Spheres of Logic. Observations and Self-Observations of a Social Scientist in Parliamentary Politics*, Working Paper 90-28, Institute of Governmental Studies, U.C. Berkeley, 1990.
3. See: R. Rosenbrock, *Industrial Health Policy in Crisis - Regressive Tendencies and New Tasks for the Professionals*. in: S. Bagnara, R. Misiti, H. Wintersberger (eds.), *Work and Health in the 1980's - Experiences of Direct Workers' Participation in Occupational Health*; Sigma: Berlin, 1985. (pp. 335-352)
4. This is part of a general pattern of health policy in western industrialized countries. See: R. Rosenbrock, *"Gesundheitssicherung durch Krankenkassenpolitik?"* In: B. Riedmüller and M. Rodenstein (eds.), *Wie Sicher ist die soziale Sicherung?* Frankfurt am Main: Suhrkamp, 1989. (pp. 135-168)
5. R. Rosenbrock, and F. Hauss (eds.), *Krankenkassen und Prävention*. Berlin: Sigma, 1985.
6. For a somewhat more explicit discussion of this crucial relationship, see: R. Rosenbrock, *Prevention and Health Promotion in the Federal*

Republic of Germany. In: E. Goepel and J.W. Salmon (eds.): *Community Participation and Empowerment Strategies in Health Promotion. Proceedings of an International Conference*, Universität Bielefeld: Bielefeld, Vol. 1, pp. 79-98.

7. For the comparable, but more advanced development in the U.S., see: Nancy Milio, *The Profitization of Health Promotion*. In: *International Journal of Health Services*, v. 18, no. 4., 1988. (pp. 573-585)

8. In the political arena, there are also alternative concepts of organization and institutionalization of health promotion/ disease prevention. See: Deutscher Bundestag: Enquête-Kommission "*Strukturreform der Gesetzlichen Krankenversicherung*" -- Endbericht; BT-DS 11/6380, (Inquiry Commission on Structural Reform of Health Insurance Law - Final Report), Bonn 1990, see note 2. Report will be reprinted and published as a book in 1990 in the series: Deutscher Bundestag (ed.): *Zur Sache: Themen parlamentarischer Beratung*, Bonn.

9. U. Laaser, P. Wolters, F.X. Kaufmann (eds.), *Gesundheitswissenschaften und Öffentliche Gesundheitsförderung; Aktuelle Modelle für eine Public Health Ausbildung in der Bundesrepublik Deutschland*. New York, Berlin, Heidelberg: Springer, 1990.

10. After decades of strictly opposing any institutionalized public health approaches in academia, it was only two years ago, that the same representatives changed their minds and began to prepare their own projects.