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

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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 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,

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 multi-faceted 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.

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

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.

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.

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

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

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-

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 neccessarily 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.

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 institutionalizaton 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.

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