

Global health issues and responses - paradigm shifts needed

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I was invited to speak at the 10th anniversary PHASA 2014 conference by the PHASA Executive and through Dr. Flavia Senkubuge, PHASA vice-president and also a member of a think tank (35 members from 27 nations) for the Epilogue of my forthcoming book, *Global Population Health and Well-Being in the 21st Century: Towards New Paradigms, Policy and Practice* (1).

To say that I felt honoured and privileged to be part of this momentous week would be an understatement, and my first trip to South Africa (SA) did not disappoint! The venue – the Protea Hotel Ranch Resort in Polokwane, Limpopo, where “hospitality is a long tradition” was certainly borne out. It was an exquisite setting in a game reserve and the conference attendees – close to 300 who came from different regions in SA and countries from Africa and beyond, many of whom I had the pleasure to meet, were extremely supportive and warm as well as passionate and committed to improving population health and well-being of those in SA. The research-sharing and poster sessions, covering a wide range of themes and topics related to SA health priorities, were highly relevant and engaging.

This brief article summarises some of the key themes of my two plenaries: the first for the PHASA delegates and the second for the Junior PHASA (JuPHASA) conference attendees. Both presentations were based on my current book, *Transforming Medical Education for the 21st Century: Megatrends, Priorities and Change* (2), which complements and builds on the seminal Lancet Commission report on ‘health professionals for a new century’ and the previously cited text on population health (1).

Global Health Issues

The global health and social issues facing the planet feel overwhelming: population growth and urbanization; conflict; climate change; fragile ecosystems, social intolerances, an ageing population in many western countries and rising chronic illnesses, broadly-based inequities, to name several difficult areas. Sub-Saharan Africa (SSA) and other nations are encountering a quadruple burden: not only do these countries have to tackle communicable diseases (e.g. HIV/AIDS, malaria, tuberculosis, and most recently Ebola), they are also confronting an increasing number of non-communicable diseases, many of which can be traced to problems of modernity, where there appears to be considerable incongruence between our lifestyle today and our genetic make-up evolved over millions of years. In addition, poverty illnesses (e.g. perinatal/maternal), violence and injury continue to undermine health and well-being and quality of life in general.

It seems paradoxical that while worldwide a population close to a billion people are undernourished those who are overweight now number over 1.5 billion and those who are considered obese now stand at over 530 million in countries from Columbia to Kazakhstan, leading to diabetes, heart disease, hypertension and high blood pressure. We are now challenged by many ‘wicked’ problems that do not conform to traditional population health interventions and an ‘ingenuity gap’ that urges us to take on a much more holistic rather than a reductionist view of reality (3) and approaches to public health interventions.

Global Responses

And while the UN Millennium Development Goals (MDGs) have made some progress (4,5,6) globally, crucial challenges remain. One of these is the need for re-balancing a world where most of the people live in the South and East (over 5.7 billion), but most of the funding for health (about \$US 7 trillion annually) is allocated in the North and West (about 1.5 billion people).

Furthermore, most medical and nursing schools are in the North and West (7) while poverty and the greatest burden of disease are found in south-east Asia, India and SSA, which has 24% of the world disease burden but only 3% of the world resources and 1% of the doctors (8,9). Doctor to people ratios are as high as 50,000:1 in several African countries and over 20,000:1 in several nations, such as Bhutan and Papua New Guinea .In effect, for many in these nations ‘health systems,’ as we define them in the literature, are non-existent. In the North and West the doctor-inhabitant ratio is about 300:1.

It is difficult to imagine for anyone living in relatively rich nations that globally two billion people do not have access to surgical procedures of any kind. According to the London International Development Centre and The Lancet, the main shortcoming of the current MDG framework is that it is concerned “with just adequate provision for some, ignoring the needs of those who are too hard to reach and not addressing the difficulties of inequality in societies that have deleterious consequences for everyone not only the poorest people.” (10) A key reason for this lack of progress, I have argued in section 4.1 of the forthcoming book, “that the MDGs fall far short in terms of addressing the broader concept of development encapsulated in the Millennium Declaration, which includes human rights, equity, democracy, and governance.” (5)

Fundamentally, there appears to be a pressing requirement to re-conceptualise the post- 2015 Sustainable Development Goals (SDGs), currently under discussion. To this end, Figure 1 proposes a framework that focuses on global social justice underpinned by peace, security and respect for basic human rights and informed by eleven key forces or indicators (5), each of which necessitates the development of realistic enabling strategies and actions. Consideration of the need for a broader SDG foundation may be made clearer by asking, as one example, ‘what is the point of treating a health condition or disease when conflict threatens the lives of the family and community or when polluted water continues to cause life-threatening diarrheal diseases?’

Criteria for evaluating the SDGs – holism, equity, sustainability, ownership and global obligation – are crucial in continuous monitoring of SDG developments as these progress from 2015 to 2030 (10).

Based on comments at the official PHASA plenary closing session, it appears that there is considerable support by PHASA delegates for these SDG directions.



Figure 1: Towards an integrated sustainable development goals framework (5)

Paradigm Shifts in this Century

To sustain the planet and its people in the long term, we are challenged with making two fundamental paradigm shifts in this century: one is moving from a stance held by many stakeholders, such as Governments and Big Business, that conceptualises “the world as a place made especially for humans and a place without limits: our task is to subdue and exploit the earth.” (3) To maintain our planet and its future generations we have little choice but to adopt a new worldview ensuring that the world is “compatible with our needs as human beings but also an outer world that is compatible with the needs of our ecosystem,” recognising “that the health of people, other animals and the ecosystems of which we are a part are inextricably woven together.” (11)

To enable “a global community of healthy people on a healthy planet” (12) demands another basic change in mindset: transitioning from a ‘sickness’ to a ‘well-being’ culture. That is, in this decade and next we need to replace our expensive industrial age model of health care, based primarily on treating ‘patient’ illnesses (a ‘sickness’ versus ‘well-being’ approach) - to one that is population and person-centred and places much more emphasis on prevention over curative measures (1), adopting a holistic biopsychosocial model of healthcare over the limited biomedical. Most non-communicable diseases – the cause of at least two thirds of deaths and morbidities worldwide are preventable! Governments – rich and poor – are feeling the funding strain and are seeking alternatives but are allocating only about 3 per cent of their health budgets to prevention and health promotion but around 97 percent to treatment and infrastructure! As one example, if the U.S. continues on its historic health expenditure path, predictions are that health care will take 58% of its GDP mid century – more than 50 cents of every dollar (13)!

Implications for Public Health Education

Dr. George Thibault, president of the Josiah Macy Jr. Foundation, the only organization in the United States dedicated to improving the health of the public, asserts that: “We will not

have enduring health care delivery reform without changes in the preparation of health professionals.” (1)

His conclusion is confirmed by The Lancet Commission report (7), which identified major global systemic failures in the education of health professionals, including:

- a mismatch between competencies and needs
- weak teamwork
- gender stratification
- hospital dominance over primary care
- labour market imbalances
- weak leadership for health system performance.

The preconference workshop that was held on 2 September 2014 was concerned primarily with the first two of these weaknesses, highlighting the importance of health and social care curricula that are based on population needs and are competency-driven, value active learning (e.g., problem or case-based) and inter-professional learning, and draw on local responsiveness with global connectivity.

Finally, one of the commendable PHASA aims is “to advocate for the conditions for a healthy society” (14). While the challenges are huge, it seems clear that PHASA, working closely with primary care, the communities and other stakeholders, has a unique opportunity to drive the much needed health system changes in public health through innovative and action-oriented public health education, playing a pivotal role ‘as a force for social change,’ and advancing ‘in policy and in practice’ the criticality of prevention and wellness across South Africa (1).

Thank you for the privilege of contributing to this PHASA newsletter.

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