

Health and wellbeing

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Health is a highly dynamic force which has shaped modern societies. After a long period in which health was thought of very much in relation to medicine's perceptions of disease, we are at a point in time where our view of health is being redefined – increasingly and persistently both by the market and by citizens. Health, it seems, is everywhere and we are caught up in a debate of what this ubiquity means.¹ Is it a new tyranny or a means to greater self-determination? Is better health a personal responsibility, or should there be significant action by the public sector to ensure health, including a restriction on goods and services that endanger health? Is health a private good or a joint responsibility of all citizens? How much health security should we expect from the state and how much can really be provided?

In the national political arenas, declarations about the importance of health, public health, health promotion and disease prevention abound, but are usually uttered in connection with a determined call to citizens to show more individual responsibility and to live healthier lifestyles. It is too tempting to reduce the spread of chronic diseases to a victim-blaming strategy with echoes of nineteenth century punitive attitudes to the causes of ill-health: those that become ill have only themselves to blame for smoking, over-eating or having sex with the wrong person. This type of argument ignores 150 years of European public policy experience. It neglects the commitment to address the conditions, the knowledge and the skills which enable people to live healthy lives, individually and collectively; it fails to address such factors as social inequalities, child poverty, tobacco control, the labelling of food products, sex education in schools. And above all it fails to have a positive vision of health and its contribution to society. There are very few countries that can claim to have a *health* policy deserving of the name, and only two countries in Europe – England and Sweden – have a minister dedicated to public health. Indeed, only one country – Sweden – has a health policy that focuses on inequality, and addresses the determinants of health.

A European opportunity

But this neglect by nation states could prove to be a window of opportunity for the European Union and for active European citizenship. The European Commission, through its work on public health, aims, 'together with the Member States, to protect and promote the health of European people. The Commission strives to improve public health in the European Union, to prevent human illness and diseases and to obviate sources of danger to human health . . . For the Commission, health is a key priority. That is why the Commission has developed

a more coordinated approach to European health policy: a high level of human health protection should be assured in setting out all Community policies' (from the Commission's public health programme website).²

The Commission was able to develop its work in public health precisely because European member states had begun to neglect their public health systems and saw no danger in giving the Commission the latitude to deal with this rather vague and undefined area of health to which they did not in fact accord very much importance. Their main concern was that the Commission would not interfere with the countries' healthcare *systems*. This shortsightedness on the part of nation states gave the Commission the opportunity systematically to strengthen its activities in public health, particularly in the past decade, for example through the establishment of a European Centre for Disease Prevention and Control (ECDC), an Executive Agency for its Public Health Programme in 2005, and strong legislative action on tobacco control through a number of Commission decisions and directives. Indeed, the more that health becomes a trans-national issue, the more health becomes a market, the more it becomes a concern of citizen's action groups at the European level, the more the Commission is challenged to provide public health strategies that concern Europe as a whole and that fit well with global health strategies.

Compared to its relevance and its potential, public health policy is still relatively weak within the Union's overall responsibilities. Indeed, other EU policies frequently contradict public health policies, despite the declared intention of the public health programme to '... promote health and prevent disease through addressing health determinants across all policies and activities'. A clear case in point is European agricultural policy. In view of the public health challenges that Europe faces in terms of health determinants and chronic and infectious diseases, all of which transcend the borders of the nation states and require trans-national responses, the time is ripe for a significant European effort that focuses on health in a new way, and gains the support of the European public. One attempt by the European Commission to do so is the proposed new joint programme that combines public health and consumer protection.²

Yet an even more critical argument for a strong public health policy at the European level is social citizenship. Major differences in health status and health services exist within and between countries in the European Union, particularly since the recent inclusion of new member states. Addressing them will be a challenge that goes to the core of what it means to be a European. Why should a Swede live longer than a Hungarian? Why should a European who is materially poor have poorer health and shorter life expectancy than someone who is better off? While there are many active patient organisations and groups that advocate on specific health issues, there is not yet a strong citizen's movement that advocates according the same rights to health to all citizens throughout the Union. Evidence shows that smoking kills; why, then, can some European countries still disregard this fact to the detriment of the health and lives of their citizens? Why is there an approach to standardisation in the European internal market, yet no standard for what European citizens can expect from their governments in terms of public health, disease prevention, health protection and promotion? Why is health not seen as being as critical to the future of Europe as is competitiveness? Indeed, why is health not recognised as a driving force of competitiveness in knowledge and information societies?

A key problem lies in the fact that, in the context of most European debates, health is usually understood as a distinct and narrowly defined organisational and policy sector, i.e. the healthcare system or the public health system. It is not regarded as a guiding value of European policy making, as a key *raison d'être* for a European Union that wants to move beyond being a common market to a union that promotes the common good for Europeans. It would seem that in order to move forward, the European Union would need to discuss *health* in different terms – to frame a health agenda in a manner that the European public understands, that European media will adopt, that policy makers can relate to, and that non-governmental groups can advocate in order to strengthen health protection and promotion and overall wellbeing. In a union of European peoples, health and wellbeing would then play a central role and constitute a core value.

New frames and mindsets

Framing ‘... refers to how messages are encoded with meaning so that they can be efficiently interpreted in relationship to existing beliefs or ideas’. Frames convey meaning and can help uphold consistent biases. For example, in terms of economics Amos Tversky and Daniel Kahneman³ have shown that framing can affect the choices one makes, so much so that several of the classic axioms of rational choice do not hold. Much depends on how the problem is presented. Similar insights come from Erving Goffman’s work⁴ in sociology; Gregory Bateson’s work in anthropology shows that cognitive models, or mind frames, influence action.⁵ Their insights are particularly applied in strategic communication approaches such as media framing and agenda setting.

It is therefore worthwhile considering how, in recent years, a number of new frames have emerged that can provide a useful entry point for a new European debate on health. These frames consider health as:

- an intrinsic value and human right;
- fairness and social justice;
- an overarching policy goal which addresses social determinants;
- a trans-national public good.

These frames obviously overlap. They represent different entry points to a common key concept – other frames also exist such as health as a resource^{6,7} or health as an investment.⁸ Each relates to specific reference and advocacy groups. Alkire and Chen⁹ argue that a rights-based approach (‘fulfilling our obligations so others are dignified’) and an equity approach (‘achieving a fairer distribution of health capabilities’) differ from one that is utilitarian (‘maximising aggregate subjective happiness’) or humanitarian (‘acting virtuously towards those in need’). However, in real life these approaches are not so easily differentiated, and health advocates from various schools of thought do not always clearly elucidate their platforms – thereby ensuring that they appeal to a wider audience and so generate more agreement. Such frames also appear in other configurations, for example in the dimensions of the Madrid Framework¹⁰ – which is itself, as indeed is this book, an exercise in framing.

Health as a value and a human right

Health is a value worth striving for in itself, as well as a factor that contributes significantly to other values, like equity, dignity, solidarity and diversity, that are relevant to the 'European social model'. Amartya Sen¹¹ emphasises that health is not only a means of reaching other individual or societal goals, but also is an end of political and societal activity in itself. This clarifies the *intrinsic* value of health. Various types of human capability (such as the capability to avoid preventable morbidity and premature mortality, or to be literate and numerate) are considered by Sen both as ends in themselves, and as key means to the achievement of other intrinsically valued ends, such as political freedoms and the capability to participate actively in life and in trade and production. It is the expansion of these human capabilities that are the real freedoms of life, and the ultimate end of public policy. Health therefore, has both a constitutive and an instrumental value – and frequently the two are difficult to disentangle, as they complement one another. Indeed it is a characteristic of the 'European social model' that social citizenship is intricately linked to political citizenship.

In many countries, the commitment to a certain system of protecting and improving health is seen as a value in itself. The Canadian report 'Medicare: A Value Worth Keeping'¹² asserts: 'Canada's healthcare system is one of this country's foremost social accomplishments, a core value that helps define our national identity.' Sorrell claims that, 'the NHS functions in the UK not only as a source of medical treatment, but as a prime medium of national solidarity and national identity.'^{13,14} At this level, health and the health system as values are 'part of the cultural fabric that allows people to engage each other with language, develop their institutions, maintain the social order necessary for survival and prosperity, play social roles, and assume personal identities'.¹⁵ This indeed seems a critical function of health in terms of the 'European social model' and European citizenship.

As inequities in health become more and more obvious, the notion of health as a human right is gaining new support.¹⁶ The human right to health was codified as such in the Declaration of Human Rights in 1948, and appears in the constitution of the WHO. This raises the issue of the interface between European values and what has been termed *universal values*. Nigel Dower points out, 'If citizens are increasingly motivated by global concerns then cosmopolitan goals enter domestic policy in that way and people can be effective global citizens by being effective globally oriented citizens of their own states.'¹⁷ In particular, this would imply a common notion of social justice and a system of international law where the right to health constitutes a legal claim. It is very relevant to the European Union, in terms of access rights to health of third country nationals within Europe, as well as with European positions taken in the global health arena. One critical such arena is women's rights and reproductive health.

Health as fairness and social justice

From the very beginning of modernity, health has been at the centre of debates on inequity, initially within the context of the nation state, and today as a key dimension of globalisation. Health governance debates are in their essence predominantly about social justice, about inclusion and exclusion – even if they are presented as fiscal debates. The value of equity commonly arises in

relation to access to, utilisation of or financing of health services, and also with regard to health outcomes and health status. Two main forms of health equity can be identified: vertical equity (preferential treatment for those with greater health needs) and horizontal equity (equal treatment for equivalent needs). *Inequalities* that are unfair, or arise from social injustices, and are also avoidable are considered *inequities*. Fairness, in this context, is used to describe the unacceptable disparities in health.¹⁸

Health inequities arise from unequal access to the determinants of health, such as education, housing, employment, and from the unequal distribution of resources and power relating to gender, race and ethnicity, and from unequal access to healthcare. This, of course, has been at the historical roots of the public health movement and is the basis for the significant action on health inequalities that is now underway, with a focus on the social determinants of health. The WHO Commission on the Social Determinants of Health describes its goal as 'to lay the foundations of health equity to be a shared global goal, and for an understanding that acting on that goal demands action on the underlying causes of ill health'.¹⁹

A shift to a model of policy and intervention based on equity and the social determinants of health will require policies that acknowledge the *structural* causes of health problems, and the constant tension between the goals of different policy sectors.

The strong correlation between the socioeconomic position of people and their life expectancy has been firmly established by research.²⁰ Not all Europeans have the same chance of remaining healthy. The WHO Health for All database clearly shows significant differences in health expectancy between social groups and between countries.²¹ As Europe has grown richer it has also become more unequal. This again reinforces the critical function that health plays in terms of the European social model and European citizenship, and the need for citizens' movements to demand European action, policies and funding mechanisms, in order to attempt to close the gaps.

Health as an overarching goal in all policies

Good health in Europe has historically been linked to good governance. Today this means two things: firstly, governing the health sector to ensure universal and equitable access, as well as quality of outcome; secondly, governing across sectors to address the determinants of health and enable healthy choices.

Several advances have been made in this direction. The European Commission, for example, has determined that all its policies should be judged on their potential impact on health.²² Commissioner David Byrne embarked on an effort to make health central to all EU policies,²³ and the EU presidency of Finland in 2006 will follow up on this theme of 'health across policy sectors'.²⁴ The UK presidency in 2005 selected the theme of health inequalities,²⁵ and the Commission has created a European working group on the social determinants of health.²⁶

The new Swedish Public Health Policy, adopted in 2003, aims to create more equity in health. It was the result of a ten-year process in policy making. In the 1980s, a parliamentary commission was asked to develop a strategy for equality of good health, focusing on the structural determinants of health. The main objectives included, but were not limited to, economic and social security, secure and favourable conditions during childhood and adolescence, participation and

influence in society, healthier working life and increased physical activity. Many ministries and governmental agencies have become involved in the implementation of Swedish Health Policy, because of its focus on the determinants of health. Policy makers in Sweden have concluded that economic policy (redistribution between income groups, age groups and regions), social welfare policy (accessibility of basic social services), labour policy (employment rate), secure conditions for early child development (quality of schools and daycare), environmental policy, food and agricultural policy (food subsidies), and alcohol policy (reducing the supply) are all integral to the aim of creating equity in health in Sweden.²⁷

Political resistance to the foundations of such a new Public Health Policy is in large part due to differences in values. The Swedish National Institute of Health in Sweden asserts, 'There is strong popular opinion for defending and developing the social welfare. On the other hand there are strong opposing forces, especially on the international level.'²⁸ The underlying issue in this case is expressed well by T McMichael and R Beaglehole: 'Tension persists between the philosophy of neo-liberalism, emphasizing self-interest of market-based economies, and the philosophy of social justice that sees collective responsibility and benefit as the prime social goal. The practice of public health, with its underlying community and population perspective, sits more comfortably with the latter philosophy.'²⁹

Health as a trans-national public good

Whether a good is considered public or private within a society is a political decision. In the 'European social model' health clearly constitutes a public good and end in itself – a view that is increasingly under attack. In her groundbreaking work on global public goods Inge Kaul³⁰ reinforces this point: 'The privateness or publicness of a good is rarely an innate property. In most instances, it is a policy choice – our policy choice – to make a good more or less public or private.' Indeed in Europe, from the eighteenth century on, claims for access to health and access to citizenship increasingly converge and become a driving force of social and political movements. The growing understanding that health and disease could be influenced through clearly described and circumscribed interventions by the nation state made the sanitary revolution part of the big reform project of the first wave of European modernity. Health or disease were not just a personal choice, they became a political choice.

The discussion on health as a global public good has also given new impetus to the discussion of health as a public good at other levels of governance. The public good concept implies that health cannot be reduced to a commodity and needs political will and a 'public push'. It must be supported by a governance infrastructure with public financing mechanisms. In this sense, health is also a *public value*. Public values are 'concerned with *State intervention to promote morally desirable ends*'.³¹ They extend beyond both individual preferences and the private realm and, in terms of health, increasingly expand from considerations of medical care provision to the provision of the social determinants of health. Wickham¹⁴ adds another dimension to this from a European perspective. He observes that in Europe the state is also the guarantor of two very European concepts: social cohesion (also explicitly mentioned in the Lisbon Agenda);³² and social inclusion. Inclusive health systems – for example migrant-friendly hospitals – play more than just a medical role, they reflect societal values. 'In the short term the health sector may be one of the promising

points of entry for policies and interventions to tackle health disparities, to prevent impoverishment due to healthcare expenses, and to prevent the decline in social position of those with chronic diseases' (WHO priorities for research to take forward the health equity policy agenda 2004).³³

In the literature on health, at national and international levels, there is a renaissance of Geoffrey Rose's public health dictum – 'The primary determinants of disease are mainly economic and social; therefore its remedies must also be economic and social.'³⁴ This concept forms the foundation of a new and broader public health field and expands it into a wide arena of economic and social rights, including a new empowerment of citizens, consumers and patients. As such it reflects a combination of social, economic and political rights which has been typical of the historical development of good health in Europe.

The concept of health as a public good and a public value is clearly under threat from economic developments, such as the growth of the private healthcare market, from social trends such as increasing individualisation, and from the view that health is an expenditure that our rich societies can no longer afford as a joint social effort. In consequence, European societies must debate the value they assign to health – as a right of citizenship, as an individualised private product and responsibility, and as an ultimate value.³⁴

Future European dialogue on health

The four frames introduced above provide a set of references for a European dialogue on health: understanding health as an intrinsic value in itself as well as a human right; seeing it as a basic contribution to fairness and social justice within a European context; ensuring that health is part of a range of policies that address determinants of health; and relating European health to global developments through an understanding of health as a global public good.

The 'European social model' is not a vague idea – it can only be understood in the context of citizenship, which means in the context of rights. Different concepts of citizenship can further help clarify European values in relation to health. According to Ralf Dahrendorf, European citizenship lies between *theoretical/soft citizenship* (such as feeling part of a community, having common goals and values) and *practical/strong citizenship*, which encompasses real rights (such as voting, fair trials, expression and association). *Active citizenship*, frequently mentioned in citizenship literature, refers to citizens who actively participate in political and social discourse. Historically, national citizenship has been constructed through social participation. Active citizenship in the EU means that citizens defend human, political, economic and social rights – including the right to health and healthcare.³³ Finally, *social citizenship* is relevant to the European context because it constitutes the core idea of a welfare state. Social rights are granted based on citizenship, not performance in the market.³⁵

In European history, health has been linked to changing concepts of citizenship. In the eighteenth century it was linked to the individual moral responsibility of the man of property. In the nineteenth century it changed radically to a collective good which became part of the rallying cry of the disenfranchised – the poor, the working class, women. In consequence it moved out of the realm of the charity of the church and philanthropic organisations, and into the realm of rights and social justice.^{1,14}

Health can again become a positive force of European citizenship. For this to happen there needs to be a health debate with many stakeholders, in order to clarify the role and value of health in the European Union. This debate will need to include dialogue with many other sectors – building on the dialogue initiated by David Byrne,²³ and on mechanisms such as the European Health Forum.³⁵ Such dialogue is crucial for a European civil society.

A comparative value study of European health documents would probably reveal, just as the Canadian study¹⁵ did, that European health policy makers have very different understandings of the ‘value’ of health. It would be crucial, however, to create the political space to discuss the common health core of the European social model, and for this discussion to be with the citizens, and not only between heads of state. This can help take values out of the realm of moral speculation and into the realm of rights at all levels of governance. Only as rights can values become instrumental in European public policy making.³⁶ Health needs to be recognised as a key dimension of social citizenship in a Europe committed to the wellbeing of its citizens, now and in the future.

Europe has the potential to be a global leader in shaping policies that promote health in the twenty-first century. The social Europe of the future requires a focus on a European identity which is inextricably linked to the concept of health rights and social citizenship in health. Health can and must play a major role in the establishment of citizenship, identity and allegiance to the modern European Union (EU), just as it did historically to the nation state. Health is an area that very concretely affects people’s wellbeing and feelings of security. Indeed a strong commitment of the European Union to health could be seen as a concrete expression of the potential that lies in its commitment to wellbeing and social justice. Health needs to move into the centre of EU policy making, especially in relation to citizens’ needs and rights.

Such a concept of citizenship also accepts a commitment to global solidarity. Europe needs to apply the lessons learned in the historical development of public health in Europe to its global responsibilities. A strong European voice in global health is presently lacking; it could make a major difference in moving forward an agenda for more equity in health in an interdependent world.

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Note

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