บทความพิเศษ

Perspectives of Health Promotion – *A Personal View*

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While strolling through a book exhibition at Khon Kaen University recently, the title 'The new world of health promotion' drew my attention and I decided to get me the volume. A note on the cover strongly forbid to sell the book in the USA even it was obviously written for students of public health there and the authors had been from North America as well. Probably one has to pay more for the book over there in the states. By seeping through the pages of my newly purchased 'treasure', I started to wonder whether it would have been wise to recommend the text to someone dealing with public health in my 'country of origin', which is Germany, since as major determinants of health, 'individual behaviors' and 'environmental factors' were highlighted by the authors. Not that I wouldn't fully agree to that statement, but while still in office as Professor of Social Medicine in Central Europe some time ago, I strongly was ad odds with a number of my colleagues because of fundamental differences between them and me as far as the underlying reasons for morbidity and mortality in the field of chronic diseases had been concerned. So what is the perception of those, dealing with medical sociology in a number of Western European countries towards the reason for most of the chronic diseases?

To answer this question I might refer to another statement of my newly purchased book about 'health promotion', mentioning as leading causes of mortality tobacco, physical inactivity and diet. One may add excessive alcohol consumption to this list as well. The problem is that mainly unhealthy behavior of the individual is to blame for the highly prevalent chronic diseases such as heart diseases, diabetes mellitus, high blood pressure, cancer and stroke. Accepting the risk factor model to explain the occurrence of chronic diseases and to base health promotion on it would require to eat only 'half of what one wants to eat', avoid sweets, exercise instead of watching television, and give up smoking and drinking too much alcohol.

The ultimate consequence of this line of thinking might be that those who are suffering from chronic diseases are responsible for their illness because of ill behavior and why then the society should cover the expenses for treatment and care? This aspect is especially important for a society in which more then 95% of the population is covered by social health insurance and social security. The system requires tremendous spending of money which also a rich country seems now no longer able to afford. The most radical consequence to solve the problem would be to give up social health insurance and social security, which of course is not feasible politically and could destabilize the country.

To avoid even to think along that line of argumentation, means to give up social security, the advocates of social security in western European countries favor to take the individual out of her or his responsibility for health and blame the society for unhealthy behavior, pointing towards 'stress' as the ultimate reason for smoking, excessive energy intake, and alcohol consumption. The argumentation is that since the society is exposing the individual to 'stress', thus causing the individual to adopt unhealthy behavior to release the stress. Since the society is to blame for unhealthy behavior by causing stress consequently should also shoulder the expenses for treatment and care.

An additional line of argumentation is to blame genetic factors for the occurrence of chronic diseases, which might explain why 'academic excellence' is linked to highly sophisticated and expensive laboratory investigations. It is almost unnecessary to mention that health promotion in Germany hardly focus on changing unhealthy behavior.

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The argumentation of the social advocates of course is not that simplistic as outlined here and they are right in opposing the notion that those suffering from chronic diseases are always to blame for their illness. For quite a number of cancers for instance, the underlying reasons are still unknown, genetic disposition for a number of chronic diseases, for instance diabetes mellitus type 2, cannot be excluded and last not least the risk model as such tells us that even in the not-exposed group there are a number of individuals who fall sick of unknown reasons. What in fact to me seems wrong under the German perspective is that the responsibility of the individual for her or his health is not outlined in strength.

The Thai situation seems to be clearly different in that healthy behavior and the responsibility of the person for its own health is well recognized and supported. In a situation where social security is by far not as all-embracing as in Western Europe it is easier for the single individual to realize that it is of overwhelming benefit to stay healthy. In Western Europe the overall coverage of social security enhance the misunderstanding that while falling sick the health delivery system will help to gain health again so it is not necessary to be too concerned about its own health. That most chronic diseases are difficult to cure or cannot be cured at all is not very well accepted by the general public. With improving social security in Thailand one might face the problem that the people are less responding to the advice to enhance healthy behavior because of the line of thinking as experienced in Western Europe.

The way the Ministry of Public Health in Thailand and others concerned about Health Promotion and chronic diseases in the country try to face the challenge of chronic diseases are remarkable. Sometime however I have the feeling things are going a bit too far. Recently I came across an abstract about an attempt to control alcohol consumption and did wonder whether the villagers really did like what was done in their community: ….'the control of alcohol consumption in the community made use of restricting alcohol distribution' and 'intervention on household level'….. Especially the latter action might have caused in Germany the inhabitants of the household to call the police in order to arrest the health promoters because of illegal entry into their privacy.

Also the goodwill of postgraduate public health students working on their thesis by trying to enhance healthy behavior in order to reduce risk factors sometime seems to be a little bit too uncritical. Turning page by page of my book I mentioned above, I detected the description of most of the theoretical models applied by the students of public health whom I assisted and supervised over the time here in Thailand. Well aware of the fact that the root of most of the chronic diseases is unhealthy behavior, the students seem to have a choice to select from quite a number of models which they might apply in changing behavior of people to be healthier, such as the health believe model, the transtheoretical model, empowerment, social marketing and there might be even more models, which I have not come across until now. It usually escapes me why one model is selected but not another one, and to me most of the models are not significantly different from what I learned to know decades ago, namely the KAP model. All of us know that the crucial point is that whatever model is used to trigger and increase motivation for a change, the individual has to jump from intention into really doing it. To go and evaluate every step of the transtheoretical model is of no use when finally the majority of the cigarette smoking 'sample' did not reach the maintenance phase.

The objective of the exercise very often is to 'improve the knowledge', as if knowing what is unhealthy would automatically result in an improvement of behavior. The approach quite often seems to be rather mechanical. Project's participants are termed as 'sample', while actually all of them are individuals, and quite clever ones, when it comes to answer lengthy questionnaires. Even in the most abundant village it seems that people know how to suit the investigators giving the correct and expected answer but which might be far away from the truth. That results finally in an overall improvement of the scores for 'perception' of the 'outcome variables'. It might be helpful to add to the project protocol some laboratory investigation in order to verify the improvements of 'perception'. For instance, if the majority of the 'sample' have 'improved' scores as far as exercise is concerned and claim that they significantly reduced fat and caloric intake, then an overall reduction in weight and decreased triglycerides and cholesterol concentration should be observed.
What distinguishes the approach to health promotion in Thailand from what I experienced in Germany is the fact that the individual is asked to actively contribute to the improvement of her or his health. Further on the risk factor model is clearly acknowledged and is the basis of intervention. The approach certainly is correct and beneficial. However while the liberal stance in Germany might go too far while in Thailand the pressure on the individual to consider health issues might be too invading. If pressure is too high people very much know how to give expected and correct answers but probably in reality might behave differently.