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Preventing Preventative Health

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Abstract

With the Earth's human population estimated to exceed 10 billion by 2050, the now globalised community has some serious discussions involving the upcoming, necessary transition to sustainable habitation and preventative healthcare. This paper examines the social and economic structures preventing this transition at individual, national and multinational levels and their responsibilities to public health. Greater responsibility for ones individual health and consumption is essential and should be supported and encouraged by national governance that in turn has a responsibility to provide the environment in which healthy sustainable lifestyles are achievable and affordable. Multi-national corporations must also accept their responsibilities to public health and cease profiting from environmental destruction, inequity and suffering. There are many levels at which preventative health is prevented from being implemented, all of which must be acknowledged honestly and tackled simultaneously for a healthy sustainable future.

Preventing Preventative Health

Academic articles, books and even occasional political speeches on the unsustainability of the current growth-dependant economic model and its rampant consumerism, health risks and environmental destruction are increasingly common. Questioning exponential growth and its wisdom (or lack thereof) is no longer the realm of hippies and greenies; it is a simple scientific fact that growth cannot occur unabated in a finite system. Although there are inspiring individuals making a huge difference and some successful sustainability programs at community levels; national and global governance and corporations are yet to seriously take responsibility for the unhealthy, unsustainable habitation crisis we currently face and are hindering the promotion of preventative health. Further exponential population growth without a fundamental shift towards ethical, equitable global systems and preventative health for the planet as a whole is simply going to be catastrophic for vast numbers of the world's populations and the planet itself.

The Unsustainable Global Situation

The United Nations (UN) estimates the 2050 global population will be between 7.8 and 10.8 billion, 80% of whom will live in developing countries. The health and growth of the population is both interlinked and interdependent upon economic systems and regulations, climate change, resource limits, environmental degradation and poverty (Hanlon, Carlisle, Reilly, Lyon, & Hannah, 2010). We are failing to provide basic health necessities to many of the current 6.5 billion people and are yet to feel the full brunt of these challenges to health. Regardless of the programs and policies being implemented in communities across the globe, providing basic health necessities for an extra 4 billion in the next 40 years is clearly not possible under the current global paradigm of growth-based prosperity for the minority.

Many believed that last year's economic crisis was a great opportunity for fundamental change and there have been greater economic regulations put in place recently

across Europe and the United States of America, reining in some of the power of the banking sector (Paletta, 2010). However, no real change towards a more equitable distribution of the worlds finances, health care and resources or an economic system that supports this has been proposed. There is almost universal acceptance that global health care systems must now focus on preventative health and the reduction of chronic diseases (Armstrong, Gillespie, Ledder, Rubin, & Russell, 2007). There is now also (amongst increasing numbers) an acceptance that the current global growth-dependant economic model is outdated, unstable and hindering the transformation to sustainability, equity and preventative health. Thankfully an economically, socially and environmentally sustainable society is a healthy society (Griffiths, 2006) and these interrelated components of human habitation can and must be tackled together in a holistic manner with all stakeholders accepting their responsibility.

Individual Responsibilities

There are increasing calls for individual responsibility for health. Many Australians were outraged this year at a government loan being approved to cover a second liver transplant for a heroin addict (Sonti, 2010), yet most fail to see the similarity to eating themselves into the dialysis ward. A huge change in attitude towards nutrition, exercise, and lifestyle and resource consumption is required of every individual fortunate enough to have access to consumables. Education is paramount. The facts must be made clear; health systems cannot possibly provide current standards of care for the predicted 50% increase in deaths globally over the next ten years from diabetes alone, let alone from other increasing chronic diseases (Commission on Social Determinants of Health, 2008). Health behaviours will impact on an individual's future health and medical expenses. An article in the *Medical Journal of Australia* back in 1999 actually proposed that self-control of one's own weight could be described as a form of bioethics (Burry, 1999).

Getting off the consumer treadmill to prevent chronic disease is, however, far easier said than done, especially in low socio-economic status groups where levels of unhealthy behaviours are higher (Dunn, 2010). Individuals must receive greater support in changing unhealthy behaviours such as sedentary lifestyles, alcohol, cigarette, sugar and fat consumption. Good prevention does work. Fifty years ago, three-quarters of Australian men smoked; now, less than one-fifth of men smoke. Road trauma deaths in Australia have reduced by 80% since 1970 due to sustained and systematic national and state programs (Moodie, 2008). The same can be done with the obesity; mental illness and chronic disease epidemics by focussing on prevention at this individual level from an early age.

Low activity levels in childhood result in the development of a self perpetuating vicious circle of obesity and physical inactivity in young adulthood (Pietiläinen, et al., 2008). Programs such as active after school exercise and specialised child community health teams are focussing on adolescent activity levels across Australia. Similar programs are happening in urban settings around the globe. The Stephanie Alexander Kitchen Garden Foundation is trialling a new program in primary schools teaching agricultural and nutritional literacy from 5 years old (Alexander, 2010). The transition town and slow food movements have spread rapidly and globally. Michael Pollan's simply termed nutrition book, *In Defence of Food* in which he advises to "eat food, not too much, mostly plants" became a worldwide best seller (Wiese, 2008). Individuals are making a difference and breaking these vicious cycles on their own and through writing and establishing small groups and organisations.

National Responsibilities

However, the constant bombardment of consumer advertising and mixed messages from governance does little to encourage the individual's good intentions or the success of lifestyle programs, preventative health and consumption reduction. Further, there are environmental influences that are well beyond an individual family's ability to modify,

including the regulation of marketing of unhealthy food choices for children and provision of safe, cheap and accessible public transport. Individuals have little say in urban planning initiatives that give priority to pedestrian-friendly environments and green spaces. Public consultation efforts tend to involve non-genuine engagement and ineffective feedback systems. Encouraging the social and providing the structural environment in which such lifestyle changes are possible has to be the responsibility of governance.

Research shows that not only does the percentage of green space in people's living environment have a positive association with the perceived general health of residents (Maas, Verhei, Groenewegen, Sjerp de Vries, & Spreeuwenberg, 2006), but is also negatively associated with disease specific morbidity rates (Maas, Verheij, Sjerp de Vries, Spreeuwenberg, & Schellevis, 2009). A 2009 Dutch study found the relation was strongest for anxiety disorder and depression. The relation was also strong for children and people with a lower socioeconomic status (Maas, Verheij, Sjerp de Vries, Spreeuwenberg, & Schellevis, 2009). With The UN Population Division predicting that nearly two thirds of the world's populations will live in urban areas within the next 30 years (Maas, Verhei, Groenewegen, Sjerp de Vries, & Spreeuwenberg, 2006), the development of urban green space must be allocated a central position in national planning policy. This would have the double benefit of providing community garden space for local food production and nutritional literacy education.

Regulating the marketing and availability of unhealthy food is another step for which national governance should take greater responsibility. The higher tax on cigarettes recently passed in Australia will assist in continuing to reduce smoking prevalence but it is time that we follow the examples being set in Europe where Norway has a tax on sugar and chocolate and Denmark and Austria have banned trans fats. Romania's health ministry is struggling with more than half its 22 million citizens overweight and is proposing a world first fast food

tax on hamburgers, chips, fizzy drinks and other fast foods with high sugar and fat content Holt, 2010).Commercials for fast food are banned at certain times of the day in Britain, Norway and Sweden. Both alcohol and unhealthy foods should be labelled with consumption risk, the same as cigarettes.

These are all measures that have to be looked at for their applicability across the globe and many have already been suggested by the Australian national preventative health taskforce which was established in 2008 (Moodie, 2008). Revenue raised through additional unhealthy consumption taxes can be channelled not just into nutritional literacy education but into subsidies for sustainably grown fruit and vegetables. Healthy food is expensive, fresh organic produce, humanely reared meat, seeds, nuts and whole grains cost far more to produce than production chain burgers and have a shorter shelf life. A study in the USA last year discovered what they called the "obesity-hunger paradox" in which areas where hunger is most reported also have the highest rates of obesity (Dolnick, 2010). The picture of global malnutrition now is not just the African child with a distended belly but also includes the obese population unable or unwilling to access affordable fresh produce. It is within the capability of governments to ensure accessibility of healthy foods and to regulate the food industry to support local sustainable agriculture instead of multi-nationals. National governance should be assisting individuals in breaking out of unhealthy, unsustainable western lifestyles, not encouraging them.

International and Multi-National Organisation Responsibilities

There are barriers to national governing bodies taking a stand on these issues, however. Not only can they be accused of creating nanny states, (which is a huge ethical quagmire) but there are international agreements that actually define many efforts made at reducing the consumption of unhealthy products as a hindrance to trade. There is another level at which responsibility for preventative health lies and it is the most controversial

because it is the level at which all the money is made. Multibillion dollar international pharmaceutical, tobacco, alcohol and junk food corporations will also have to participate in the transition to healthy sustainability, instead of profiting from the consumer treadmill.

There are currently several international trade agreements that put business over health, for example; the agreement on trade related aspects of intellectual property (TRIPS) which protects patents and copyrights and prevents developing countries making many of their own pharmaceutical drugs (Stiglitz, 2006). The agreement on technical barriers to trade protects companies' rights to trade in and advertise substances with safety issues such as tobacco, food preservatives and alcohol (Shaffer, Waitzkin, Brenner, & Jasso-Aguilar, 2005). Trade tribunals without expertise in health can decree that laws and regulations that protect health are unnecessary barriers to trade. These legal agreements produce profound flow on effects in public health across the world, hindering many governments 'ability to protect the health of their people'.

These international agreements have resulted in clearly unethical public health issues such as the US beef industry successfully overturning the EU ban on meat treated with artificial hormones (Shaffer, Waitzkin, Brenner, & Jasso-Aguilar, 2005). Ninety-six percent of pharmaceutical research and development occurs in just 4 western countries (Rao & Ghauri, 2009), 90% of which is directed at chronic western diseases for which there is the most profit potential. This is not promoting innovation in technology as claimed but largely ignoring the greatest burden of disease which is suffered in developing countries where communicable diseases desperately need greater research (Smith, Correa, & Oh, 2009). There is a fundamental conflict here between these companies' objective to maximise shareholder wealth and a national government's objective to maximize the welfare of its citizens that needs to be acknowledged (Rao & Ghauri, 2009). Reform under the current paradigm is not going to cut it, the WHO stated in their 2008 commission report that business

as usual is increasingly unfeasible (CSDH, 2008). Changes will have to be made at international trade agreement level to ensure governments can adequately educate their citizens about health risks associated with consumption of certain products and to cover their resulting health costs.

Trade Equity and Global Priorities

There has been some success in moving towards greater trade equity in recent years (Shaffer, Waitzkin, Brenner, & Jasso-Aguilar, 2005). Coordinated international efforts to expand the availability of antiretroviral medications in Africa despite TRIPS restrictions led to the 2001 DOHA declaration. It stated that TRIPS should not prevent nations dealing with public health crisis (Stiglitz, 2006). Such flexibilities have proved difficult for developing countries to access and can be over-ridden by free trade agreements but they are a step in the right direction (Smith, Correa, & Oh, 2009). India managed to successfully oppose a 2009 patent application filed by Novatis for a drug almost identical to its previously patented drug. This process, known as 'ever-greening' effectively extends the length of the patent, increasing the time a country has to wait to produce a generic version. India also has local generic firms developing their own drugs and even forging collaborations with the developed-country pharmaceutical companies (Rao & Ghauri, 2009). Brazil and Thailand now have substantial capacity to produce generic drugs as well (Smith, Correa, & Oh, 2009).

Victory, for people and developing countries, though few and far between at this international trade level sets a precedent for separating health from big business and enabling a change in the world's priorities. Global priorities currently leave a lot to be desired and are fuelled by celebrity culture and the status associated with personal appearance and possessions. Europe spends US$2 billion more on ice-cream each year than it would cost to provide water and sanitation to every person on the planet (Shah, 2010). Upgrading the world's slums to a habitable standard with essential services looks fairly daunting at an

estimated US$100 billion until one compares it to the US$5 trillion forked out to cover the financial mismanagement by the banks that resulted in the 2009 global financial crisis (Marmot & Bell, 2009).

Discussions regarding the health issues and inequities that stem from the current growth based economy and its dysfunctional priorities and trade practices are urgently required. Former Prime Minister Rudd's proposal to ban all brand advertising on cigarette packets (if upheld) and the current move towards policy around junk foods in Europe should bring to the fore trade agreements protecting multi-national fast food, alcohol and tobacco companies. Until there are international regulations that allow public health to be completely integrated with sustainable development at the global level, programs and policy will have limited success with national and individual focussed preventative health programs.

From Emergency Health to Preventative Health

Individuals certainly need to take on more responsibility but when so many cannot see any realistic, affordable alternative lifestyle options, unhealthy behaviours especially in low socioeconomic groups and developing countries will continue to burden global health systems with resulting diseases. Educating people to look after themselves and reduce their consumption is necessary but leading by example is imperative as is providing the structural and economic environment in which this is possible. Although the economic reforms needed are highly debated, healthcare providers have known for decades what needs to be done to provide health care; it was spelt out and agreed upon in clear terms in the Millennium development goals back in 2000.

Frontline primary care professionals everywhere should be trained in and promoting good nutrition, achieved sustainably through local foods (Coombes, 2009). They should be able to recommend patients to local free activities for exercise and encourage low-stress, low consumption lifestyles that are also encouraged by their government and are affordable.

Reproductive and maternal health services need to be rolled out immediately to every corner of the globe. A doubling in investment in family planning could halve the global death rate, while reducing the population growth (Moszynski, 2009). Education for girls has shown to be the most cost effective way to alleviate poverty and reduce birth rate, childhood and maternal mortality (United Nations Population Fund, 2009). Providing clean water and sanitation is not only affordable as has been seen by comparisons with recent expenditure, but it is essential. Developing countries must be able to access affordable pharmaceuticals and the results of publicly funded research through clearly defined and accessible flexibilities in trade agreements (Rao & Ghauri, 2009; Smith, Correa, & Oh, 2009). Lifting developing countries and disadvantaged populations out of poverty is the only way humankind can build the global resistance to climate change, population pressure, food scarcity and disease.

This does not mean just spending at least the promised and forgotten 0.7% GDP in aid although that is a good place to start (Sachs, 2004). Expenditure must be cost effective, culturally appropriate and aimed at establishing long term self sufficiency rather than ongoing dependency on aid. Waste such as shipping counting for half the cost of US aid because US refuses to buy food locally, is unacceptable (Day, 2009). Controversies around WHO vaccine advisors receiving payments from pharmaceutical companies for their research facilities are equally unacceptable (Carlowe, 2010). Organisations trusted with global aid and health issues must be accountable and transparent.

Organisations trusted with global finance and economic systems must also be accountable and transparent. The WTO and the IMF must be regulated into setting policies that are sustainable, ethically responsible and adhere to the UN charter of human rights. A sustainable global economic system that does not lock humanity into the collision course of exponential growth in a finite system must also involve some redistribution of income. Research shows that the more equally wealth is distributed the better the health of the society

(Picket & Richardson, 2009). The health benefits gained from small increases in income amongst the poor are substantial where as reducing luxury expenditure among the rich is shown to have little effect on their health (Picket & Richardson, 2009). This is yet another ethical quagmire to tackle in these difficult, honest discussions ahead; but one which must be confronted soon. It is not just the health sector promoting a restructuring of the global economy but there have been very vocal calls from climate change, environmental health and biodiversity scientists, all fields intricately linked with public health. In 2001 the Nobel Prize for economics was awarded to Joseph Stiglitz for his work on alternative, more sustainable economic frameworks (Stiglitz, 2006). The call to action is not new, only unheeded.

The next 50 years are going to be one of the most challenging periods for humanity in memory. There is so much that can be done at all levels to encourage a transition period that will lessen inequalities, combat problems such as mal-nutrition, obesity, depression and addictive behaviours, and improve wellbeing (McCartney & Hanlon, 2009). Pressure must be kept on governments and all multi-national organisations for transparency and equity in decisions that affect health nationally and globally. Mankind must demand equitable access to health care and basic necessities for all as well as realistic dialog at global forums regarding the urgent economic, climate, energy and population crisis and transitioning to sustainable, healthy societies. Humanity needs global economic systems and trade agreements that promote rather than prevent preventable health models being implemented. This would give individuals and communities globally a viable chance at managing the upcoming transition and reclaiming health as their right rather than someone else's business opportunity.

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