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Primary Prevention to Fight Inequalities – The German Experience and Lessons Learned

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When I speak about primary prevention I am talking about all organized efforts to lower the probability of illnesses occurring, and to lower the probability of ill health as a whole. Such efforts are at the heart of the theory and practice of public health. In order to understand the current situation and future perspectives of public health in Germany, we first have to take a look at the history.

The Scientific Origins: Solid Base

German doctors and scientists played an important role in developing the scientific and practical basis for population-based health measures. Right back in the eighteenth century, Johann Peter Frank (1745–1821) formulated rules and measures for disease prevention in cities, schools, and medical care, in his six-volume *System einer vollständigen medizinischen Polizey* (System of a Complete Medical Policy). Rudolf Virchow (1821–1902) combined medical research and social reform in his thought and activities. For him medicine was “a social science, and politics nothing other than medicine writ large” Virchow believed that health arose out of “liberty and her daughters education and prosperity.” (That is true to this day, though now we might instead say “education and her daughters prosperity and liberty.”) On the basis of his epidemiological observations, Germany’s first professor of hygiene, Max von Pettenkofer (1818–1901), developed proposals for a healthy water supply, and indeed got them implemented as part of the struggle against cholera. In their work of 1913, *Krankheit und Soziale Lage* (Illness and Social Position), Max Mosse and Gustav Tugendreich summarized contemporary knowledge on the subject of “equity.” In 1920, Alfred Grotjahn (1869–1931) was appointed to the first German Chair of Social Hygiene, at the Humboldt University in Berlin. His proposals for social reform in the guise of health policy remain remarkable to this day, but became lost in the economic and political crisis of the Weimar Republic.

Alfred Grotjahn, however, was not only a highly creative and committed public health scholar. He was also involved in the debates over eugenics, and for example proposed the forced sterilization of those who he referred to as “socially inferior.”

The lesson to be drawn here is that even the most committed engagement for the health of the public cannot justify absolutizing the value of “health.” Human rights mark the limits of every intervention.

To summarize, by the end of the 1920s Germany was in both scientific and practical terms one of the world’s leading nations in those fields that today come under the term “public health” – epidemiology, social epidemiology, hygiene, social hygiene, social determinants of health, state and municipal health structures, political aspects, and experience with implemen-

tation. The basis had been laid for positive international cooperation to further the production of knowledge and solutions for the health of the population.

(Another point is interesting here, especially in the light of current debates on “evidence based public health”: Almost all the explanations and proposals for primary prevention were based on incorrect ideas and models for the causes of sickness and health, or on none at all. (Rudolf Virchow for example believed that vapors (miasma) were the actual cause of infections and, like Max von Pettenkofer, trenchantly rejected Robert Koch’s bacteriological explanation that arose during the same period). Nonetheless, the proposals they developed were plausible, based on precise observations, and above all effective, with their implementation leading to epidemiologically measurable successes. So many of the great triumphs of public health from which we still benefit today were based on trial and error.)

Barbarism Disguised as a Public Health Movement: Fascism in Germany

We know that the story did not turn out well in Germany, but led instead to fascist barbarism and consequently to World War II. The progressive ideas of the social hygiene movement were transformed into the tenets of “racial hygiene.” The duty to protect the weak was supplanted by the tyranny of the strong, who appointed themselves as the “master race.” Public health scientists, many of whom were left-wingers and German Jews, were dismissed, persecuted, many were murdered. Many also went into exile, especially to the English-speaking countries, where they often made enormous contributions to scientific research in their countries of exile. The success of fascism in Germany was based not least on its ability to mask itself as a health movement. “Volksgesundheit,” or the health of the race or nation, was central to Nazi propaganda; ideas such as “exterminating parasites from the body of the nation,” and “destroying unworthy life” in the service of the health of the nation. Incidentally, “Volksgesundheit” would also be the obvious German word for “public health,” and this terrible misuse of the word by the Nazis is the reason why in Germany to this day we still have no obvious acceptable German word for “public health,” and tend to use the English alternative instead.

Fascism gives us a lesson and a legacy of mistrust that will always be with us: those who claim to act in the name of health do not always mean well, and may indeed be the worst of criminals. The decisive point for our judgment is not any reference to the issue of “health,” but that no person is excluded, that personal liberties are protected, and that improvements are sought above all through empowering self-determination especially of the weakest members of society and not through political control and policing.

The Era of Reconstruction: Health Services Flourish – without Public Health

In fact, the fledgling Federal Republic of Germany drew a different conclusion from the trauma of fascism, one that was to have fateful consequences for public health. Apart from the control of infectious diseases through medical measures at the individual level (vaccination programs in particular), strategies relating to groups and to the population as a whole fell into disrepute. The perspective of health policy in the early years of West Germany was that of the

doctor with his or her own individual practice. In short, the structures of the health care system reflected the general trend in post-war West Germany, namely the return of power to the elite which had existed before. Through until the 1970s there was only one chair of social epidemiology in the whole of Germany, and not one single university in West Germany taught public health. In fact, although we have an office of public health in every city and county, more and more resources were withdrawn from these public health authorities. State health policy was reduced to funding and managing medical care. Thanks to a health insurance system based on contributions from wages and salaries and the very favorable economic situation through until the 1970s, the outcome was a generally accessible health care system with many new hospitals (today we say, too many hospitals) and Europe's highest pharmaceutical prices. In other words, a lot of expense but at the same time great deficits in quality and efficiency. In this world there was no place for health goals. In this vision of the "leveled middle-class society" even social inequality seemed to lose its significance. Attempts were made to combat the increase in so-called lifestyle diseases with ideas of risk factor treatment imported from the United States, with more screening, more medicines, and rather ineffectual appeals to alter personal behavior.

(Before it disappeared from the map in 1989, the other German state, East Germany, took a different and interesting approach, which considerations of time prevent me from going into in more detail here. The following will have to suffice. In matters of public health East Germany, rather than loyally toeing the Soviet line, much more harked back to the social democratic ideas of the Weimar Republic. This allowed it to pursue its own independent course in prevention and health care, including some very fruitful concepts. Participatory approaches, however, which are inherent to health promotion, did not have a place in the more authoritarian structures of East Germany. Unfortunately, there was no carry over of successful programs from the East German health care system into the new structures built following unification. West German approaches and institutions were quickly established – in some cases freely, in others by decree.)

From the post-war developments in West Germany there is a lesson to be drawn that is almost trivial, but is confirmed again and again. Of themselves the health care system and curative medicine orientated on the individual produce almost nothing in the way of concepts or initiatives for population-based prevention or for reducing social inequalities. What the doctor experiences in his or her practice is very often the outcome of lacking or failed prevention. For that reason – with very many important exceptions – doctors have little faith in the possibilities of primary prevention. And because the doctor in his or her practice cannot change much about the factors that produce inequality of health opportunities (and does not even see them directly) he (or she) tends to dismiss these factors or to view them as God-given. The intrinsic "downstream" perspective of the medical profession, which is forcefully and generously backed by the medical-industrial complex, needs to be supplemented by the "upstream" view and the corresponding practice, in a sense from the outside (i.e. through health policy) and often against resistance.

Stimulus for Innovation: The Health Movement

The initiative for this innovation and the consequent rediscovery of the history of public health in Germany did not initially come through health policy, but from the “health movement.” Under this heading a conglomeration of forces came together in the 1970s: self-help groups, critics of the risk factor approach and the strategies of the pharmaceuticals industry, supporters of social medicine and prevention, parts of the women’s and labor movements, peace and third world activists, historians looking for an honest reckoning with Nazi medicine, sociologists wanting to point out growing inequality, economists interested in the superprofits occurring in the medical sector, technology skeptics, esoterics, and many others. The core of this health movement was made up of academic and practical activists from the student movement, who had provided surprises, new ideas, and radical plans across Europe during the late 1960s. The heterogeneity of the participants meant that this health movement was not going to last long, but this current was nonetheless capable of organizing a health conference attended by more than twenty thousand participants in West Berlin in 1980, where all these themes were discussed, and subsequently published too. Further health conferences were held until 1987, still with thousands of participants but with declining overall significance. The program of the first health conference in 1980 included the agenda for the academic and political rebirth of public health in Germany.

At this point an aside: Social movements have always had an important role to play in innovations in the social and political treatment of health. And conversely “health,” because of its exceptional power to bond alliances, plays an important role on the agenda of most social movements. To that extent the German “health movement,” as one of the offshoots of a declining student movement, was following a well-known historical pattern. Social movements often have effects other than those their initiators and participants were thinking of. Looking back today, the student movement with its far-reaching visions was actually not a revolutionary development but served instead in many areas of society as a driving force for an overdue modernization of the largely ossified thinking and institutions of West German society. The “health movement” failed to achieve its vision of a “healthy society,” but it did help to cast light on the barbaric story of Nazi medicine, to relativize the importance of medicine for health, to enhance the role of the individual (in sickness and in health), and to productively question health policy and thus to push open the door for social innovations.

Admittedly, at first health policy failed to respond at all to the appearance of hundreds of health initiatives, thousands of increasingly networked self-help groups, and a strengthening opposition among the medical profession (orientated on social medicine). The first funding programs for health research in the 1980s – encompassing themes such as primary prevention at work and in the community, strengthening patients’ autonomy, self-help, and social inequality – were set up not by the health ministry but by the research ministry. The professional health sector did not have questions of this kind, because it was not interested in these issues. The seed for the reconstruction of public health in the academic world had thus been sown, following a break lasting nearly a half century.

Stimulus for Innovation: Federal Program ‘Humanizing the World of Work’

The “Humanizing the World of Work” program also funded by the research ministry was to have considerable influence. Launched in 1974 (in other words in the middle of the West German “golden age of reform”), this program not only researched and implemented ways to optimize new technologies to suit the needs and abilities of employees. It was also about suitable forms of organization and participation, above all building on Scandinavian models and experience. important groundwork was laid for the participatory workplace health promotion schemes that are so successful in Germany today.

Two lessons can be drawn here. Firstly, the example shows that blueprints and impetus for social innovations that promote health and further effective prevention by no means only come from fields bearing the label “public health.” In many areas of policy and in many fields of intervention scientists and practitioners work on improving forms of cooperation in organizations and communities together and with others. So public health as a scientific discipline must always analyze the developments in these “neighboring” fields, must draw on useful innovations for its own theory and practice, and add health-promoting components to the practice in other fields.

The second lesson is that with the “Humanizing the World of Work” program the government was primarily pursuing the goal of modernizing Germany’s industrial base, which had often been hastily rebuilt in the aftermath of World War II. Improving the quality of working life was really a secondary goal here. So the motivation of health gained weight and impact not on its own account, but through its connection with a dominant motivation in society, namely, businesses’ pursuit of profit. Health, as we know, is a morally strong but politically rather weak concern. As an issue, health is stronger and social innovations connected with health have better chances of implementation if the health question is allied to a more influential one.

Stimulus for Innovation: The HIV/AIDS-Epidemic

We experienced this even more notably, and with great success, in the next milestone in the reconstruction of public health in Germany: in the HIV/AIDS epidemic. In the early and mid-1980s the representatives of “old” and “new” public health found themselves entrenched in irreconcilable positions. The proponents of “old public health” wanted to defeat the HIV epidemic using first and foremost the means of compulsory testing, threats, sex bans, punishment, and so on. In the mid-1980s (in other words even before the Ottawa Charter), following vehement, heated debate with this position and its ideological supporters, a primary prevention model was accepted and implemented with state funding and support. In the German context it was highly innovative; its central elements were participation, mobilizing and involving affected groups, shifting state responsibilities to NGOs and affected communities, addressing and changing structural conditions for preventive behavior, peer education, enabling, and empowerment. As such, it corresponded closely to the principles of the Ottawa Charter. The victory of “new” over “old” public health thus depended not least on the connection of two themes. Here the theme of health allied itself with the theme of civil rights, which a broad coalition of significant forces and social movements had come together to protect in the face of the AIDS epidemic.

(The rising rate of infections, which is worrying even in Germany (where it has increased from approximately 2,000 to 2,600 new infections per annum in a population of approximately eighty million) is being met with refinements of the existing model. These include, for example, strong participatory elements in quality assurance, where practitioners and scientists work as equals and cooperatively adjust the work of the AIDS service organizations to meet the new challenges. Alongside workplace health promotion, AIDS is the second German paradigm for successful primary prevention according to the tenets of new public health.)

Buds of Innovation: Study Programmes and Schools of Public Health

These paradigms have also had their effects on the curricula of the first university research programs and courses in public health, which Germany established at the end of the 1980s with state funding. The early years were a time of reforming zeal. There was agreement that the discipline of “public health” had to be close to medicine, because public health strategies generally depend on medical knowledge about etiology and pathogenesis, but also that schools of public health should not become schools of medicine, because the traditional preponderance of medicine could materially harm the agenda of the discipline of public health. Central public health issues such as social determinants of health, equity, primary prevention and health promotion, community interventions, and the relationship between policies, politics, and polity could then lose the prominent position they need to occupy on the agenda. Unfortunately, although this position still stands, four of the seven university courses in public health have been established in medical faculties, and once the current restructuring in Berlin has been completed the figure will rise to five out of seven. At universities of applied sciences there are about seventy courses outside the field of medicine that have a large public health component. For more than fifteen years now, teaching for the Master of Public Health degree has emphasized the need for graduates to form networks, with the result that today in all the relevant ministries, associations, health insurance funds, and other branches of social insurance you will regularly find professionals who speak the language of public health. For Germany that represents a great step forward, but it is the first step on a journey of a thousand miles.

Buds of Innovation: Primary Prevention by Health Insurance Funds

Another factor guided developments into this trajectory, and continues to do so. Traditionally the social health insurance funds in Germany have the job of funding and managing health care for their approximately seventy million members, including secondary prevention. In 1989 they were also given the task of offering primary prevention services. Initially this innovation suffered from a degree mismanagement, which led to vehement attacks from conservative political forces and from the medical profession. Since 2000 there has been a statutory provision that primary prevention services should “improve the state of health of the whole population and in particular make a contribution to reducing the social inequality of health opportunities.” This means pursuing the broad policy goal of reducing health gradients. For this task the health insurance funds are permitted to spend about €2.75 per member per year, or approximately 0.13 percent of the insurance funds’ total spending of about €150,000 million. This money is used, for example, to fund the aforementioned participatory workplace

health promotion, and for some years now also projects designed to inject health promotion into processes and structures in socially disadvantaged schools using a similar participatory approach. But much more money continues to be spent on health courses and behavior-related services whose impact is small or often altogether questionable and that are primarily taken up by fund members from the middle classes.

The reason why this is so contains another lesson, too: Because in Germany, as elsewhere, the suitability of competition and the market as a means for efficient management in the fields of health and social services is enormously overestimated, German health insurance funds stand in competition with one another. The incentives are structured so as to give an advantage to health insurance funds with the highest proportion of young, healthy, well-educated members. So the insurance funds face a dilemma. Their business policies must be generally tailored to recruiting as many “good risks” as possible while the law on primary prevention tells them to orientate their services on the needs of the poor and less educated. In case of doubt, and this is the lesson derived from the discussion of this issue, which still continues today, the economic motivation is stronger than any moral imperative and any such initiative will require additional energy from science, politics, or the social movements if it is to be realized.

Buds of Innovation: Pilot Programmes by Health Insurance Funds and the Federal Centre of Health Education

Social inequality in opportunities for good health and a long life has become an increasingly important issue in Germany. One reason for this is the real growth in inequality as a consequence of neoliberal economic policies and an education policy that tends to reinforce social differentiation. But the growing attention paid to social inequality is also a success of the public health community. In its 2005 report, the Advisory Board for the Health Service summed up the statistical data for Germany. If the population of Germany is divided into quintiles according to income, education, and professional status, we find that individuals in the bottom quintile have – over their whole life, in other words from the cradle to the grave – roughly double the risk of becoming seriously ill or dying prematurely compared to individuals in the top fifth of the population. For men that means an average difference in life expectancy of ten years, for women five years. Furthermore, because the phase of life with chronic sickness and multimorbidity begins on average about seven years earlier for those in the bottom fifth, they profit a great deal less from the “compression of morbidity. State health policy has not yet really begun tackling this central challenge. But there are important initiatives in the field that at least keep the topic on the agenda. As already mentioned, health insurance funds finance, for example, a pilot project where about sixty disadvantaged schools are to be developed into health-promoting settings. That is in a sense a deductive approach, where the schools to which such interventions are to be offered are identified according to criteria of social disadvantage: school type, proportion of welfare recipients, unemployed, migrants, etc.

But as well as the deductive approach, there is also an inductive one. At the initiative of the Federal Center for Health Education, the NGO Gesundheit Berlin was commissioned to set up an interactive database to collect and evaluate information on primary prevention and health promotion projects for and with the socially disadvantaged. The database today contains about three thousand projects. In order to compensate the great lack of quality, quality control, and

sustainability in these projects, small offices (“nodes”) were set up in each of the sixteen federal states to support them with advice, networking, and qualification. A group of thirty-eight institutions came together to support and fund this project as a whole, including many state health ministries and the most important NGOs in the fields of prevention and health promotion, as well as the German Medical Association and all the health insurance funds. In my Public Health Research Group at the Social Science Research Center in Berlin we are going a step further to develop and test methods of participatory quality control based on concepts, experience, and methods from the community-based participatory action research pursued above all in the English-speaking countries.

In the end, neither the deductive nor the inductive approaches possess enough strength to reverse the trend of growing inequality of health opportunities. But they are suited to make interventions more effective and to generate knowledge for further optimization. And also – and this is no less important – they help to keep the subject of social inequality of health opportunities on the public and political agenda.

Hope for Innovation: National Legislation on Primary Prevention

The German public health community expects a major boost in this direction from a new piece of national legislation on non-medical primary prevention that was due to be passed in 2005 after long internal discussions. Its provisions are designed primarily to reduce social and gender-related inequality in health opportunities. The concept provides for the establishment of a national foundation into which the health insurance funds and the social insurance funds for nursing care, pensions, and workplace accidents would contribute a total of €250 million per annum (in other words only a moderate increase over the previous funding through the health insurance funds). Health targets, procedures and criteria for quality control and reporting, and national health campaigns would be defined at the national level, with €50 million per annum provided for this. About €100 million, or 40 percent of the total budget, would be spent on community-based projects. Concrete decisions on selection and funding would be taken at state level by bodies representing the social insurance funds, the public health authorities, and important NGOs. The same sum, €100 million per annum, was to be spent by the social insurance funds on primary prevention.

For the situation in Germany it would have been a great step forward to have a specific legislative basis at last for non-medical primary prevention interventions. An orientation on targets, an absolute obligation to quality control, and the quantification of resources for community-based projects would also have represented a big step forward. The same also applies to integrating the “health campaigns” among the politically recognized instruments of health policy. Financing through the social insurance funds would not only have had the effect of augmenting the budget, but would have also served to create an incentive for these institutions not only to see themselves as insurers for individual cases (where a claim has arisen) but also to turn their attention to preventing insurance cases, to address claims that have not yet occurred.

Things turned out differently. In 2005 unexpected early elections were called for Germany’s national parliament, and in the resulting political turbulence the Bundesrat (the second cham-

ber representing the interests of the states) refused to approve the new law, even though it had already passed its final reading in the Bundestag.

Currently talks are under way in the political apparatus and among the actors to prepare a second attempt to have this legislation passed. Many professionals and activists are working to make sure the aforementioned positive components and instruments of the first version are kept on in the second. Currently health policy attention is being directed toward reform of the nursing care insurance system. The primary prevention legislation is scheduled to come before parliament in spring 2009. Whether it will be as good as hoped and whether the timetable can be maintained are currently open questions.

But here, too, we can draw a general lesson. As the great German sociologist Max Weber put it at the beginning of the twentieth century: "Politics is a strong and slow boring of hard boards. It takes both passion and perspective."

About the author

Rolf Rosenbrock is Professor for Social Sciences and Public Health Policy at the Technical University of Berlin and Head of the Research Group Public Health at the Social Science Research Center Berlin (WZB). For over twenty years he has conducted research and served as a political advisor at the national level in Germany regarding economic issues and the organisation of the health care system; organizational development and health; disease prevention and health promotion; AIDS policy, politics, prevention and care; and the structures of the German health insurance system. He is currently a member of the Advisory Board to the Federal Minister of Health; member of the Scientific Advisory Board for the German Coordination Agency for Public Health; member of the National AIDS Advisory Board; and Chair of the Scientific Advisory Board for the German Federal Office for Health Education. Rolf Rosenbrock is the author of numerous publications, including most recently an introduction to health policy in Germany which has become the leading textbook in the field.