FEATURE

Challenges to the Teaching of Public Health Education in Asia

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ABSTRACT - The twenty-first century will bring major changes in the Asian health scene. Globalization and communication technology, changing disease epidemiology, increasing population and environmental degradation, and changing demographics, with more urban population and an increase in the number of the elderly are some of the trends which are occurring. Health issues are increasingly dealt with by professionals who have no training in the health field. Public health education must respond to these changing trends by teaching courses such as Health Policy Development and Health Advocacy, as well as incorporating communications and technology skills into the curriculum. Even the methods of teaching should adapt to the new needs of society. When society changes, higher education must respond appropriately in order to continue meeting the need for quality health care.

The Changing Asian Health Scenario

The twenty-first century Asian health scenario and Asian public health education will be shaped and directly affected by the following mega trends: (1) globalization and the tremendous leap in consumer knowledge via information and communication technology, (2) changes in disease epidemiology, (3) increasing population pressure and environmental degradation, (4) changing demographics with rapid urbanization and an increase in the proportion of the elderly.

1. Globalization and Communication Technology

These changes can be viewed in two ways: the bad side and the good side. On the bad side, there will be greater inequities in society with the increasing economic and political control of the world's economy by the multinational corporations transgressing the political boundaries of nations, especially the poor and underdeveloped

countries. Inequities will increase with the poor becoming poorer and the rich becoming richer. On the good side, there can be a knowledge and communication revolution that will empower a far greater number of people and at a much faster rate than in the past century. This will facilitate dialogue and exchange among the citizens of the world, which will permit them to unite along lines of common interests and concerns to address poverty, inequity and underdevelopment, and to work towards peace, justice and harmony.

2. Changing disease epidemiology

With the exception of a very few of the least-developed countries in Asia (Cambodia, Laos, East Timor, Bangladesh, and Nepal), most countries will be moving from the current double burden of infectious diseases and chronic degenerative diseases to the increasing prevalence of lifestyle diseases which are currently common in Japan, South Korea, Singapore, Hong Kong and Taiwan.

3.   Increasing population pressure and environmental degradation

Asia will still hold half of the world's population with 3 billion Asians in a world population of 6 billion. Within this century, the Asian population will double, increasing pressure on all aspects of life from employment, food production, and housing to environment, education, and health care. Air, water and food production resources will become more difficult to manage as pollution increases in the atmosphere, seas and rivers and human settlements. Watersheds and forests will decrease in size, and less and less land will be devoted to agriculture. With resources becoming scarce, there could be increasing violence and conflict in the division and sharing of these resources.

4. Changing demographics with rapid urbanization and an increase in the number of elderly

Asia will develop more megacities, with an increasing proportion of the population living in urban areas, mainly still characterized by slums and informal settlers. Urban leaders and planners will be unable to cope with the rapid migration and the natural increase of the urban population. While the general Asian population will remain young, the proportion of the elderly in each Asian country will increase as never experienced before, because of longer life expectancies.

Health Sector Development

In the development of the health sector, the following trends will be witnessed: health care will become more complex with technological developments in diagnostics and therapeutics; greater civil society involvement and the fragmentation of health services with decentralization and devolution. The Ministries of Health will change their role from service providers to policy makers and regulators of health care; markets and privatization will play a dominant role in health and the number of players and stakeholders in health and health care will increase.

The Creation of Health

The creation of health will become more and more outside the realm of the Ministry of Health and outside the Schools of Medicine, Public Health and Health Sciences. Water is essential to health, yet water resources are in the hands of local governments, water authorities and ministries of public works. Environmental and air protection, sanitation and solid waste disposal are also essential to health, yet these are in the control of the ministries of environment and natural resources and local governments. Peace and order is essential to health, yet these are in the hands of the local police and the Ministry of Defense. Health education and promotion are essential to health, yet these are in the hands of the Ministry of Education. Transportation safety and accident prevention are important, but these are controlled by the Ministry of Transportation and Communication. Food production and food security are essential to health, yet these are in the hands of the Ministry of Agriculture and agrarian reform. Health budgets and health financing are essential to health care, but the decisions are made by the Ministry of finance, and health insurance corporations. Essential drugs, health care supplies, and equipment are important in health care, yet the decision makers in the availability of these are in the Ministry of Trade and Industry. Occupational health and safety is essential to health but it is in the hands of the Ministry of Labor and Employment.

Clearly, almost all aspects of health are in the hands of other decision makers outside of the Ministry of Health and health development happens outside of Schools of Medicine, Public Health and Health Sciences. The Ministry of Health must now assume the role of coordinator of health: the orchestra conductor of the various health players to produce a symphony of health and wellness.

Most unfortunate of all these trends will be the continuing decline in health budgets and investments in health, whether by

governments, donor agencies, academia or the private sector. The low political influence of Ministers/Secretaries of Health compared to the economic ministers will persist in the decision making for allocation of a country's fiscal revenues and resources. Health will still be a non-priority concern for most Asian governments.

Social Responsibility and Public Health Education

All these trends and developments will have profound effects on public health education. With these come new challenges that public health educators must face. To safeguard the health human rights of the people as well as to uphold patients' rights especially of the poor and the deprived, public health education in the twenty-first century must respond to the changing Asian health scenario. Health sciences schools must be more open to having a multi-disciplinary faculty. Being public and community directed and focused, schools must manifest social responsibility with the following four essential elements: relevance, quality, cost-effectiveness and equity with a bias for the poor and the underserved.

Public Health Education in Health Policy Development and Health Advocacy

Health Policy Development and Health Advocacy have become dynamic health concerns only in the late '80s and '90s and into the Twenty-first century. Whereas before, senior health managers were pre-occupied with health service delivery systems, public health administration, health planning and health program management, nowadays, health managers have been giving equal, if not greater attention to the formulation, analysis and development of health policies and how such policies can be effectively articulated and disseminated to the health sector, political decision makers, and the general public.

The advent of Health Policy Development and Health Advocacy has been the offshoot of the worldwide democratization processes that started with the peaceful people power 1986 Philippine EDSA Revolution. Thereafter came perestroika, the crumbling of the Berlin wall, the breaking up of the Soviet Empire, the birth of Namibia, the death of apartheid in South Africa, the downfall of military regimes in Latin America, the opening up of Indo-China, and the Tian-anmen Square student mass action, to name a few in the series. With greater participation in their socio-economic and political life, people's empowerment in the health sector became inevitable. More and more, governmental systems have started to devolve and decentralize.

In the Philippines, the Local Government Code of 1991, a national law, initiated the process of devolution of central political budgetary powers to local government units. Included in the decentralization were the structures in health, social welfare, agriculture, environment and natural resources. The Department of Health (DOH) has been converted from a frontline service organization to a servicer of servicers. Governors and mayors of local government units have taken the helm as health managers. The DOH has repackaged itself with revitalized roles in health policy and health legislation, standards, licensing and regulations, health advocacy and social mobilization, technical assistance to local government units, disaster preparedness and management, and resource mobilization and management

Health Policy Development - **Then and Now**

Before, health policies were designed and developed by just a few decision makers in the Ministry/Department of Health. The policies were made in the major urban areas with little or no consultation with the regions and rural areas. There was minimal inter-sectoral, multi-level and multi-disciplinary participation. Legislation in health was very much formulated and acted upon in the same mold.

International health policies were also initiated by donor countries and large donor organizations. Bilateral health agreements were usually one-sided, favoring the stronger party. World health policy meetings and conferences tended to be dominated by the rich nations.

Today, however, is the era of telecommunications, the information highway, CNN, e-mail, the internet, multimedia technologies, satellite video conferences, cellular phones, text messaging, beepers/pagers, CD-ROMs, computer networking, etc. All these have made the world smaller and have empowered greater masses of people with access to knowledge, information and technology. Coupled with a higher awareness and enlightened consciousness of democratic processes, plus greater motivation to be organized for unified action and mobilization, peoples and nations who felt themselves disenfranchised have now been asserting their rights and voices to be heard and for them to meaningfully participate in policy development and critical thinking. Nor has Health Policy Development escaped these worldwide phenomena. It is high time for health policy makers to involve various forces, personalities,

organizations and communities in the formulation and design of key health decisions.

Areas for Health Policy Development

Health issues have also become more complex, thus the necessity to get other disciplines such as economists, anthropologists, computer wizards, engineers, architects, actuaries, educators, communications and media experts, community organizers, etc. into the act. Consultation would have to be multi-level, starting ith the media experts and community organizers. It would have to begin with grassroots, civil society groups, non-government organizations (NGOs), local governments, academia, the private business sector, national, and international organizations.

The current areas for health policy development are in the realm of health care financing, health insurance systems, health investment planning, health resources mobilization and management; standards, licensing, regulations and quality assurance of public health facilities and procedures; medical ethics, bioethics and biotechnology development; health human resources development; health human rights, and patients' rights; the effects of globalization on health; health informatics, health in media; and even in specific areas like women's health, adolescent health, health of indigenous peoples, health of the differently-abled and health of the elderly.

Health Advocacy-Then and Now

Before, health professionals and health bureaucrats tended to view themselves as technocrats, speaking in scientific and medical jargon. Health scientists vied to write in glossy, highly academic scientific journals whose subscriptions are very expensive, thus circulation is limited. The formal education of physicians did not even include teaching learning communication skills, pedagogy, or mass communications strategies. Health teaching was delegated to health educators. Health information materials were drab, unexciting, and lacking mass appeal.

Now, health communication is changing. Health managers need to be communicative. They have to become comfortable dealing with the press and doing interviews whether on radio or television. Knowledge of the various public multi-media technologies is a must.

The guideline used is 'Will the health message be understood by an ordinary farmer?' or 'Is it easily comprehended by a poor urban woman?' Should there be opportunities to use a catchy phrase or a slogan, then let it be! The end goal is to be able to arouse, motivate

and mobilize the public in actualizing good health.

Areas for Health Advocacy

Health advocacy has a number of priority audiences. While the underserved, the poor and those with little or no access to health education and health services are the top priority, health advocacy should also gear its target to the top decision makers in the country-- the President/Prime Minister and the Cabinet; the Senate/Congress/Parliament officials.

With on-going decentralization, governors, mayors, local city/provincial/ municipal councils, village heads and their councils are also the new audiences for health advocacy. Not to be ignored are the leaders of non-government organizations (NGOs), civil society groups, the private business commercial sector, religious and civic leaders, health science academics and heads of grassroots and people's organizations.

In addressing the communication needs of top decision makers, creative techniques such as one-pagers in glossy, colorful and bullet/capsulized information or a no more than 3- to 5-minute video/story board presentation with crisp, to-the-point messages, are the current state of the art advocacy tools. Always end these with an action point that the top official will decide upon.

For local government executives, distinctive color brochures/pamphlets with provocative titles like "Governor! This is what you can do for the Health of your People" will surely call their attention to give time and priority for health issues and concerns. Mayors and governors take care of a thousand things daily and health managers need to get their commitment to health with a variety of creative and innovative techniques.

With the availability of mass media and health education tools and technologies earlier mentioned, there should no longer be any room for sloppy audiovisuals or printed materials. Health communication materials must always have the high standards of quality and creativity, clarity and simplicity of message, attractiveness and charm to guarantee an imprint and an impact on the awareness, behavior and actions of people.

Implications for Public Health Education

In the light of all these societal changes which affect people's health, public health education must respond by changing the way

health professionals are educated. Public health education programs must now understand and pay more attention to the political and financial aspects of health. Public health education must respond to the needs and demands from the many stakeholders in health policy development. They must interact increasingly with policy, and with the inter-disciplinary community leaders who design and enforce it. Health social science must also play a big role in the public health education curriculum. Included in this are considerations regarding gender-sensitivity, equal opportunities, and religious tolerance.

Classes such as Health Policy Development and Health Advocacy should be included in public health education. Public health experts, health science academics and health managers must develop the value of openness to mass media technologies, the daringness to use creative communication methods, the humility to use the people's everyday language and even the readiness to utilize wit and humor at times. In terms of skills, health managers must further hone their ability for inter-sectoral, multi-disciplinary and multilevel dialogue, coordination and partnership with as many stakeholders in the health field. They need to further advance their critical and analytical skills in the interpretation of the interplay of factors and actors and how all these impact of health policy development also in need of improvement the ability to negotiate, motivate and mobilize people to agree and commit themselves for health actions.

Knowledge-wise, competencies in the following would be valuable: audience analysis and segmentation; structural and systems analysis; environmental analysis; strategic planning and thinking; focus group discussion; qualitative methods of research; the advantages and disadvantages of the latest technologies in communication, computers and media.

Health Leadership and Stewardship

Since health is already marginalized in the list of national priorities, resource allocation and political decision making, health leadership should now be a major course in public health education. Health leaders must be trained to be more assertive and to communicate in an effective manner for their voices to be heard at national and local government levels. Skills in coordination, negotiating governance and stewardship are essential in the development of health leaders.

New Ways of Teaching-Learning-Communicating in Public

Health Education

There are now also new ways of educating and training public health personnel. Seminars, lectures, workshops, and conferences are no longer the sole methods of teaching and training. There should be greater effort in reaching as many public health professional as possible through distance learning methodologies, self-learning modules, self-answering manuals, small group learning or individual learning through videos, audio, and self-instructional learning materials. Master's and doctoral courses may also be offered in a staggered manner. Sub-specialty training courses and apprenticeships should also be encouraged for health policy development and health advocacy.

A further challenge is to develop new evaluation methods to measure the new competencies and new tools in determining the impact of public health education at various levels. These measures must be capable of monitoring and evaluating the changes in actions and behavior, attitudes, knowledge and skills, both qualitatively and quantitatively.

Conclusion

The twenty- first century has arrived, and a new millennium has dawned upon us. Let there also be the birth of a new breed of public health education professionals and workers, equipped with new knowledge, skills and attitudes in health policy development, health advocacy and health leadership learned through a multi-disciplinary and multi-level approach, socially responsible in addressing access, quality, equity and cost effectiveness, that will benefit the poor and the underserved: public health education truly geared to meet the demands and challenges of the new millennium.

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